



*Therapy for the Severe Older
Adolescent and Adult
Stutterer*

A Program for Change

George G. Helliesen

©2006 George G. Helliesen

Printed in the United States of America

Apollo Press, Inc.

270 Enterprise Drive

Newport News, VA 23603

800-683-9713

www.apollopress.com

First Edition

All rights reserved. No part of this book may be used or reproduced or transmitted in any form without permission of the author, except in the case of brief quotations in critical articles or reviews.

PREFACE

Many different therapies for stutterers have been introduced throughout the world since the beginning of time. Some we must acknowledge as having legitimate value and worth in helping the older severe stutterer and some even appear to be “quack” therapy from bygone days. Some quack therapies have continued to persist into the 21st century and are even gaining a second or third popularity.

One therapy has stood the test of time and continues to be used today. Its value remains with us and continues to flourish. This therapy was developed by Dr. Charles Van Riper (2003) of Western Michigan University from 1938 through his retirement in 1976 and well into the printing of the ninth edition of *Speech Correction*, a book he wrote with Dr. Robert Erickson in 1996. The development of this therapy transcends a period of well over forty years.

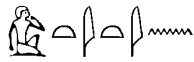
As a severe stutterer since an early age, I was introduced to Van Riperian therapy when I sought help for my own disability and received formal therapy from Dr. Van Riper over several months. Subsequently, I earned two degrees in speech pathology and served in the field as a speech pathologist, college instructor, clinic director and public school special education director for thirty years. All this time I used Dr. Van Riper’s techniques to control my stuttering and maintain good speech. (See my personal story, *Forty Years After Therapy: One Man’s Story*.)

Dr. Van Riper has administered speech therapy to stutterers from all points of the globe and has been very successful and possibly the most successful of all speech pathologists in working with stutterers, especially the older stutterer, in later adolescence through adulthood. He has helped hundreds of stutterers through his teaching of control techniques and sharing his philosophy of maintaining a well-disciplined life. As he once stated in his *Notes on Speech Correction Principles and Methods*, sixth edition, (1978) “Heaven knows, I’m pretty much a free-wheeler in actual therapy. I’ve always had a fairly broad, overall therapy design when I work with a client, but I extemporize a lot. The illustrative experiences that I describe in my text are suggestive, not mandatory. Indeed, I rarely use any standard approach because I can always invent a better, more pertinent one for the special person with whom I’m working. Most good clinicians do the same thing.”

I hope that the professional speech therapist will find value, help, and motivation in providing therapy to the severe stutterer through the use of this manual and the information contained within.

For the purposes of this text I will assume the reader has a basic therapeutic understanding of the person who stutters, including theories regarding the causation and symptomatology of the older severe stutterer, both overt and covert.

This is not a self-help text. I do not believe an older severe stutterer can come out of the swamp of stuttering by him or herself. This person needs a guide, motivator, and a knowledgeable, confident therapist.



INTRODUCTION

This book is written for the practicing clinician or the clinician who has the desire to work with the older adolescent or adult severe stutterer. Many good books have been written for the young stutterer or the child exhibiting an abnormal amount of dysfluencies, but relatively little practical information is available to the clinician about “hands-on therapy” for the older severe stutterer. The pendulum is again swinging back to the twenties, thirties, and forties regarding many of the therapies now being practiced for the above population. Timing mechanisms, both manual and automatic devices, and breathing and relaxation techniques are once again being introduced to the stutterer seeking help. The author believes along with many other speech pathologists, that gadgets, tricks, or other distraction devices are not the most advantageous methods available to stutterers in attempting to control their stuttering.

The Van Riperian method is a “take control and self-responsibility” method for controlling one’s own speech and destiny. Certain techniques are taught to the stutterer for controlling his stuttering, thus allowing him to be an effective communicator, thereby decreasing the negative emotions and symptomatology associated with stuttering. Much dedication and practice is expected from the stutterer in developing the skills needed to master his speech. Being an effective communicator also implies that the listener can receive the verbal communication with little distraction caused by the stutterer’s speech. The therapist’s role is to guide the stutterer out of the “swamp of despair” by being knowledgeable and one whom the stutterer can trust and respect as a partner in therapy. The therapist must also provide motivation to the stutterer, reinforcing those moments of triumph and helping the stutterer analyze speech therapy failures and turn them into successes.

In the initial stage of Van Riperian therapy, the therapist must determine if the stutterer is “motivated” for therapy. That is, is the stutterer mature enough to have a serious attitude toward therapy and is he ready to put forth the effort needed to experience success? Certain techniques help the therapist make a rational and clinical assessment of the stutterer’s readiness for therapy. If the therapist decides the stutterer is an appropriate candidate, the stutterer may be enrolled in therapy, in single or group sessions, or both. The more consistent and constant the therapy, the easier it will be for the stutterer to experience success and gain control of his stuttering.

At the forefront of therapy is the fact that the therapist must manipulate all available factors that will allow both the stutterer and therapist to experience success. The therapist also must be motivated to continue to provide therapy to the stutterer and to work with this very significant and devastating phenomenon. There is no motivation to anyone who fails. We cannot be afraid to fail, but rather use our fear as a learning experience to help foster further continued success.

Van Riperian therapy also focuses on symptomatology. The stutterer, with the help of the therapist, must identify those overt and covert factors and symptomatology that describe all of the characteristics and facets of his stuttering. They must be identified in concrete, observable, and meaningful terms. These become those factors that must be decreased and controlled, to allow the stutterer to have as normal speech and communication as possible. These factors can be placed into two categories: covert feelings or negative emotions that interfere with the stutterer’s ability to understand that he is maintaining stuttering in

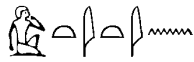
his own speech; and overt, learned factors that are the observable components of his individual stuttering. After these factors are identified they must be changed and controlled to allow the stutterer to approach the speech of the fluent person to the maximum degree possible.

We are not looking for total and complete fluency, because this would be detrimental to the stutterer's success and it is certainly not needed for "successful" communication. Total fluency is not our goal, but rather fluency that will allow the stutterer to communicate effectively and with relative ease and to the degree that satisfies the stutterer, therapist, and listener. For all practical purposes, many stutterers can gain a degree of control where the listener will not be distracted by the stutterer's speech and may not even think of the stutterer as a person with a speech disability. Yet, we want to teach the stutterer to stutter in a way he feels comfortable with and to control his speech to a degree that it does not cause embarrassment and will allow him to communicate effectively in the most stressful and adverse conditions.

Each of the stages of Van Riperian therapy will be discussed in detail within the context of this text. The characteristics of stuttering, such as avoidance and struggle, will be reviewed as they contribute to the maintaining causes of stuttering. These must be dealt with in therapy. Many theories, both old and new, attempt to explain the onset of stuttering. These theories will not be discussed in this text because currently they appear not to have therapeutic value except as effective maintaining causes that may be entirely different from the initial cause or etiology.

After the client's individual stuttering characteristics have been identified, some study must be given to those negative emotions that, according to Van Riper, probably help to maintain the stuttering, such as, penalty, frustration, anxiety, guilt, and hostility. These will all be reduced during the course of therapy. Of course, desensitization therapy occurs continually as therapy proceeds, and this allows the stutterer to look more objectively at his speech as he progresses through the various steps. The stutterer must learn how to vary or modify his old habitual stuttering pattern and how to initiate a more fluent pattern of speaking under various conditions through the use of controls he has practiced and has been taught by his therapist. The final phase of therapy consists of having the stutterer stabilize the controls that work best for him in various situations until they become automatic and he reaches the degree of fluency he desires. Learning to control one's stuttering is like learning to play a musical instrument: practice makes perfect. Without practice, one may lose the skills he has learned, both in controls and in insight.

The author will introduce abbreviated therapy plans into the text to help the therapist see meaningful relationships between rule and practice and to help the therapist organize a meaningful sequence of therapy.



CHAPTER ONE

STUTTERING: A LOOK AT THE PROBLEM

More and more studies are looking at organicity as the primary cause of stuttering while at the same time acknowledging that various causes may be in effect for different individuals who stutter. These include studies being conducted by Dr. Christine Weber-Fox and Dr. Anne Smith of Purdue University (2004), Dr. Ann Foundas (2005) of Tulane University, and Dr. Dennis Drayna (2004) at the National Institute of Deafness and Other Communication Disorders, to name just a few. Dr. Weber-Fox (2004) states, "... stuttering emerges from complex interactions among factors including genetics, language processing, emotional/social aspects, and speech motor control. One important underlying assumption of this model is that these factors may not play the same role in different individuals who stutter and very likely vary in significance over different stages of development." Dr. Smith (2004) says that "Our research found many complex interactions between the language and motor systems, which leads us to believe that there is no single cause for stuttering. Stuttering is the result of a complex interaction among many factors, including genetic, language, motor and emotional." Dr. Foundas (2005) "believes that developmental stuttering is a complex motor speech disorder with a strong genetic link and that different therapies may benefit different biologically specific types of stuttering."

Dr. Foundas (2005) further states that "... it is well established that the dysfluencies observed in individuals who stutter may be reduced under a number of conditions including choral reading and altered auditory feedback." Therapy using delayed auditory feedback (DAF) is a vital part of Van Riperian therapy and enhances the client's oral proprioceptive feedback, which is used in teaching a stutterer to monitor the movement of his speech articulators. This decreases dependency on his auditory feedback, thus helping him maintain appropriate fluency. This greatly helps him change focus from listening to his speech production to feeling the movement of his articulators as he is speaking. This is one of the primary therapy techniques used to help a stutterer maintain control over his stuttering and decrease his dysfluencies. According to Van Riper (1973), "In terms of servo theory, since speech seems to be automatically controlled by feedback and there seems to be some real evidence that some failure in the auditory processing system produces the basic disruptions, we train the stutterer to monitor this speech by emphasizing proprioception thus bypassing to some degree that auditory feedback system." The author had DAF programmed into his therapy in the early 1960s. It is very effective and is still being used after forty years. More will be said about DAF in our discussion of stabilization.

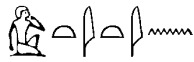
Dr. Drayna (2004) cautions people "not to expect quick cures from his research" and states, "Our goal is to use genetic studies to understand at least some of the underlying causes of stuttering. While not all stuttering is genetic in nature, we look forward to unraveling this part of the puzzle of stuttering, which will hopefully lead to better treatment in the future."

Current research is focusing on organic causes, which is good, while at the same time acknowledging other causes are also at work.

Because of the multiplicity of potential causes of stuttering, we are concerned with the maintaining causes rather than the etiology of stuttering in providing therapy to the older stutterer. The maintaining causes that result in observable overt and covert symptomatology must be identified and controlled if the older stutterer is to exhibit satisfactory speech to both himself and to his listener. These symptoms become his stuttering. Van Riperian therapy directly addresses the loci of his stuttering and provides learning techniques to control it, while decreasing or eliminating those overt feelings or symptoms that help perpetuate the stuttering.

In the initial stages of therapy, certain tenets of the therapy must be studied and examined in detail. The therapist must decide if it is an optimal time or even an appropriate time for the stutterer to begin therapy. The stutterer may have identifiable problems that will not allow success at this time. If it is not an appropriate time to begin therapy and therapy is initiated, several negative consequences may develop for both the client and the therapist. For example, failure in therapy may greatly decrease the stutterer's motivation to again seek therapy and may cause the therapist undue concern for not having the skills necessary to provide "good, solid" or some may say professional, therapy to the stutterer. The therapist must assess the readiness and sincerity of the stutterer to begin therapy at this time. Both the stutterer and the therapist need every possible advantage to succeed in therapy and to develop the best psychological conditions for a successful relationship.

The author believes it is always appropriate to tell the stutterer that the first several meetings are trial sessions to determine if he or she is an appropriate candidate or "ready" for therapy. The first session also provides an opportunity to explain the therapy sequence to the stutterer, and this will help the client and the therapist determine if the program is of interest to him. Hopefully, the stutterer will be able to support the therapy program, but he may not be able to. The program elicits a rediscovery of self, is difficult and requires much hard work. It is not a permanent cure, but rather a means to an end, ### "controlled speech" ### and will have to be used continually to maintain any degree of control, and it may not be pleasant at times. On the other hand, the positive benefits cannot be appreciated until one has gone through the program and experienced success. The benefits are unqualifiedly enormous. They let the advanced stutterer join the human race and experience the benefits of being a member. A few stutterers have been able to gain completely fluent speech.



CHAPTER TWO

HOW SEVERE STUTTERING DEVELOPS

To understand Van Riperian therapy and some of my own beliefs about stuttering therapy, certain tenets concerning the development of stuttering and therapy must be elaborated upon. Dr. Van Riper developed his therapy over fifty years ago, and I have been using his methods and techniques for controlling my own stuttering and in treating other stutterers for over forty years.

Let us look at one of the tenets relevant to this type of therapy. Some children may be predisposed to exhibit excessive dysfluencies during their developmental speech period. This could be caused by many factors, some obvious while others are not so obvious. During this critical developmental period, the child's environment may cause an exorbitant amount of stress. The child may exhibit and develop excessive dysfluencies in reaction to this stress and if this pattern continues unchecked, without environmental adjustments or professional interventions, some children will continue to advance in their degree of stuttering and develop into severe secondary stutterers. Are we saying that some stutterers learn to be dysfluent? Yes!

Some individuals may be predisposed to exhibit dysfluency or other deviant symptomatology because of circumstances not previously understood. These predispositions may have an organically based etiology and/or may be learned through environmental experiences. If a learned factor was involved in the stutterer's development, then stuttering can be unlearned and a more desirable form of speech learned in its place. This new learned form of speech, controlled stuttering, will approximate the speech of the non-stutterer or fluent adult. As stated before, I have used this specific type of therapy in maintaining my own speech and in providing speech therapy to other stutterers.

Not all stutterers want to change their speech behavior. They have fooled themselves into believing they are comfortable with their stuttering and they are very uncomfortable with any degree of fluency. "It's just not them," and they know what to expect when they are not fluent, but don't know what to expect if they are. Many stutterers feel threatened by change and the fear of the unknown greatly decreases their motivation for change. It appears that some stutterers have very sensitive or fragile personalities that react easily to outside stimuli, both positive and negative. Sometimes reactions may be in the form of excessive dysfluent speech or stuttering. As Dr. Van Riper often stated, "stuttering begets stuttering."

The overt "tricks" a stutterer develops to attempt to stop stuttering will probably develop into individual symptomatology or stuttering characteristics. Some of the more common "tricks" a stutterer uses in an attempt to speak are known as "starters." Starters are usually movements of the body or certain words, phrases, or lead-ins that a stutterer uses to try to initiate speech or to avoid stuttering. Some stutterers jerk their heads, swing their arms or even stick their tongues out on certain sounds. I had a friend who stuttered on the [l] and in an attempt to articulate the sound; he would stick his tongue out while trying to produce it. Another student in speech therapy would pucker his lips in an attempt to say certain sounds. My primary characteristic was to bite my tongue. Each body movement helps the stutterer say the word initially, but the novelty stimulus or distraction properties of the starter wear off and eventually no longer help the stutterer say the word. Once these extraneous body movements no longer work, they remain as

part of the stutterer's repertoire of speech habits and they become part of the stuttering symptomatology. A stutterer may have a certain word, such as "see," that he either uses at the beginning of sentences or anywhere in the sentence that he believes will present difficulty. He may say the word "see" several times in a sentence, such as, "See, see, see, what time see, see, see, see, is it?" The word "see" has given him a running start in the past and helped him get through or articulate feared words initially, but when the novelty effect wore off, the characteristics remained.

As stuttering behavior advances in severity, the stutterer uses starters and/or body movements in an attempt to decrease abnormal speech and avoid stuttering. This is why there cannot be a finite definition of stuttering. Van Riper (1963) (1996) states, "Stuttering occurs when the flow of speech is interrupted abnormally by repetitions or prolongations of a sound or syllable or posture or by avoidance or struggle behavior." Stutterers develop many different characteristics in an attempt to hide, eliminate, and sometimes control their stuttering.

A stutterer learns behaviors in an ever-compelling attempt to stop stuttering by either trying to hide it or by creating distractions. He hopes that if he can pretend his stuttering is not there, or if he can get a running jump on a feared word or sound, he can avert the stuttering and its negativity. For example, a stutterer may be having difficulty saying his name, e.g., George. Sometimes he articulates it normally and sometime he stutters on it or cannot say it at all. A block may occur when least expected or when it is expected, it may not occur. If he has a block on the [dʒ] he may, with his mouth open, have a very small head jerk. Which initially allows him to say his name. After using this trick, or starter a few times, he may find that it does not work with such a small jerk and a larger jerk is needed to say his name. Finally the new jerk's novelty stimulus value as a distraction or lead-in device no longer works and it will not allow him to say the word. The stutterer keeps trying and in all likelihood may end up writhing his head in a backward and forward motion, something he cannot easily stop. Thus a secondary characteristic of stuttering is added to his repertoire of behaviors that no longer assist him in saying the word.

The stutterer could take the opposite direction as I did. When I attempted to say my first name and could not, I would clench my teeth and jaw together trying to hide the fact that I stuttered and couldn't say my name. My bite was impressive and the tension in my face was visible, particularly in my cheeks. At the same time I would intermittently add voice to my attempt. Of course this just became part of my total symptomatology. It worked for a while, but gradually the distraction's novelty stimulus value wore off and failed to help me articulate, but remained as part of my stuttering. Sometimes I would place my tongue between my teeth, to keep from biting down so tightly. I thought that if I could feel my teeth bearing down on my tongue, this would alert me to what I was doing. This worked for several years, but I had to continually bite harder in order to release myself from the block. Finally it no longer worked and I continued to bite down on my tongue until it bled. I tried to hide my stuttering as best I knew how in an attempt to talk like a normal person.

A stutterer can develop an infinite number of symptoms in an attempt to avoid and hide stuttering and to speak normally. These characteristics can remain, however, because the stutterer doesn't realize he is using them, for they are too negative to confront and acknowledge. Even if he knows they exist he may be unable to do anything about them. It can be strongly speculated that, in the adult who stutters severely, the maintaining cause may be organic, since constant negative emotions are always present and are continually being regenerated because of the severity of the speech and communication problem. The presence of constant fear, anxiety, frustration, anger, and an abnormally heightened sense of failure and rejection may create a chemical imbalance or physiological changes, which can trigger abnormal neural firings or

dyssynchronization of the speech muscle. This high state of fear also interferes with the stutterer's ability to be rational and objective in speech situations.

When a stutterer is having a severe block, contact with reality as a self-preservation mechanism is lost, just as people lose consciousness to escape severe pain. When some severe stutterers cannot control their own speech, or while attempting to do so, they lose objectivity about their stuttering behavior as well as the behavior and reactions of their listeners. Fear and other negative emotions are so intense that the stutterer cannot focus on the reality of the situation, including his own actions and the reactions of the listener. The automaticity of fluent speech is not present in the stutterer because he has learned otherwise. A severe stutterer can easily spend the majority of his day thinking about his speech and then stutter in his dreams at night. This fear and its consequences cannot be overemphasized. It can both physically and psychologically drain the stutterer, which may make him give up speech attempts and avoid social situations. Many stutterers attempt suicide because of their feelings of isolation and depression.

It takes a lot of effort, both cognitive and physical, on the part of the stutterer to stutter. When trying to speak, when exhibiting severe secondary symptoms during a conversation, and after experiencing intense negative emotions, a stutterer can easily become completely exhausted, both physically and emotionally. After I began to gain some fluency during therapy, I started to experience a new phenomenon during relaxation periods. When I laid down to rest and also before going to sleep, I would experience a slight jerking of my entire body, similar to experiencing a small electrical shock passing through my body. It would happen a couple of times a day and last for only a fraction of a second. Dr. Van Riper and I discussed this several times and theorized that my body had built up so much energy, both mental and physical, to use in an attempt to speak and that it was now unnecessary because of the fluency I had attained. The extra energy that had built up had to be expended and the little jerks were the results of the body purging itself of this energy.

As we begin the discussion of therapy for a severe secondary stutterer, it is appropriate to cite a lecture given by Dr. Van Riper, which is addressed to a new stutterer entering therapy.

TO THE STUTTERER AS HE BEGINS HIS SPEECH THERAPY

Dr. Charles Van Riper

The stutterer, entering the speech clinic for the first time, usually goes through a period of bewilderment and confusion. He usually wants free speech immediately, not realizing that a speech defect, which has been growing for years, cannot be discarded overnight. He is looking for a method of talking without stuttering, which can be applied at once. He often will attempt any trick as the cure-all. He wants someone else to cure him and to do it quickly. All these desires are natural enough but they are doomed to be felt in vain.

THE STUTTERER MUST CONQUER HIS OWN SPEECH PROBLEM. No one else can do the job for him. The speech clinician can show him much, can give him the know-how, the guidance and the opportunity; but only the stutterer can solve his problem and learn to handle his stuttering. It is his responsibility and his alone.

NO ONE ENTERS THERAPY AS A FAILURE BECAUSE THE STUTTERER HAS NOT TRIED THE PROGRAM BEFORE. Many stutterers have little faith in themselves. They have failed so often that they constantly expect to do so again. Their blundering methods of self-help, of following the misguided suggestions of parents, teachers, doctors and friends who knew little about stuttering were doomed to failure from the beginning, but the stutterer does not realize that fact. All he knows is that he has flopped. Many people – friends, family and strangers – have shown by their attitudes that they think he is inferior or weak-willed or to be pitied. Often the stutterer has accepted their beliefs and has built a personality to fit them; sometimes by becoming antagonistic, sometimes by withdrawing. In this clinic, so far as failure is concerned, we are all starting from scratch. There will be a lot of failing throughout the therapy program because no one can succeed immediately in the job of learning or unlearning. But we will have no failures. All of you will succeed to one degree or another. The stutterer who works at the job of unraveling his speech problem, who reacts to a momentary defeat by a new and better approach, is bound to succeed.

THE ONLY WAY TO FAIL HERE IS TO NOT TRY. You say, of course, you'll try! But each year we have one to two stutterers who work harder at failing than at succeeding, who sabotage our effort to help them help themselves, who give up and beg for pity or comfort, who rely on someone else to do the work for them, who sometimes attack us at every turn, who cheat on their assignments, who lie and twist at every turn. These people we dismiss from the clinic, first for a weekend, then, if the same lack of cooperation and initiative persists, for good. We will not compare you with others in achievement. Do not compare yourself with others. We evaluate you in terms of what you yourself have the possibilities of doing. Self-competition is stressed here, not competition with others, whether they be stutterers or non-stutterers. Hoe your own garden!

The speech clinic may, at first, seem a rather cold and barren place in which you are compelled to face the thing you have always hated – your stuttering. But very soon, unless you are careful, it can become a little harbor and haven in which you feel secure and safe, where stuttering is accepted and tolerated and where you will want to limit your open stuttering. Most of your work should be done in real-life situations, in the city itself, in your classes, at your work, on your dates or in your social life. Do not restrict your situations to a few “safe” places, to a few “close” friends or to the clinic. Hunt for challenges, for the difficult situations. Here, we prefer to work on stuttering not by gradually building upward from very easy to the very difficult situations, but by working on it in the everyday situations and under the usual conditions of everyday life. Don't make the clinic an escape from life!

ONE OF OUR MAJOR AIMS HERE IS TO KEEP FROM BECOMING EMOTIONAL AND UPSET OVER OUR STUTTERING. Work toward this goal not only when you stutter but also when you listen to someone else doing it. As you look around you here, you will see that there are other stutterers. Some of them may seem much worse than you and others may have fewer or less peculiar blocks. At first, when they stutter you may feel embarrassed, sorry for them or irritated by them. They may be feeling the same way about you. All of you will get used to each other before long and will learn that you can get a great deal by observing each other. We do not look away when someone stutters. We watch the stutterer and analyze his stutters. You have been a lone wolf in your stuttering long enough. Get acquainted with the others and help them over some of the same rough spots, which you will experience.

ABOUT FAITH. A very few hysterical stutterers seem to be cured by faith alone, at least, temporarily. These rare stutterers have been helped by voodoo, suggestions, by arm swinging, by hocus-

pocus of every sort. We try to avoid this tendency on the part of the stutterer to paint us with absolute faith, hope and charity. We do not save souls. Our feet are full of clay. We have never cured a stutterer. Each person must solve his own speech problem. We know a lot more about stuttering and its treatment than you do – that is why you have come to the clinic. Nevertheless, our treatment for stuttering is still far from perfect and there is much about the disorder we still don't understand. Put your faith in yourselves, not in us. There are no miracles performed here. You earn what you get and you get what you earn!

BEWARE OF FALSE FLUENCY. Every stutterer can speak freely at times but little good it does him when he finds himself stuck in a block. What you need to know is not how to speak freely but what to do when you are in a feared situation or must say a feared word. You need to learn how to communicate with others. You need to know what to do when you get stuck or think you are about to get stuck. Some stutterers avoid their moments of stuttering with every possible bit of ingenuity and energy within their ability. Occasionally, they are temporarily successful but not for long. Murder will come out and so will stuttering. If this is true, then use that ingenuity and energy in a more constructive manner. Let's get the stuttering out in the open where we can attack and destroy it rather than ducking and dodging our way through a fluent world. At first, you may apparently seem to be getting worse as you give up your tricks of avoidance. That, oddly enough, is a good clinical sign. You came here to work on your stuttering, then why not have some to work with, to learn to handle. We have never succeeded with stutterers who manage by hook or crook to keep from stuttering in the clinic or on their assignments.

There are many methods for treating stuttering and many theories about its cause and nature. Why, then, do we use the methods we do? Simply because, to date, they seem to be the best ones available. Since you came to this clinic, we assume you want what we have to give. We don't feel that these methods are infallible. There are too many failures to account for. But you can be assured of our honesty and interest in your success! We'll do our utmost and we expect you to do the same. How long will it take? We don't know you well enough to answer that. What are the chances of your success? We don't know you well enough to answer that. All we do know is that a good share of our stutterers gets good speech and that they earn it.

THE THERAPY. Our basic aim is to teach you how to stutter, and without obvious abnormality, in a way which does not interrupt the flow of your speech. If you can do this, it should solve your speech difficulty. It should eliminate your fears, both of speaking situations and of difficult words. Free speech, then, is the by-product rather than the goal of our therapy. We want to teach you how to stutter so quickly, effortlessly and unnoticeably that your stuttering will be no problem whatsoever. You probably have observed before that no two stutterers stutter in exactly the same way. Is there still another way in which no abnormality is evident? We hope to show you!

It would be pleasant for all of us if this goal could be achieved instantly but our experience shows us that it cannot. You have been stuttering in your present fashion too long. You have created and developed strong fears, habits and attitudes that cannot be erased so easily. First of all, we must weaken the old reactions, the long practiced form of stuttering, which you know, you possess. Right now your stuttering is automatic, almost involuntary. You have little control either of your speech or of your emotions. Therefore, we must proceed up a long ladder of goals each of which takes you closer to the conquest of our speech defect.

Here is the ladder, beginning with the bottom rung:

1. You must understand the over-all plan of treatment.
2. You must, for the time being, be willing to stutter openly and with as little embarrassment as possible.
3. You must acquire the ability to keep good eye contact with your listener throughout your moment of stuttering.
4. You must stop avoiding feared words and feared speech situations.
5. You must stop postponing, retrials and half-hearted speech attempts.
6. You must be able to analyze your own stuttering in terms of its varying symptoms.
7. You must learn to cancel. This refers to a technique wherein you go right through your old block, then pause and study the block you have just had and, then, try the word again in a different way.
8. You must master the principle of negative practice. By this we mean that you must be able to duplicate or initiate at will each typical sample of your own stuttering.
9. You must learn how to pull out of your old blocks voluntarily, to get them under voluntary control before completing the word you are stuttering on.
10. You must learn how to use a preparatory set, to prepare for the speech attempt on feared words so they can be spoken without interruption.
11. You must learn how to build barriers against disturbing influences.
12. You must learn how to fill much of your speech with voluntary loose movements.
13. You must learn how to reinforce your new fluency each day.

Does this sound like an impossible achievement? If it does, it should help to convince you that a real effort is required on your part, that no half-measures are going to be successful. Actually, if we climb but one rung of the ladder at a time, it should not be too difficult.

Most stutterers, peculiarly enough, are pessimistic perfectionists. They demand perfection. They demand perfection of themselves and yet do not expect it. We of the speech clinic neither demand nor expect perfection. For example, in the second goal mentioned above we ask the stutterer to be willing for the time being, but not forever, to stutter openly and without embarrassment. This may strike you as an impossible task. But we are realistic. We do not demand of you that you do this on all words or in all situations or all at once. We ask, during this period of therapy, that you collect a good many experiences in which you achieve this goal. We will help you to do so by providing the opportunities and the methods. Indeed, your mastery of self-control during stuttering will grow throughout the therapy program.

As you go to a new goal, you will not throw away the control you have previously acquired. You will constantly reinforce it and add additional experiences to fortify it. Let's learn one thing at a time as best as we can and work for its complete mastery later.

So far, we have outlined the speech therapy. Along with it, there will be other work done with you as an individual. Most stutterers have old wounds that ache and which need opening up and draining if they are ever to heal. Some stutterers have many strong emotional feelings about their stuttering and about themselves as stutterers. These attitudes and feelings stem from past experiences, which they continue to remember and relive with each present experience. Many of the conferences you will have may be devoted to exploring these experiences and their emotional conflicts and toward their solutions. Old resistances may interfere but, here, you may find the counseling service you have long desired.

Finally, we try to help the stutterer become social beings. Some of you are already secure in this area. You date or have wives or have many friends. But others of you need to develop confidence in yourselves and an acceptance of others for this socialization. We shall help you to make these adjustments so far as we are able.

(From information distributed by Dr. Van Riper in class)

Much valuable information is provided in this handout from Dr. Van Riper. It has great importance for therapy and clarifies many topics that are only discussed briefly in this text. Therefore, it is recommended that the therapist review the handout several times and outline the main points, as this will be a great asset in the development of therapy plans.



CHAPTER THREE

INITIAL SESSIONS

During one of the first sessions, the therapist must discuss the tenets of therapy and the experiences the stutterer must undergo in order to have positive results in therapy. These are reported by Dr. Van Riper (1964) in the WMU *Journal of Speech Therapy*.

1. *That the therapist is competent and can be trusted.*
2. *That the stutterer is responsible for his own behavior – including the stuttering that he does.*
3. *That he can deliberately endure touch and study his stuttering.*
4. *That avoidance of speech attempts increases fear and therefore stuttering.*
5. *That his struggling, hurried escape reactions and recoil make the stuttering worse than it needs be, and tends to make it persist.*
6. *That he can learn to attempt to utter his feared words in a more and more normal fashion.*
7. *That he can release himself voluntarily from tremors, fixations and oscillations.*
8. *That when he stutters he can observe what he is doing and he can erase its evil effects significantly.*
9. *That by monitoring his normal speech he can reduce his stuttering.*
10. *That telling himself or feeling that he is going to stutter can be resisted and that he can control his stuttering.*
11. *That he can build barriers to listener reactions that are unfavorable.*
12. *That he can reduce his feelings of ambivalence, anxiety, guilt and hostility, thereby decreasing his dysfluencies.*
13. *That self-confidence and self-respect can be increased.*
14. *That he is rewarded by other persons for confronting and working with his stuttering problem.*
15. *That it is more rewarding and easier to speak more normally than to stutter.*
16. *That when he does nothing to interfere with his speaking he speaks better.*

Suggestions for Therapy I

Examples for the Initial Sessions of Therapy

Objective 1

Help the client understand how each tenet as outlined by Van Riper will affect his therapy program.

Activity 1

Discuss through examples and reflection how the tenet develops the therapy program and the role it plays in therapy.

Objective 2

Motivate the client trust in the therapist.

Activity 1

Share with the client your willingness and desire to work with him/her. Share successes, and perhaps failures in working with others who stutter. Share with the client your previous study and knowledge of stuttering.

Objective 3

Help the client understand how avoidance of speech attempts increases fear and therefore stuttering.

Activity 1

Give specific examples relevant to the client's life and check for understanding.

Objective 4

Help the client understand how monitoring his speech through proper proprioceptive, tactual and kinesthetic feedback will increase fluency.

Activity 1

Use servo theory and explain the difference between suspected non-stutterer's feedback and stutterer's feedback and how this may be changed to help stutterers gain and maintain fluency.

Objective 5

Help the client understand that he can alter his feared words in a more normal fashion or with less stuttering.

Activity 1

Have the client change the stuttering characteristics of one word the therapist stutters on and one word he stutters on. This can be done through decreasing the length of the block and/or imitating a different type of block. Many more activities need to be developed in this area.

Objective 6

Help the stutterer realize that when he does nothing to interfere with his speaking, he speaks better.

Activity 1

Imitate for the client severe versus mild stuttering on the same passage and discuss the communicative success of each and the specifics that contribute to the overall reception, both auditorily and psychologically, for each example.

Several activities should be developed to help the stutterer understand the tenets used in therapy. A thorough understanding with practice is not currently necessary, but will be discussed in detail later. It will be very motivational to discuss the tenets of therapy with the client, since this is new information,

not previously considered by the stutterer. The discussion will provide hope and motivation to the stutterer.

There are a few good therapy programs available to stutterers and many different types of stutterers with different overt and covert symptoms and therapy needs. The therapy described herein is primarily Van Riperian therapy, which worked well for the author. Many others have also been helped with this type of therapy. It is suggested that the therapist do some trial therapy with the stutterer during the first sessions to determine the stutterer's readiness for therapy. The therapist is assessing the stutterer's ability to make habitual changes in both his speech and thought processes and psychological set as they relate to his stuttering.

As Dr. Sheldon H. Gottlieb (2004) states in his summary of change theories, "To make a positive change in behavior, according to theories, people must want to make a change, have the ability to make the change, believe that their life will improve if they make the change, believe that the change is 'right for them,' and learn how and when to make changes." This is definitely true for the older severe stutterer. To control stuttering for the sake of exhibiting more normal fluency, thereby improving quality of life through learning and using control techniques, and acquiring a more positive self-attitude will lead to a positive change in speech and communication and ultimately in quality of life.

Trial therapy allows the therapist to decide the suitability for this type of therapy and the probability that the client will experience success. Is the client ready for therapy at this stage of his/her life?

Beginning with the first session, trial therapy should be assessed, using the following procedures and activities.

1. Tell the stutterer you are going to stutter in different ways and that you want him or her to imitate you. This can be done at both the sound and word level and with short sentences. It should also be done with and without the stutterer's secondary symptoms. You can create secondary symptoms other than those habitually used by the stutterer. Four to five different types of stuttering will give you a good indication of the stutterer's ability to change his old habitual patterns. The tasks can be very simple. You are assessing the stutterer's ability to change the old established pattern. If he can make a change in his own speech, just a little, it indicates that he wants to change his speech pattern and may be willing to work hard to do so. It also shows the stutterer that he can somewhat control his speech by changing his type of stuttering and that his stuttering is not some evil mystical entity over which he has no control. Initially you may have to lead in the change or do so in unison with the stutterer to help him exhibit a different pattern of stuttering. BE CREATIVE IN YOUR APPROACH TO ALL THERAPY. It is not that difficult, and the more YOU can CREATE, the more enjoyment you will receive out of working with the stutterer. A therapist's ability to create and implement therapy ideas at the right time is the key to success in therapy and it can be very exciting!
 2. Modify the stutterer's block so that you have a different type of release; smooth and easy is a good one. Ask the stutterer to imitate you. Use a sound or word on which the stutterer has had a severe block.
 3. Have the stutterer watch himself in a mirror while he is having a block and ask him to identify his secondary symptoms. Secondary symptoms are usually those actions that the stutterer exhibits other than feelings and emotions. They are the main components of his stuttering. If it is too difficult for the stutterer to observe himself and it might very well be, the therapist may have to begin this diagnostic procedure by imitating a severe block exhibited by the stutterer or by
-

creating a severe fake block unlike that of the stutterer. Have the stutterer acknowledge the presence of some of the secondary symptoms by identifying and describing them.

4. The stutterer and therapist can read in unison. The therapist can interject dysfluencies of different types and ask the stutterer to resist the urge to stutter when the therapist exhibits the dysfluencies. This is very interesting to observe.
5. Ask the stutterer how important it is for him to have therapy at this time. Why does he want better speech?
6. Watch out for insincerity, inappropriate answers, and the lack of genuine desire on the stutterer's part to want to work on his speech for improvement. Remember, you don't want either yourself or your client to fail in therapy.
7. Briefly describe the goal of therapy to the stutterer, which is speech controlled to the degree that it does not interfere with communication and that both he and the listener feel comfortable with.

Towards the end of the session or shortly thereafter, the therapist, with the stutterer's help, must decide if the stutterer is an appropriate candidate for therapy at this time. Discuss the reasons for any decision you make. If his readiness is questionable, you must ask, "Can he be motivated to begin with a high probability of success or should he be considered for therapy at a later time?" If the therapist believes the stutterer will experience success, an outline of therapy should be provided and further sessions scheduled. The outline should be discussed with the stutterer and this, in turn will provide him with additional motivation and direction.

The therapy outline does not have to be discussed in great detail at this time. The client needs to know when therapy will start, who his therapist will be, frequency of therapy, and more importantly his role in therapy. This includes therapy expectations and therapy protocol, such as how and when to contact his therapist if he is unable to come and how long he must wait if his therapist is not immediately available. My therapist was once late, and I left the clinic, looking for any excuse to get out of therapy for the day. During the next session, the therapist chastised me for not waiting the entire therapy session for him and informed me to never let it happen again. The therapist made a definite impression on me.

THOUGHTS FOR THE THERAPIST

Some of the questions the therapist must be able to answer for himself are:

1. What characteristics does the stutterer exhibit that lead you to believe he will be a successful candidate for therapy at this time?
 2. What does "successful candidate" mean to you?
 3. What are some of the consequences, both negative and positive, of having the stutterer in therapy if he is not ready for therapy at this time?
 4. What are some of the pitfalls to be aware of in administering therapy to a stutterer when the client and therapist are of the opposite sex?
 5. If the above scenario develops, how would you handle it in a professional way?
 6. Would the candidate for therapy have better success in a program other than Van Riper's?
-

Two of the most utilized scales to rate stuttering as identified by Guitar (1999) are the *Stutterer's Self Rating of Reactions to Speech Situations* (Darely and Spriesterback, 1978) and the *Modified Erickson Scale of Communication Attitudes*, (Andrew and Cutler, 1974 and Erickson, 1969)

A SUGGESTED OUTLINE OF THERAPY

1. Explain the tenets of therapy to the potential client.
 2. Assess the client's readiness for trial therapy. Discuss results with client.
 3. Inform the client of rules, protocol, and expectations of therapy.
 4. Discuss the therapy outline with client.
 5. Have stutterer develop a stuttering profile of his own speech.
 6. Begin to identify characteristics of stutterer's dysfluent speech pattern, including overt and covert symptomatology.
 7. Identify and study negative emotions, penalties, frustrations, anxiety, guilt, and hesitations that contribute to and help maintain the stutterer's dysfluencies.
 8. Identify situation and communicative fears that help to perpetuate and maintain the client's stuttering.
 9. Identify the relationships between the importance of communication at any specific time and the degree of dysfluency experienced by the stutterer.
 10. Have the stutterer be able to identify a complete repertoire of both his covert and overt symptoms.
 11. Discuss the overall goals of therapy and the controlled speech that the stutterer should expect to achieve.
 12. Have the stutterer experience the ability to control his dysfluencies by varying the utterance of his own speech.
 13. Discuss, practice, and learn the control techniques that will help the stutterer speak in a more fluent controlled manner.
 - a) cancellations
 - b) pull-outs
 - c) preparatory sets
 14. Discuss the importance of faking one's own type of stuttering or a variation.
 15. Discuss the importance of learning to monitor one's own speech by
-

- using proprioceptive feedback of the articulators.
16. Discuss the concept of false fluency and the negative and positive benefits of the phenomenon.
 17. Develop therapy plans to help the stutterer stabilize his newly learned control, using a hierarchy of developmental experiences from therapist-developed therapy to completely client-developed therapy.
 18. Discuss resistive-type therapy.
 19. Discuss relapses and how to rebound and get control of one's speech.

These are the main concepts in Van-Riperian type therapy. The stutterer is taught to manage and reduce unnecessary stress, which will allow him to more easily control his speech. The stutterer is taught how to use certain controls that will decrease his stuttering and eventually how to “monitor” his speech through paying attention to the movement of his articulators, therefore being able to intentionally control their movement on an almost unconscious level. The stutterer learns to stutter in an easier fashion that may be only perceptible to himself or a very acute therapist. Quality of life improves to the degree that the stutterer can join the “human race,” maybe for the first time, and become a productive member of society. Because of the severity of the disability, a severe stutterer will not be able to accomplish these tasks by himself, but only under the guidance and direction of a knowledgeable and dedicated speech therapist.

There may also be history, social, speech, and developmental questionnaires and other pertinent forms that need to be completed. The client can take the questionnaires home and complete them as homework assignments. You need to know a lot of information about the person in order to establish an appropriate and good rapport for successful therapy and to develop the individual therapy plans. The following questions are the type used in a speech sociological and may be answered either orally or in written form as a homework assignment. Therapy plans can easily be developed around the questions and answers.

The stutterer will have many homework assignments and he needs to be introduced to them early in his therapy. It is also reinforcing and motivating to the stutterer to get down to business as soon as possible. Always ask the stutterer to describe in detail answers to the following types of questions.

- a. What do you mean when you say you stutter? Can you tell me about it? Can you show me? (The therapist may want to provide assistance with the answers.)
 - b. Does your speech ever hinder or stop you from participating in social events?
 - c. Did you ever want to do something or go somewhere but avoided the experience or situation because you felt that your speech held you back?
 - d. When did you first notice stuttering in your speech?
 - e. What do you think initially caused your stuttering? Is the same cause currently maintaining your stuttering or is the cause different now?
 - f. Why are you seeking help at this time?
-

- g. Do you have any idea when you are just about to stutter? (Believe it or not, the therapist may have to explain some characteristics of stuttering to the stutterer because his feelings may be so intense regarding his speech that he cannot bare to confront and acknowledge them. Therefore, he doesn't know they exist.)
 - h. Are there any special times or speaking situations in which you feel you do not stutter or that your stuttering is reduced?
 - i. What increases your stuttering and why?
 - j. Do you have any "tricks" you use to help stop or shorten a block? If so, what are they and can you demonstrate a couple. The therapist may have to demonstrate "starters."
 - k. Do you avoid speaking situations? If so, have the stutterer explain them to you.
 - l. Does your stuttering increase or decrease when you sing? Why do you think this happens?
 - m. Are you stuttering a lot now or not very much? Why do you think so?
 - n. Do you have any feared words that you almost always stutter on?
 - o. Do you have any "starter " words that help you begin talking? For example "uh," "well," etc.
 - p. Do you have any secondary characteristics, such as closing your eyes, head jerks or fixations that you use to help you speak? If so, can you please demonstrate? (The therapist may have to give an example of either secondary characteristics that the stutterer uses or one that he doesn't use.)
 - q. Do you use the telephone very often? When you get a phone call do you answer with hello or some other phrase? What are some of the negative experiences you have had on the phone?
 - r. When you're alone do you like to read, talk to yourself, or talk to pets? Do you stutter in these situations?
 - s. Do you stutter in your dreams?
 - t. When do you stutter the most and the least? Tell why in your opinion.
 - u. Have you had any therapy before coming to our clinic? If so, describe. How do you feel about it?
 - v. Who have you talked to about your stuttering? How did they react and what did they say?
 - w. If you didn't stutter, what would you do that you don't do now because of your speech?
 - x. Have you ever met another stutterer? If so, describe your reactions and
-

feelings to the situation.

- y. What do you think your future might be like if you keep stuttering?
- z. Among your immediate family members, who do you stutter the most with and the least with? Why do you think you stutter in different degrees with different people?
- aa. If you had to rate yourself on a stuttering scale from 1 to 10, with 10 being the most severe, how would you rate your stuttering?
- bb. Do you desire therapy as it has been explained to you? Why? What other difficult tasks in your life have you succeeded in and are proud to have accomplished? Are you willing to work hard on your speech?
- cc. How will a decrease in stuttering or an increase in fluency change your life?

Questions of this nature are very helpful to both the therapist and the client. The therapist will gain valuable information regarding the stutterer and how he feels about himself, his speech, and his ability to work on his speech. It also introduces new concepts, definitions, techniques, and insights to the stutterer regarding his own speech and widens his view of the individual components of his stuttering phenomenon.

If, in your opinion, the stutterer is not ready for therapy, either because he is too immature or has a more advanced personality problem, one which you do not feel qualified to treat, you need to be very honest with him and share your thoughts. He will respect you for being honest and his response may lead you to change your opinion about his readiness. You may need to ask him to return home and think about your discussion, and perhaps at a later date he may be more ready to pursue therapy. This should be related in a non-threatening manner, conducive to encouraging him to return. Again, you do not want to set the stage for failure.



CHAPTER FOUR

BEGINNING THERAPY

The speech of a severe stutterer is so negative and unbearable, some stutterers even say evil that it is far too offensive for them to observe or even acknowledge. We maintain our premise that a learned behavior can be unlearned and more appropriate behavior can be learned to replace the old undesirable behavior, stuttering. Even if the current stuttering is maintained, partially by organic factors, it seems that new speech behavior can replace the old.

Since a stutterer's speech is unbearably negative, too hot to handle, some stutterers almost devoid themselves of their stuttering at the time of a block, to the degree that they are in a trance while blocking, and have no idea of their behavior or the characteristics of their stuttering. If this behavior is to be changed, it first must be identified and analyzed. A stutterer needs real blocks and opportunities to learn controls so that he can perfect them.

As we go through the process, you can see that a stutterer's stuttering is like a phobia. The more it is acknowledged, studied, reviewed, and analyzed, the less hot it becomes and the more objective the stutterer can become regarding his own speech. How do we get a stutterer to analyze his own speech pattern and identify those characteristics that comprise his symptomatology? There are many ways.

Initially, the therapist must determine the degree that the avoidance behavior controls the stutterer and his ability to acknowledge his own speech patterns. Most stutterers, but not all, cannot acknowledge the specifics of their own stuttering characteristics. Some severe stutterers just cannot bear to look at their own speech, but may be able to examine the speech of others.

Before beginning any task, always explain to the stutterer the goal of the assignment or task. If the stutterer does not believe it to be a valid, necessary, and worthwhile experience, he may refuse to participate or be dishonest in his participation.

Tell the stutterer that you are going to imitate some unusual speech patterns and you want him to either tell you or write down what he sees and hears. Initially imitate some stuttering patterns unlike his and have him identify the components. You may have to help him at first. You also must learn to imitate his blocks in all of their minute factors, so you know exactly what he does when he stutters and how it should be changed.

At some point in therapy, tell him he needs to teach you how he stutters, so you can learn his particular pattern, to better understand overt and covert symptoms when he blocks or tries to say a word that gives him difficulty. How can you, the clinician, or the stutterer know what to unlearn if you cannot identify what has been learned? You can imitate his type of block, beginning with only a few characteristics at first, and ask him to again help you identify his characteristics. You need not even tell him at this time that these are his characteristics. Add more and more characteristics as he can identify those presented.

After the stutterer acknowledges that he may exhibit some of the characteristics the two of you are discussing, he can begin to observe those characteristics that make up his stuttering. This is a giant step for some stutterers and very exciting for them. They are, for the very first time, acknowledging, with interest, their own stuttering and its many facets. It may even become fascinating to study the evil they have been avoiding and running away from for so many years. Now that the stutterer is beginning to approach his stuttering, it can be analyzed and changed. Great therapeutic value is inherent in this process. Both learning and desensitization are taking place.

There are simple tools available to help the stutterer learn all that he can about his dysfluent speech and its characteristics. A cassette or CD recorder helps the stutterer learn and acknowledge the auditory components of his stuttering. Being videotaped during stuttering is a very simple and valuable tool, which will help him see the visual components. After he can do this successfully, using a mirror presents a shorter stimulus for the stutterer and makes the identification of the stuttering pattern more difficult for him, because the stimulus is of such short duration. He can also feel his speech musculature and identify constrictions or tension in the face, neck, limbs, and other areas of the body. Next, the stutterer should seek feedback from others and ask for their observations regarding his stuttering.

Severe stutterers often develop tremors. This occurs when the stutterer is in a block and is exerting so much pressure, generally with the speech articulators, that a tremor develops in the muscles involved in producing the sound or word. The lips or jaw muscles shake because of the pressure, but generally the stutterer is unaware of this tension. Pushing down hard on a hard surface with one's fingers can easily experience a tremor. If you do it hard enough, you will set up a tremor in your finger. This is the same way a stutterer develops a tremor with the speech muscles when he is having a block. With a therapist's help (each stutterer will need a different degree of assistance), all facets and aspects of the stutterer's characteristics must be identified.

Activities for these objectives are very easy to develop and the amount of time on task depends on the individual need of the stutterer.

Suggestions for Therapy II

Examples for Identifying Stuttering Characteristics

Objective 1

The stutterer will stutter openly.

Activity 1

In reading or speaking, identify words that the client will stutter on and the type of dysfluency he will exhibit. Set goals for the number and duration of stuttering behaviors that the stutterer will exhibit. The therapist can do this first, and then the stutterer.

Objective 2

The stutterer will speak, read, or verbalize without avoiding feared words or sounds after they have been identified.

Activity 1

Help the stutterer identify words or sounds in a reading passage that he believes he will stutter on. Verify through reading a passage or some verbal exercise. This may need to be recorded at first.

Objective 3

The stutterer will identify specific words or sounds that he will most likely stutter on.

Activity 1

These can be underlined in a passage and then the stutterer will read the passage, maybe silently at first and then orally. He and the therapist can both verify the expected difficulty.

Objective 4

Have the stutterer identify any specific overt symptoms that either precede a block or develop during the block.

Activity 1

The therapist will initially exhibit and identify. Next, the stutterer will need to observe himself on video or in a mirror and record overt symptomatology.

Objective 5

Have the stutterer identify the intensity of a block.

Activity 1

The therapist develops a simple severity rating scale from 1 to 10 and the stutterer notes the intensity of his block verbally, auditorily, and kinesthetically on the scale.

As the stutterer gains proficiency in this phase of therapy, introduce additional stressors, such as an audience, one person, two people, etc. Create!

The stutterer must also be able to identify his feelings and the feelings of others that are associated with his stuttering. He must understand how these feelings help cause and maintain his stuttering and how they can and will be changed during therapy. This extremely important part of therapy may in itself decrease his stuttering. By decreasing some of the fear of trying to hide his stuttering, the stutterer is developing an objective attitude about his speech and is able to take responsibility for it. In addition, he has a friend, maybe the first, who is taking a sincere interest in him and wants to help him with his most dreaded problem. Most importantly, he is seeking out or approaching his stuttering for the first time for objective and positive reasons.

Emotions can be very intense and powerful in a stutterer. They are all learned from past experiences. Negative emotions can completely disrupt a stutterer's ability to be rational, coherent, and in control of his speech or even to realize how severely he is stuttering. They can overpower a stutterer so intensely that he can go into a self-imposed hypnotic trance to avoid experiencing them. Again, this behavior is self-reinforcing and self-perpetuating. The more severe the stuttering, the more difficult it is for the stutterer to be objective about his own stuttering because of the interference from his heightened emotions.

Dr. Van Riper (1972) has identified several factors that can cause stuttering to increase when experienced in excess. These include several emotions or feelings, such as, guilt, anxiety, hostility, communicative stress, and penalties experienced by the stutterer. More specific examples are:

Guilt caused by lying, cheating, stealing, dishonesty, and procrastination, etc.

Anxiety caused by fear, unknown consequences of future actions, unknown outcomes or circumstances, etc.

Hostility caused by inability to communicate, being treated unfairly in speaking situations, etc.

Communication stress caused by a disrespectful listener, the degree of importance of the conversation, demand put upon the stutterer, etc.

Penalties include the lack of communication, isolation, limited or absent social interaction.

When any of these emotions are too intense for a stutterer, they place undue psychological strain or worry on him/her that can easily contribute to an increase in dysfluency. The therapist need not have extensive counseling skills, but only the ability to help the stutterer identify those feelings or factors that are intense enough to cause an increase in stuttering behavior. For example, if a stutterer fears a speaking situation because he knows his stuttering will increase, is his fear reality based or is he placing an unsubstantiated expectation on himself? When these feelings are identified in specific detail, it can be determined if they are justified or not. Some may be, others will not. When reality is confronted and fiction is separated from fact, the stutterer can acknowledge that his expectations and observations may be incorrect or unrealistic and a decrease in stuttering will occur. This will become a life-long process.

If too much fluency appears too fast as the above therapy progresses, this may be a danger sign, something Dr. Van Riper called “false fluency,” which develops as negative emotions decrease through the identification process. Feelings associated with years of stuttering also decrease along with the abnormal personality characteristics that were learned over the years, as ways to avoid speaking and stuttering. The development of some fluency is always good, for it motivates the stutterer to continue in therapy. Too much fluency, too soon, is not controlled fluency, because the stutterer is not using the controls he will eventually need to maintain fluency in the prominently fluent world. The increased fluency is the result of decreased stress. New stressors can easily cause a stutterer to lose all speech fluency and revert back to his old stuttering pattern when he has no tools to deal with the stuttering. Also, a stutterer needs real blocks and opportunities to learn controls so that he can perfect them.

This happened to me, and my dysfluent behaviors began to decrease too rapidly. I was doing the opposite of everything I had ever done or thought of in regard to my stuttering and because of this my stuttering behaviors began to decrease too quickly. False fluency can be handled in several appropriate ways, e.g., by creating enough stress to cause dysfluencies or by faking the old type of block and practicing controls in speaking situations. Some refer to faking a block as “negative practice.”

In addition to identifying physical characteristics of my stuttering, I had to identify sounds, words, situations, and persons that were fearful and that triggered the stuttering. These stimuli caused negative

emotions and memories that were so traumatic; they set the stage for dysfluency. These same stimuli caused me to be dysfluent while talking to animals and inanimate objects, such as a chair in my parents' house that brought back old negative memories or a tree in the yard. I even stuttered in my dreams. My thoughts became ones of disconnected language and considerable dysfluency. Of course, my speaking experiences with most people were very negative. These triggered a fear of speaking that resulted in either an avoidance of the entire speaking situation or severe stuttering. When I encountered an old memory that had negative speech consequences, the memory would create such a fear of speaking because of the past experience and the learning that took place that I expected to stutter.

Remember, “stuttering begets stuttering.” A stutterer needs to fulfill his expectation to stutter and he feels somewhat secure when he stutters because he has fulfilled his expectation. There is comfort in fulfilling an expectation, even though it may have negative consequences. The stuttering itself has been learned because the stutterer was once rewarded for its use ### it allowed him to communicate. No matter how inappropriate his speech was, it allowed him to either avoid the speaking situation or attempt some communication. Either way, he was rewarded for exhibiting some of his stuttering behavior. When the behavior no longer has new stimulus properties, such as distraction, and no longer releases the stutterer from his block, it is not abandoned, but is added to the overall stuttering characteristics, or it increases in magnitude.

Avoidance becomes a large part of the stutterer's symptomatology. If, when walking down the street, I saw someone approaching whom I may have needed to speak to, rather than just nod my head or make some other meaningful gesture, I would cross the street to avoid any speech or turn around and go back the same way I came, avoiding the situation altogether. In high school I would drop a class if the teacher stated there would be considerable oral work.

According to Dr. Van Riper in *Speech Correction* (1996) “... when stuttering develops into its final stage, little hope can be held that it will be outgrown or disappear. Even when the environment is changed so that it is permissive and free from fluency disrupters, the person continues to stutter. A few individuals are able to escape even after they enter this stage only because their morale is powerfully strengthened through other achievements. But usually, once fear and frustration, avoidance and escape, have shown themselves, the disorder becomes self-perpetuating. There are several vicious circles, or rather spirals that characterize the confirmed stutterer. The more he fears, the more he avoids certain words or situations, and with each avoidance his fears increase. Also, the more he struggles as he tries to escape from his communicative frustration, the more guilt he feels. Once caught in this trap ### or whirlpool ### stuttering seems to be able to maintain and to perpetuate itself with a tenacity that normal speakers find difficult to understand. Nevertheless, competent speech pathologists can do much to alleviate the difficulties of even the most severe stutterer and enable him to become reasonably fluent.”

Below is a typical speech assignment given to me during my therapy with Dr. Van Riper, which also includes my responses.

March 26, 1964

Assignment: What is your average morale? And why?

Response: It was pretty good today! When I awoke this morning, I felt like I really wanted to put a good day's work in on my speech.

Assignment: Describe your dominant emotions of the day.

Response: My dominant emotions were those of worry, fear, and anxiety. Wondering what my speech would be like over spring vacation caused these. I have been invited to spend the time with a friend and this will present a new situation with new stressors.

Assignment: Rate yourself as to the overall amount of the following reactions experienced.

Response:

GUILT ### Very little

HOSTILITY ### Very little

FEAR ### I worry too much about the reaction of others. Fear seems to come and go. I cannot predict it.

Assignment: Describe the situation in which you exhibited the most severe stuttering. Did the people or the situation remind you of the past?

Response: The situation in which I had my most severe stuttering occurred while I was sitting at a table in the student union and talking to a couple of people in speech therapy. Stuttering was infrequent, but intense when it did occur. This situation did not remind me of the past. (Now that I think about the situation, it probably did remind me of the past.)

Assignment: Describe your dominant speech problems during an hour. Which were most frequent during the day?

Response: My dominant speech problem appeared to be chopped up speech. My thoughts were not fluent, nor was my speech. This seemed to be true for both an intense hour of observation and for the entire day.

Assignment: List the people or situations with which you were completely fluent.

Response: None. (I do not believe this to be a valid response. Probably I could not make an objective analysis of the people I talked to or of the situations I spoke in. A stutterer always exhibits some fluency and I am sure I did also.)

Assignment: Describe the worst block of the day – how you felt before, during, and after.

Response: The worst block of the day was a two- or three-second fixation or prolongation. Before the block I was tired and sleepy. During the block I realized that I must hold onto it and attempt to control it by having a smooth release. It was so painful that it appears that I lost contact with the outside world. After the block I was wide-awake and I wondered why in the hell I didn't do a better job in attempting to control it.

Assignment: Rate yourself on fluency for the entire day. Give an illustration.

Response: I had quite a few large and small blocks today, but I was able to control the majority of them. I worked on each block and did a fairly good job, but some were more intense than others.

Assignment: Which speech situation pleased you the most and why?

Response: I was talking to a friend about pipes and different pipe tobaccos during the early evening while sitting in my dorm room. He seemed to be very interested and I had pretty good speech with few blocks.

Assignment: Report the situations in which you did the following successfully.

Response:

- a. Cancelled carefully. While calling home and while talking to a fellow student in a gym class.
 - b. Pulled out of a block slowly and strongly after smoothing out the tremor. Sitting in the Union with fellow students, while calling home,
-

talking to a student in the dorm, talking in organic class, and in therapy.

c. Got set for a feared word and handled it appropriately. Sitting in the Union with fellow students, while calling home, talking to a student in the dorm, talking in organic class, and in therapy. (It appears to be the same as the above.)

Assignment: Fake one of your old types of blocks in a feared situation. Describe the situation, the word and practice a type of speech control in the situation while remaining calm. Report the word you had the fake on and the control used. How did the fake and control affect the rest of the situation?

Response: When I called home I faked a block on the number two while talking to the operator. It was not a feared word. I went back and cancelled the fake block until I said it in a fluent manner. The speech work had no bearing on the rest of the conversation, although I had some anxiety about the reaction of the operator, even though I could not see her.

Assignment: Describe nucleus situations in which you worked on your speech and what control seems to help you the most?

Response: Many of the nuclei situations are occurring in and around the dorm. All controls help greatly, but it appears that proprioceptive monitoring helps the most. I will try and use this type of kinesthetic feedback as well as bone conduction feedback intensively over the holidays.

Assignment: Report a stressful speech situation which you deliberately entered into and that you had previously feared. Plan your speech assignment out beforehand.

Response: I carried this out in my Organic class. Mr. D had marked some questions wrong, which I thought were correct. Instead of just trying to get Mr. D to see my side, I wanted the class to become involved in the discussion, thinking I would have a better chance of convincing Mr. D that my answers were correct, if the class would agree with me. I thought very carefully what I would say and it worked. He accepted my answers as correct. (I don't remember anything about my speech in this assignment.)

Assignment: Check the following if you used them to work on your speech since the last time we met.

a. Tape recorded phone calls, conversations, oral reading, paraphrasing, and recitations.

Response: All checked as being done.

b. Free verbal association aloud to self, proprioceptive reading

Response: Yes. (This is good to do for many reasons, but mainly to increase fluency.)

c. Verbalization of emotions to others.

Response: Yes. (To get the good, the bad, and the ugly out so that you study how they affect your speech.)

d. Worked out on delayed feedback machine.

Response: Yes. (This machine helps the stutterer increase and pay attention to his kinesthetic and proprioceptive feedback, which will increase his fluency.)

e. Practiced shouting while talking.

Response: Yes. (This helps to increase fluency.)

f. Anything else you used?

Response: No.

Assignment: How else do you think you have made progress?

Response: I have had a lot of controlled and fluent stuttering, more so than in the past.

This was a rather intense, long, and thorough assignment and it summarized what had been studied for a week. It would have been completed on the weekend and discussed on Monday either in individual or group therapy with Dr. Van Riper or with my student therapists.

THOUGHTS FOR THE THERAPIST

1. Study each of the above assignments and responses. What therapeutic value do you see in each assignment? Think about each of the author's responses. Were they appropriate? Do you think the author received the therapeutic value intended from each assignment? Do you believe any of the author's responses were fake and that he did not actually carry out the assignment? Stutterers can be very conniving individuals and you have to be skeptical, empathic, motivating, and very observant, all at the same time.
2. Develop three different assignments in each of the four following areas: help a stutterer identify the components of his stuttering ### auditory, situational, physical, and communicative. Always be creative.
3. Assign and/or help your client develop a form with all of the necessary components to record the above.
4. You must learn to stutter exactly like your client. Why and how?
5. Why does your client need to be desensitized to his fears, both situational and communicative?
6. How do you help your client begin to be desensitized to his speech?

Develop several exercises to help your client begin this process.

Suggestions for Therapy III ***Examples of Identification Therapy***

Objective 1

The stutterer will be able to identify changes in his speech and the speech of others.

Activity 1

The therapist educates the stutterer very simply as to the overt characteristics of several different types of stuttering.

Activity 2

The therapist reads a passage and informally verbalizes while interjecting dysfluent speech, such as repetitions and prolongations. The stutterer must respond, by a method chosen by the therapist, when the dysfluencies occur and describe the characteristics of the dysfluency.

Activity 3

The stutterer reads a passage and signals either when he thinks he is going to stutter and/or when he actually has a block. The therapist records both his and the stutterer's assessment and compares the two.

Activity 4

The therapist exhibits overt symptoms other than dysfluent verbalization and has the stutterer identify, such as abnormal physical features.

Activity 5

The stutterer carries out a similar activity as the therapist's in Activity 4.

Activities for these objectives are very easy to develop. Their duration depends on the individual need of the client.

As noted several times, a stutterer needs to be desensitized to both situational fears and communicative stress. Situational fears must be identified and studied to understand the specific circumstances that elicit or trigger the fear. They should also be ranked in a hierarchy, ranging from the least stressful to the most stressful. The stutterer should work on the least feared situation first and progress to the most feared situations. This allows the stutterer to experience success more easily and quickly; with more reinforcement and motivational value than if the more severe stressful situations are studied first.

After identifying the situational fears and factors, the stutterer needs to analyze the information in terms of its reality. Do the facts really develop into circumstances that warrant the stutterer's fear that the stutterer is experiencing? Generally they do not, and the stutterer, through objective study and analysis, can come to realize he is creating a lot of unnecessary fear. At first the therapist must take a lead role in this analysis and help the stutterer talk through and report on his observations.

Once the stutterer can objectively identify situational fears, he and the therapist can create further desensitization by developing similar feared situations, entering into them and reporting on them as objectively as possible. Both client and therapist should describe their own observations in writing and compare them for an objective analysis. One way desensitization occurs is by testing reality and looking at all possible hypotheses regarding the cause of the fear. As the stutterer progresses in therapy and experiences success using speech controls in feared situations,

desensitization will occur more rapidly.

The well-being of the stutterer, both physical and psychological, can cause dysfluent speech. All stutterers develop generalized sound and word fears. As an example, if a stutterer had a great fear of the [s] (the author is a prime example), he would try and say a word that began with [s], and he would become fixated on the [s], so that he could not articulate the rest of the word. He would just continue to produce an [s] until he ran out of air. Sometimes he would have to take a second and third breath and continue to produce the [s] in an attempt to say the word. If he could articulate an [s], which happened infrequently, he might become fixated on the next sound. Sometimes he would exhibit a secondary symptom in an attempt to say the word. Generally it did not work, but when it did and the stutterer said the word, the secondary characteristic would be reinforced, because he believed it helped him articulate the word. It may have briefly distracted the stutterer from the fear and allowed him to say the word.

Some stutterers have a large vocabulary because they have learned many words to substitute for their feared words: words that begin with their feared sounds or have the feared sounds embedded within them. Some stutterers have many feared sounds. You may see a stutterer stop in the middle of his sentence, not stuttering, but searching for a substitute for a word that is coming in his sentence that he is afraid to try and believes he cannot say. A stutterer's radar is continually scanning ahead, looking for feared words that he believes he will have difficulty saying. Generally a stutterer cannot or will not substitute his name and this is why the typical stutterer stutters when saying his name. I substituted a

fictitious name, “Steve Stroller,” for my own name on many occasions. In some way that I can’t explain, I could say Steve Stroller perfectly when I could not say my own name, and the [s] was my most feared sound. This worked rather well when I had a fear of saying my own name.

Communicative stress, which may be covert in nature, is dealt with through the same study and analysis as situational fears. Communicative stress appears to be more prevalent than situational fears and may generate more negative emotion, which greatly increases the probability of dysfluent speech. By identifying the stutterer’s fears and stresses, their intensity will change as the stutterer progresses through therapy. It is important to identify the stutterer’s most intense fears and stresses so that they can be used all through therapy as areas needing attention and work. Identification initiates desensitization and possibly some stuttering that can be used in further therapy work. Both the stutterer and the therapist should keep verbal and written logs for future reference and to compare therapy assignments and their results. The more fears and stress factors identified, the more areas the stutterer can work on, and the more all-inclusive will be his therapy. Much more information on situational fears and communicative stress could be added, but time does not allow. Nevertheless, these two areas are very important in helping the stutterer control his speech.

THOUGHTS FOR THE THERAPIST

1. List five different areas of feared situations for your client and their causes. Are the causes valid or not? Watch out!
2. List five different types of communicative stress and situational fears for your client. Be as specific and detailed as possible.
3. Choose one example from each of the above and trace its development. Be very thorough.
4. Outline a program to help a stutterer identify his specific fears for both situational and communicative stresses.
5. Outline a program to help the stutterer become desensitized to the fear identified above. You may wish to solicit the stutterer’s input from which he will gain insight. This will be desensitizing in itself.

Several factors relating to situational fears and communicative stress affect the stutterer’s degree of dysfluency or his expected dysfluency. Some of these factors include importance of the situation or communication, past negative experience in similar situations, proficiency in using his controls, negative emotions experienced just before or during verbal communication, to name just a few. Again, all types of communicative stress and situational fears must be identified by the therapist and the stutterer and reviewed from a reality base. The stutterer must be desensitized to the effects of these stressors, and this will greatly increase his ability to control his speech.

Suggestions for Therapy IV

Examples of Identifying Negative Emotions and Stressors

Objective 1

Have the stutterer identify those feelings of guilt that affect his speech, their importance, and relative reality base.

Activity 1

The therapist can define guilt and give examples in his own life that affect himself or people in general.

Activity 2

Verbalize the consequences.

Activity 3

Help the client identify guilt factors in his life that may affect speech.

Activity 4

Develop an intensity scale and have the stutterer place identified situations on the scale.

Activity 5

Discuss the reality base of the circumstances and situations identified. If there is a reality base, how can the situation be changed to decrease the circumstances that develop the guilt?

Objective 2

Have the stutterer identify and rate situations or circumstances that cause unnecessary communication stress.

Activity 1

Identify, discuss, and note intensity. Examples that can cause communication stress include such situations as talking to the opposite sex or to superiors, using the telephone, and ordering in a restaurant. Again, be specific in describing the situation and its rate of intensity. Discuss the reality of the stress and if it is substantiated, discuss how to decrease the intensity. If the cause of the stress cannot be identified, why not?

The more important the communication, the greater the stress experienced by the stutterer and the greater the dysfluency that may appear. Desensitization will occur when stress is identified and analyzed. This will also allow you to decrease those factors that cause stress.

Earlier we discussed “false fluency,” when a stutterer’s dysfluency decreases too rapidly. This is undesirable because the stutterer did not earn his new fluency and if he does become too fluent too quickly, he will not have the dysfluency necessary to practice his newly learned controls. This false fluency results from the stutterer’s tremendous release from fears he developed in his effort to avoid speaking situations. The fear generated by the need to talk, the attempt to speak, and the inability to communicate will result in severe stuttering and all of its manifestations.

When the avoidance pattern changes, the stutterer begins to analyze his stuttering problem objectively. It may become very fascinating to him as it did to the author. As this occurs, the stutterer experiences a great psychological relief, which leads to different degrees of fluency. The stutterer may for the first time begin to approach his speech instead of avoiding its negative ramifications. Generally this fluency is of short duration, maybe only several months, and may cause a loss of motivation to the stutterer because he does not understand what is happening. If the false fluency is not understood and dealt with, the stutterer will return to his old pattern with possibly more severity than before, because of an overly zealous effort to maintain this new fluency.

In my case, as I analyzed my stuttering problem, it was such a relief to do the exact opposite with my speech than I had done for the majority of my life, that fluency came quickly. As with almost everything in

life, the fluency was both good and bad. It showed me what fluency tasted like and it was good, but it also didn't give me much of an opportunity to work on my speech using the controls I had to learn.

To allow a learning opportunity to work, the stutterer and therapist must use a technique called "faking," which provides the stutterer with a model of his old habitual stuttering pattern while giving him time to learn, and perfect, and stabilize his controls in various situations. Through analysis of the stutterer's blocks, both the stutterer and therapist should be able to imitate a typical block of the "old" type. When this can be done, a fake block occurs.

The therapist must be able to imitate a block that occurs with each stutterer that he/she works with. The therapist must know what happens during a block so that the stutterer can be helped to know and identify exactly what he is doing and how to make a change. The stutterer should learn to imitate his own block; in effect, to fake a block. This includes implementing those components of his block in a controlled fashion and on purpose.

When the stutterer can fake one of his own blocks on cue from himself or others, he has developed a very important tool that can be used in his therapy. For one, these fakes can replace some of the false fluency that has developed and still give him an opportunity to practice newly learned speech controls and other techniques. When a stutterer can fake his severe blocks in the presence of others, and maintain control, he is controlling his speech and his speech is not controlling him. He is exhibiting, on purpose, this dreaded and evil phenomenon called stuttering that he runs from.

This had an extremely positive psychological effect for me, when I realized for the first time that I had control over my speech. It has great therapeutic importance since it desensitizes the stutterer to the real world, to himself and to others. It is like making a deposit into a savings account. The more deposits, or fakes, the stutterer makes the more he will have in reserve when he really needs good fluency. In other words, as the stutterer accumulates the fakes, the negative emotions caused by stuttering decrease, which helps fluency to be maintained.

The stutterer can also have some fun with faking, sometimes known as negative practice, that he has not had before. At some point, he may want to provide some very severe fakes to certain listeners, just to retaliate for the many years the listeners have provided negative reactions to his blocks. The stutterer is making the listener feel uncomfortable by exhibiting fake stuttering, which he is controlling. This is not intended to be a sadistic event. Faking is such a powerful tool that some therapies for stutterers consisted primarily of teaching the stutterer to learn to fake his habitual speech pattern. Many assignments can be developed around faking and it can be a very useful tool. When a stutterer fakes a block, he is making several statements.

"Watch me people, I can stutter and I'm not afraid of it."

"I still stutter and it is o.k."

"I don't need perfect speech, and it gives me an opportunity to work on the techniques that I am learning to control my stuttering."

During my own therapy, I would be given an assignment to exhibit fifty fake blocks during the day, collect and record the word and other characteristics of the block, and turn the information in to my therapist. I

would do five hundred instead of fifty. Look at all the deposits I made for a rainy day when I would need good fluency and less interference from my emotions! I knew I could control my speech in an emergency.

Faking is also a great tension- or stress-reducer. Stuttering on purpose desensitizes the stutterer by reducing the fear of uncontrolled stuttering. The stutterer can also use faking in therapy to analyze the reactions of others and to identify his own strengths and weaknesses regarding his speech. The therapist must always learn to fake the client's complete stuttering pattern.

Therapists must also be desensitized to the listener's reactions, to help the stutterer in therapy. They must learn exactly what the stutterer is doing, and is experiencing, and feeling when he blocks. It makes for a better therapist if he experiences the client's many facets and emotions.

Learning to fake stuttering also has negative implications for the stutterer. The therapist must learn to know when the stutterer begins to feel too comfortable with this pattern of speech; this feeling of safety could limit further progress in speech therapy. The stutterer may say, "It's good enough." As Dr. Bryng Bryngelson (1960) once stated about the positive benefits of faking:

1. It is something over which you have control and is, therefore healthier than your old way of stuttering.
2. It is another way of bringing stuttering out into the open and talking about it.
3. It lessens your fears, because the need for covering up stuttering has been done away with.
4. It does away with forcing and other tricks you have learned to use to cover up stuttering.
5. It relieves strain and tension which comes from trying to cover up stuttering.
6. It is by practicing a thing; one becomes able to control it.

He further stated some important rules in using voluntary stuttering or faking:

1. If it turns real, the failure, so-called, must be cancelled by re-attempt.
 2. It must be done any place and everywhere.
 3. You must not be ashamed of it, because it is much healthier than your old uncontrolled way of stuttering and it is, therefore, a step toward changing your habit patterns of stuttering.
 4. It must be done according to a pattern you decided on before starting. This pattern should be changed frequently.
 5. It is wise to use it when you prefer to have free speech.
 6. If it is easier to fake in a situation than to attempt controlled stuttering, it is advisable not to fake.
-

As noted earlier, there is, for the stutterer, a feeling of safety and security in stuttering. Even though it is a burden and a curse at times, it is a known entity he has learned to live with. Faking can turn into a real block very easily, more so during the beginning of its use and less so as the stutterer progresses through therapy. This also has positive and negative benefits.

If a fake does turn into a real block, it provides the stutterer an opportunity to work on his speech and practice the controls he has learned to release himself from the block and control his speech. But he may not be able to use this to his benefit. He may not be able to control the fake if it turns into a real block and this may be too negative, decreasing his motivation to continue to work on his speech.

A stutterer can learn to fake a block that does not exhibit the majority of his particular characteristics. Blocks can consist of repetitions, prolongations and an infinite array of overt symptoms. These types of faking may be necessary at first for some stutterers because they appear easier to imitate. Therapists must have their radar on at all times to analyze the true benefits the stutterer appears to be receiving from all aspects of therapy. Many things can happen when they are least expected. Yet, most stutterers are “tough old birds” and can take a lot of criticism as long as it is positive and constructive.

Dr. Van Riper had some interesting comments about “stuttering openly”:

Even more revealing than the presenting symptoms is the general behavior of the stutterer when, in the course of speech therapy, he begins to display and to manipulate and modify his stuttering reactions. As in psychoanalysis, where there occurs strong initial resistance to the method of free association as demanded by the analyst, so too there is usually found a similar resistance to free uninhibited stuttering as demanded by the speech therapist. As the case finds his stuttering offerings accepted permissibly by the therapist without penalty but with interest, a transference relationship comes into being as it does in analysis. With this supportive relationship existing and in part due to the presence of similar reinforcement from the other members of the group receiving therapy, the stutterer begins to get interested in his stuttering as revelatory of self. He begins to assign himself large cathartic doses of real and pseudo-stuttering. As his tolerance of himself as a stutterer increases, he begins to use the therapist and other members of the group as parental or sibling figures and a process very similar to abreaction takes place. At this stage the stuttering becomes much more frequent and severe. Much emotional heat is generated and discharged upon the therapist, the other stutterers receiving group therapy, and upon certain innocent auditors in the world outside the speech clinic. A good amount of reality testing takes place. Since the basis of the therapeutic method is the collection by the stutterer of a certain quota of stuttering in self-chosen speaking situations each day as a vehicle for the exploration, understanding, and control of self, the choice of auditors becomes of great significance. Instead of conjuring up a father image verbally on the psychiatrist's couch; the case finds a flesh-and-blood yet symbolic one in the traffic policeman on the corner. With him he can interact. He can confront his anxieties, his compulsions, and defenses in his moment of stuttering and recount these to the therapist in his report, or the therapist can be with him at the time to observe, protect, and occasionally to interpret. If he finds the situation too threatening, he has the perfect right to retreat, providing he attempts to understand why he must do so. Even as the analyst and later the case learn much from trains of thought which become blocked, refused, or diverted into safer channels, so the therapist and stutterer achieve much insight from these experiences. Active analysis, such as that in which graded tasks performed by the patient during treatment contribute much to insight, gives us some precedent for using this type of symptomatic therapy in the interest of self-understanding.

In any psychotherapy, there is a need not only to understand one's impulses toward socially reprehensible behavior, but an equally important need to assess the self-punitive aspects of our beings. How stutterers feel about their moments of stuttering can reveal much about how they feel about themselves. At any rate,

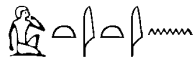
a marked change in attitude occurs during the early stages of therapy both toward self and toward stuttering. Most cases magnify and exaggerate the penalties they have received and those they expect to receive. As they try to achieve the goal of stuttering openly and freely they tend to whittle their blown-up superegos down to size. They find that the less they punish themselves, the less punishment they receive from others. The permissiveness of the therapist transfers to permissiveness in the case and this attitude in turn transfers to many of his auditors. By actively displaying their free stuttering in communicative situations, much reality testing is accomplished in this area as well. **(From information distributed by Dr. Van Riper in class)**

We have concluded a review of the symptomatology and characteristics of stuttering and have discussed therapy that initially requires the stutterer to analyze, observe, and record his own behavior. At the same time the stutterer is being desensitized to the adversities of his dysfluency. The identifying and desensitizing will occur throughout life or until a cure is found for organicity, which will allow the stutterer to completely stop stuttering. Only after desensitization has occurred can the stutterer put his hand in the fire and touch his stuttering without getting burned.

The next phase of therapy consists of teaching the stutterer how to use certain controls. These will allow him to control his stuttering so it does not interfere with his ability to communicate or with the listener's ability to receive the communication. Several therapeutic controls will be explained, including cancellations, pull-outs, preparatory sets, kinesthetic monitoring, and resisting, which will help the stutterer to greatly decrease his stuttering and increase fluency. Remember, we do not want to teach the stutterer to try and stop stuttering, because this is too stressful and will just increase his stuttering.

Cancellations, pull-outs, and preparatory sets are techniques that allow a severe stutterer to begin to control his speech, thereby reducing his stuttering behaviors, and begin to articulate words in a more normal fashion, canceling out old speech patterns and learning new ones. The techniques also demonstrate to a stutterer that he can control his speech and do something about his stuttering. He is not at its mercy and is not out of control, but rather he is purposely making a change.

As we begin to study the processes involved in Van Riperian therapy, we must never fear the unknown, for therein lies the secret of success through self-discovery for both therapist and client. Remember, be creative!



CHAPTER FIVE

CANCELLATIONS

When a stutterer cancels a block, he simply has a block on a word and cancels out the block by articulating the word again, but this time in a more normal fashion. By now he should have the ability to analyze his blocks and know precisely what he did when he stuttered. By knowing in detail what he did when he stuttered on a particular word or sound, he should be able to begin to reformulate the articulation or phonation of the word or sound more normally by using new articulation opposite or different from what he did when he stuttered on the word. Stuttering has been so negative to the stutterer in the past that he has not been able to do this.

Cancellation may also consist of eliminating secondary characteristics that are part of a stutterer's overall symptomatology. If he jerks his head, swings an arm or sticks his tongue out in an attempt to articulate a word, these movements will be eliminated or changed when he attempts to say the word a second time, third time, fourth time, or whatever the goal requires.

When I said my first name, "George," I would press my lower teeth against my upper teeth and bite down with great tension, usually until a tremor developed from the intense pressure. Also, my tongue would be caught between my teeth, lips pressed together tightly and no sound was generated. This attempt to say my name did not allow for the articulation of the word, resulting in a severe block, which generally created great anxiety and all of the negative emotions and consequences that occur when a stutterer stutters. I had to learn to say my name without clamping my teeth together, without putting my tongue between my teeth and pressing my lips tightly together, and by generating some type of sound while approximating the correct articulation. This becomes very interesting to both the stutterer and the therapist. How do we make these changes? What did I need to do differently to say the word?

With my ability to analyze and identify what I was doing when I stuttered, and with my therapist's assistance in learning what I had to do differently to say the word in a more fluent fashion, I began to say my name in a controlled manner, canceling out the old stuttering pattern. I had to cancel some words ten or fifteen times just to make subtle changes toward more fluent speech. Now you can see why it is important for the therapist to learn the stuttering pattern of the stutterer, to help make the change from the old speech pattern to a new and better speech pattern.

The learning that occurs from cancellations may appear slow at first, but as the stutterer gains proficiency through trial and error, the learning rate increases rapidly. Once this technique benefits the stutterer, interest in it grows. This new control technique fascinates him, so he will cancel more and begin to control his speech more and more. The result is more fluency. The cancellation technique becomes self-perpetuating. After many attempts to say the word in a more controlled and fluent manner without much success, cancellations may become discouraging to some stutterers. Any progress at all ### decreasing secondary symptoms or controlling some of the primary speech symptoms ### should be pointed out to the stutterer as significant steps in the right direction. The therapist should continually emphasize that the stutterer's goal is not to eliminate his stuttering completely, but rather to become more proficient in using the tools to control his stuttering, to the degree that he is comfortable with his speech, and to the degree

that his speech does not impair the listener's ability to receive the communication. Use all of the self-help tools and appropriate technology available to help the stutterer control his stuttering.

When I was having therapy forty years ago, the main tools available were a mirror, an old-style reel-to-reel tape recorder, a delayed feedback machine, and, of course, my therapist and other listeners whom I could use with my speech assignments. Even though they were simple, they were enough to allow me to learn to control my stuttering.

The therapist may have to help the stutterer learn to generate sound on command so that he is not caught in a silent block where there is supposed to be sound. My name, George, sets the stage for a block on the first sound in the word because of a partial fixation pattern in the articulation of the [dʒ]. I had to learn not to press the tongue up tight against the palate, but instead have loose contact with my tongue against the roof of my mouth, so I could produce a small flow of air when I wanted to say the [dʒ]. I found it a great help when attempting to articulate a word to consciously expel a slight amount of air between the articulators on words where I had previously shut off the airflow. I found it extremely difficult to have a fixation type block while I expelled a good stream of air when producing certain words or sounds. A conscious production of expelled air, not a breath, but more of a controlled release for sound production, helped me significantly in controlling my speech and articulating words and sounds more fluently. This may not be the articulation pattern of the non-stutterer, but it approaches the speech of a non-stutterer and gives the stutterer some control over sounds that otherwise may develop into a severe block.

Using the lower jaw as a “prime mover” in articulating speech assisted me greatly in controlling my stuttering. By this we mean, when appropriate in speech production, the stutterer should make a highly conscious effort to drop his lower jaw to help him initiate speech production. The jaw is called the prime mover because its movement is used in the majority of sound productions. It is difficult for a stutterer to have a block if his articulators are in motion. It is somewhat easy for the stutterer to learn to raise and lower his mandible with an exaggerated movement, if necessary to assist in speech production. It will not become a secondary symptom and will be discussed later as the basis of a self-monitoring technique that greatly enhances fluency through one of the primary controls a stutterer will learn. A stutterer should do this as a conscious effort only when it is appropriate or when it is in the normal articulation sequence in the production of a word or sound being worked on in the cancellation phase of therapy.

Like all phases of therapy, cancellations of old learned stuttering patterns by newly learned controlled speech is a continuous learning process. The more cancellations I did, the easier and more automatic they became, and the result was more controlled, fluent speech. Of course cancellations cannot be done on every single word, or can they? For every assignment that I was given, I generally tripled my efforts, thereby learning more, learning quickly, and making a lot more deposits in my bank account for future fluency needs. I saw great value in Van Riperian therapy for myself and I wanted to experience it to its fullest.

THOUGHTS FOR THE THERAPIST

1. How would you teach a stutterer to attempt to cancel out his block on words that started with the [s] when his block consisted of a prolongation of the [s] sound? Think about the next sound in the word.
2. When a stutterer has a block he squeezes his eyes shut and auditorily blocks out all sound. Why did he choose the above two symptoms? How do you teach him to cancel out the secondary characteristics of his stuttering?
3. A stutterer has learned some of the technique of cancellation. Develop an assignment for him to practice cancellation techniques in six different situations. He must record all facets and results of the exercise for you. Should you, his therapist, be his first “guinea pig” and does he need an observer to help him in the remaining assignments? You decide.

Van Riper discusses cancellations in much more detail when he states,

This consists of coming to a complete halt after the stuttered word has been finally uttered, pausing a moment and then attempting to say the word again with even less struggle and avoidance. The case is not to try to say the word without stuttering. Even when the fear and threat is gone and he knows he can say it without having any symptoms, he deliberately does some pseudo-stuttering which should not be a facsimile of the original symptom, but represent a modification of them in the direction of normal nonfluency.

The pause in the cancellation is used for scrutinizing the symptoms and feelings during the preceding block in light of his newly found insight into self. In the pause the case also evaluates his preceding behavior in terms of its adjustive pertinence to efficient communication. For example, he may say to himself, “that was a silly reaction; trying to utter the word, business, with my mouth wide open. Can’t be done. Why did I just give up?” During the interim between the original stuttering and the new canceling attempt, the stutterer finds himself altering his sets and making plans for the subsequent modification of symptoms.

From the point of view of psychotherapy, what have we in this canceling technique? First of all we have provided an opportunity of self-confrontation and evaluation. We have also prevented the repression that usually takes immediately after a moment of stuttering. Most stutterers verbally flee the site of the crime. They distract themselves. They try to avoid contemplating their fiascos. Much of the self-reinforcing value in stuttering is due to this immediate repression of auditor hostility or self-revulsion. The pause and new attempt are valuable in yet another way; by deliberately interrupting the communicative process they allow the stutterer to test his independence of auditor penalty and his own strength. In effect, he says to the world, ‘Behold! I stutter, but I am working with it, trying to conquer it. If this bothers you, I’m sorry, but I’ve a job to do.’ It also gives the stutterer an opportunity for discovering his new potentialities for controlling his emotions and behavior. It enables him to test the reality of his evaluation.

From the point of view of learning theory, cancellation has three advantages. It takes advantage of the moment of reaction inhibition, the point in time at which the old stuttering response is weakest. It interferes with the self-reinforcing tendency of stuttering symptoms to terminate the fear. It increases the strength of the approach factor in the approach-avoidance conflict. It facilitates discrimination of the phonetic and other cues. It provides a substitute response which society in general rewards. (People generally approve of an individual who shows evidence of wrestling with his problem.) Finally, it provides

a symbolic goal. The stutterer realizes that a form of stuttering similar to that, which is demonstrated in the cancellation, would be tolerable to both himself and other people. It demonstrates to the stutterer that it might be possible to stutter in another way, that he might be able to stutter and still communicate, that stuttering need not be catastrophic. When such reassurance comes from one's own behavior rather than from the verbalizations of the therapist, it is an extremely potent force in psychotherapy.

Let us point out again the parallel between this “symptomatic technique” and what happens in psychoanalysis. In the latter, as a result of the intensive exploration of self, there comes a stage in which the victim of a compulsion, such as the urge to scrub the hands fiercely, has gained considerable insight into the origins and dynamics of this behavior, yet finds himself still doing it as soon as certain cues appear. In any specific instance, however, it is only after hand washing has taken place that he can analyze and understand why he did what he did, and what else he might have done under the same circumstances. In a very real sense he is doing the same thing our cases are doing when they cancel. **(From information distributed by Dr. Van Riper in class)**

Suggestions for Therapy V

Examples of Cancellation Therapy

Objective 1

The client will cancel twenty words or sounds that he stutters on and change their production to a more fluent articulation.

Activity 1

The therapist discusses and demonstrates a cancellation for the client.

Activity 2

Through reading and videotaping, have the stutterer identify several words or sounds on which the stuttering characteristics are easily identifiable.

Activity 3

Discuss and list the specific stuttering characteristics. Identify the characteristics in minute detail.

Activity 4

Identify and list changes that are required to articulate the sound or word in a more controlled, fluent manner.

Activity 5

Have the stutterer attempt to articulate the sound or word using the changes, which the client and therapist have identified.

Activity 6

Continue this activity until changes have been assimilated and cancellation occurs without stuttering or a specific goal has been met. Practice canceling words in isolation in a short sentence. Initially practice only on one word in a sentence.

Objective 2

Have the client begin to keep a log on cancellation activities.

Activity 1

The stutterer will keep a log that includes the following components for each word/sound cancelled:

- a. Therapist or self designed activity?
 - b. Word cancelled?
 - c. Changes made to word in the cancellation process?
 - d. Successfully cancelled or not? Why?
 - e. Number of attempts on each word or sound?
 - f. Person talking to?
 - g. Place cancellation occurred?
 - h. Did learning occur?
 - i. Overall assessment of the therapy activity.
-



CHAPTER SIX

PULL-OUTS

The next control to be taught is called a “pull-out.” It is a little more difficult for the stutterer to utilize and a little more sophisticated than fake stuttering or cancellations. It is more advanced in the hierarchy of controls, possibly because it occurs instantaneously and the stutterer must be able to react on a moment’s notice. When a stutterer fakes a block, he has lots of time, as he does when he cancels a block, which is attempting to say the word again in a more fluent manner. In those situations, he has all the time he needs, but not so when a pullout is used.

Digressing for a moment, I used to fake blocks until the listener couldn’t bear it anymore and he would give up and walk away. When this happened, I knew I was controlling him with my speech and that he was not making me dance to his tune by showing rejection and pity on me because of a disability. I could say it was fun to do this, but that would probably be sadistic.

Some people, and I generally agree, say I am a perfectionist. This was certainly demonstrated in my work on my speech when I used cancellations. Sometimes I would cancel a word thirty times or until I believed I had said it to the degree that I was satisfied with its production and it sounded and felt good, both auditorily and kinesthetically, to me. Sometimes the listener would walk away out of frustration because I was monopolizing the speaking situation by saying the same word over and over. Crazy? Hopefully not! For several reasons, I wanted to say the word correctly and have control, before I continued on in the communication.

First and foremost, I wanted to establish a fluent pattern of the word, both auditorily and kinesthetically, because I had neither. My memory banks stored information only on the dysfluent production of words. I knew I needed to learn a fluent production and I had to learn this as the opportunity occurred. How better to learn this than to say the word and change its production until I said it in a more fluent manner and I was satisfied with its production. I would often practice on those words I had collected through the day, by myself, with a friend or with my therapist. I even did so while laying in bed at night before I went to sleep. I often dreamed that I was working on my speech. This is a good indication that speech therapy is becoming meaningful to the stutterer because it shows that the stutterer is working on his speech at a subconscious level.

In addition, I wanted to control the speech situation, which was a new joy for me. Instead of running away from the speech situation, I approached it with enthusiasm and the determination that I was going to win at all costs and come out with a smile on my face. My way of saying, “I got you, you bastard!”

Our goal is for all of the stutterer’s controls to become automatic so he uses them effortlessly and at the right time. When this happens, the stutterer is well on his way to becoming a fluent speaker with controlled stuttering.

A stutterer pulls out of a block as the block is occurring. The working time for a pull-out is of much shorter duration than faking or using a cancellation and this makes it a much more difficult procedure. Once this control is perfected, the stutterer is much closer to fluent speech. An example of this technique occurs in articulating my last name, Helliesen.

As we know, the [h] is silent and has no sound except that of the air being expelled. The second sound in the word is the vowel [ɛ]. Therefore, when I had a block on my last name generally there would be no exhalation for the [h], nor was a sound generated and articulated for the [ɛ]. I might have attempted to say the word with my mouth open and lips apart slightly or I might have used my old pattern of clenching my teeth. No sound was generated in either type of block.

In a pull-out, the stutterer holds the block and begins to identify, through analysis, what keeps him from saying the word. I would identify the lack of airflow, the lack of any sound for the vowel and the lack of movement by the mandible for the production of the word or any sounds in the word. This identification took place instantaneously. After identifying those factors that did not allow me to say the word, I would attempt to implement a change by doing the exact opposite. In this example, I would begin a small exhaled stream of air for the [h], then purposely generate sound and place the articulators in the position for a correct [ɛ], and use the mandible as a prime mover of the articulators. Doing all this, I learned to say my last name. The pull-out is done in a fraction of a second without releasing the initial attempt of the word, which has turned into a real block. A second block could occur during the production of the word on the [l] sound. I would attempt a pull-out on that sound also by analyzing what I did incorrectly in trying to say the word and what I needed to change in its production to speak in a more controlled, fluent manner.

A stutterer may need several pull-outs during the articulation of a single word. As can be seen, this is a very powerful tool that a stutterer can use to approach normalcy of fluent speech. Also, if the stutterer doesn't like the way he controls his stuttering using a pullout, he can cancel the pullout by saying it again and by using a fake pull-out. It sounds somewhat complicated, but with practice, the stutterer and therapist can perfect it until it becomes automatic and so short in duration that only a trained listener can detect a change.

The time required to develop the technique depends on the dedication and motivation of both the stutterer and the therapist. It may take five or ten seconds to use this technique initially, but a stutterer, through practice, can perfect it so it takes but a fraction of a second. A pull-out can be done with such skill that only the stutterer knows he is having a block. He is controlling his stuttering precisely, so it does not interfere with his or the listener's communication. It can also become an automatic control technique.

Dr. Van Riper goes into more detail:

Later on, the insight and understanding move forward in time and take place during the compulsive hand washing which is interrupted at that point and replaced by behavior, which is more adaptive. Similarly, in our symptomatic therapy, once cancellation has become a fairly common practice on the part of the stutterer, we provide another technique call "pull-out". In pulling out of blocks, the stutterer does not let the original blocking run its course as he does in cancellation. Instead, he makes a deliberate attempt to modify it before the release occurs and before the word is spoken. The same analysis and insight, which in cancellation took place subsequent to the stuttering, now takes place during it. Again, he tries to modify the symptoms in the direction of normal nonfluency. Again, we find a real battle against his neurotic tendencies. Gradually the insight comes to dominate the resistance, and a further resolution of the conflict

occurs. The struggle for control of conflicting impulses is the heart of all-psychotherapeutic healing. We have it here.

At this point let us describe something of the mechanics of the pullout process. Many workers in the field of stuttering see only one side of the stuttering problem, viewing it as a clear example of the approach-avoidance conflict. With them, we agree wholeheartedly so far as this describes symptoms of avoidance, postponement, and disguise, which precede the actual speech attempt. But we feel there is something else equally important. In most but not all moments of stuttering we find a TREMOR to which the stutterer reacts maladaptively and with feelings of helplessness and inability. This tremor is similar to intentional tremor in many ways, though we do not consider the stuttering tremor to be organically caused.

In order to occur, this tremor requires a sudden surge of localized tension in a certain area of the speech musculatures and is triggered by a posture or contact differing from those used in normal speech. The assumption of these trigger postures can be envisaged as being conditioned to certain phonetic cues, for example, the perception of the *b* in the word *busy* as threatening stuttering. The old terms CLONUS and TONUS, formerly used to classify stuttering symptoms, were probably due to recognition by early observers of these tremor and trigger-posture states.

Once in a stuttering tremor, the case is caught in a physiological trap. He may stop it at will, but only by giving up his intention to utter the word. If he attempts the word again, the same trigger posture may be assumed and a new tremor started. When this fails to solve the problem, his response to the renewed tremor is a natural one. He merely increases the tremor amplitude and/or frequency and renders release more difficult. The same mechanism can be seen in athetosis and other tremors. With enough effort, the tremor speeds up until it creates the tonic state of contraction so familiar in severe stuttering.

The picture of oscillation and postural fixation as a result of the organism's being confronted by two equally punishing alternatives is well known. Avoidance-avoidance conflicts produce them routinely. A long gap of silence in the midst of important communication can be extremely punishing. When speaking and non-speaking are punishing, tremor and tonic fixation tend to appear.

How then, does the stutterer ever get out of the trap? Van Riper, using a pneumatic recording device, examined jaw tremor of nine stutterers in an effort to determine what happened at the moment of release from block. All stutterers showed three basic patterns; the tremors decreased in amplitude or they decreased in frequency or a large sudden movement of the jaw out of phase with the tremor occurred. When the large movement was in phase, no release took place. We would explain these tentative findings as follows; in approaching a feared word, the stutterer expects a certain amount of unpleasantness. The more the fear, the greater is the unpleasantness expected. Stutterers in general, seem to be able to predict the duration of their stuttering with a fair amount of accuracy. The point we wish to make here is that once the amount of expected abnormality has taken place, the fear is satisfied and the tension reduction takes place. This in turn causes a decrease in the amplitude and frequency of the tremor and the alteration of the trigger posture, and release results. This occurs in some of the blockings. In other blockings, random struggle and repeated attempts to jerk out of the tremor may shift the focus of tension, alter the trigger posture, or break the oscillation by an out-of-phase movement of the tremored structured. But, at best, this is relatively the poorest of the three ways of releasing oneself from tremor. Not only does the effort to jerk out of the tremor result in bizarre symptoms, which the subsequent release rewards and fixates, but also in many cases (if in phase) it merely bounces the stutterer back into his tremor. Trying to pull out of a tremor by any out-of-phase movement calls for precise timing and a good deal of luck.

Observation of any severe stutterer will yield many instances in which syllables and whole words are actually uttered during the throes of his struggle only to have the stutterer continue stuttering.

When the stutterer, during the course of his symptomatic therapy, begins to pull out of his blocks, he learns to discard this third way and instead he spends his efforts trying to smooth out the tremor and slow it down. By this time, the moment of stuttering no longer is the shaking experience it was formerly. He can experiment with it, varying the tension, altering the trigger contacts and postures. At this point the therapist suggests the possibility of learning how he can deliberately throw himself into tremors. Again resistance is found and overcome and out of the experience comes a marked gain in his feeling of control and self-responsibility. No longer does the symptom control the stutterer; instead he is the master.

In terms of learning theory, the pullout technique has effectiveness because the release (the utterance) rewards not the uncontrolled abnormality, which formerly preceded it but the voluntary smoothing out and slowing down of the tremor. The anxiety reduction has its greatest potency at this moment. The behavior immediately preceding release from punishment gets the strongest reinforcement. The gradient of reinforcement is steepest at this point. During therapy it is interesting to observe how swiftly the stutterer gains an ability to take charge of his tremors and to affect a controlled release. Even more interesting is the change in the approach-avoidance features of the conflict. The awareness of approaching stuttering no longer repels. Instead, it signifies an opportunity for winning a new battle. The cases go out to look for trouble. They hunt for feared words and situations. It is axiomatic, of course, that this desired result is the consequence of a long learning process with many unsuccessful trials along the way. But even if the case fails in his attempt to pull out of a block, he can still cancel; and in any event he learns a good deal about himself. All therapy is structured in terms of the question: what did you discover about yourself when you stuttered? The therapist is always interested and permissive and he is supportive to the degree required by the case. Often he is able to clarify an experience, to interpret a bit of behavior on the part of either the stutterer or his listener. He is always far more the psychotherapist than the dog-trainer. **(From information distributed by Dr. Van Riper in class)**

Suggestions for Therapy VI

Examples of Pull-out Therapy

Objective 1

The stutterer will pull-out of a block on a sound or word as it occurs.

Activity 1

Discuss and demonstrate a pull-out for the client.

Activity 2

It may be easier to fake a block on a sound at the beginning of a word and have the stutterer identify those characteristics of the block.

Activity 3

After characteristics have been identified, have the stutterer practice making the necessary changes to say the word in a more fluent manner as the block occurs. The stutterer may need to start with isolated sounds, then isolated words, words in a sentence, and finally as an automatic control.

Activity 4

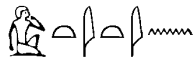
Target goals need to be set for the stutterer in every phase of therapy.

Objective 2

Have the stutterer maintain a log on pull-out activities as he did with cancellations.

Activity 1

Maintain a log for the therapist and the stutterer to analyze the learning that took place and the reasons why.



CHAPTER SEVEN

PREPARATORY SETS

The next control that I was taught, again a more advanced and complex one, is the preparatory set, one of the advanced control techniques taught in Van Riperian therapy. This consists of anticipating a block before it occurs and preparing to control the block and articulate the word in a more easy and fluent manner before attempting to say the word. The stutterer is not avoiding stuttering, but rather is attempting to control the stuttering before it occurs. Cancellation is used after the stuttering has occurred, a pull-out is used during the moment of stuttering, and a preparatory set is used before the stuttering occurs, in anticipation of having a block and having difficulty saying the word. In using a preparatory set I used what I had learned in the identification phase, the information I was exposed to when I cancelled a block, and especially what I learned in using pull-outs. As an example, on a word beginning with the [s], the block occurs on the [s] and may occur in several different ways. As we know, in the production of this sound, the airflow must be of such velocity that a high-pitched, strident sound is produced when the air is constricted between certain articulators. A block may occur when the articulators are pressed tightly together, thereby not allowing air to escape. As we know, the production of the [s] is continuous and the stutterer, therefore, cannot articulate the second sound, generally a vowel. I have a friend who blocks on the [s] by starting and stopping its production. He sounds like an old train with a steam engine trying to pull a heavy load uphill. Different stutterers can block on the same sound in many different ways; another reason the therapist must learn the various types of blocks stutterers use.

In speech, I use my radar and scan the sentence as I see it developing long before it is articulated. As I scan, I articulate the current sentence and use pull-outs or preparatory sets, depending on my skill level. I see an [s] word several words in the future and in the middle of the next sentence. From past experience, identifying and analyzing my type of block on the [s] sound, I know that when I block on the sound, I stop the exhaled flow of air because I press my tongue tightly against my hard palate. Sometimes it's pressed so tightly that a tremor is produced in some of the muscles that move the articulators. My mandible is also locked in a closed position, with my upper and lower teeth in contact with each other, and even more disturbing, my tongue is sometimes caught between my teeth. This is done in an attempt to avoid or hide my stuttering. A hell of a way to try and produce an [s]!

How do I prepare to control the production of the [s] in a more fluent way before I even arrive at the word in an approaching sentence? Of course, I could just forget it and have an old fashioned block on the [s], disrupting my ability to communicate and the listener's ability to receive the communication. I could substitute a non-[s] word for the desired [s] word, or use some "starter" that may have worked in the past, but I have decided to use a preparatory set and attempt to control the block before it ever occurs. Therefore, I have learned from past experiences that I must do several things on a highly conscious level. First, I must intentionally produce a light stream of air and exhale it through my articulators that I have consciously placed in the proper position for the production of the [s]. This consists of having my teeth apart and my tongue lightly placed against my hard palate, yet with enough opening for the air to escape. The muscles of the articulators must not be rigid or too tense, yet the lips are somewhat round and the tongue and jaw are held in position for the production of the [s].

Another very important control I learned was to think of the mandible as the "prime mover" and consciously lower it, sometimes with an exaggerated emphasis on the movement of being lowered. This

movement is very deliberate and allows me to begin the rest of the word. If I do this, I am not fixated in the block. Therefore, my preparatory set for controlling a block on an [s] consists of setting the articulators for a correct production, initiating a correct flow of air for the sound, and timing the movement of the jaw for the articulation of the next sound or the remainder of the word. This should not be too difficult for the stutterer if he has mastered the earlier controls. With practice, he will easily perfect the technique until it becomes automatic. He will pay it little attention, and the listener will not detect it. The execution of a preparatory set is of such short duration that a trained therapist may have difficulty identifying it. Van Riper states, when discussing preparatory sets:

To describe the dynamics of the terminal stages of therapy is always difficult. The case has less need for the therapist; he 'feels like a different person'; he loses interest in his symptoms; his emotions are less intense; he becomes involved in new fields of endeavor; he begins to accept responsibility for his own failures and difficulties; he learns to monitor his behavior in terms of the realities that exist; he can both venture and control. Viewed from the vantage point of learning theory, new competitive responses have become conditioned to the stimuli, which formerly sets off the whole stuttering volley of behavioral and emotional reaction. These have moved forward in time so that they now exist as preparatory sets. With enough experience in pulling out of tremors of fairly long duration, the stutterer finds himself able to get this control sooner. The tremors get shorter. The case can take charge earlier. He soon finds himself preparing in advance to smooth out and slow down his tremors and when this happens preparatory sets are being used.

At this point the stutterer becomes able to control the duration of his abnormality, to stutter so briefly that his listener will not react to it with penalty. The symptoms become tolerable. Indeed, they become normal non-fluency. What happens is that the stutterer learns to stutter fluently? This can be a very pleasant experience. The approach-avoidance and the avoidance-avoidance conflicts have turned into an approach-approach situation. The vicious circle is broken. No longer does the tension subside only when struggle results in verbal utterance. No longer does anxiety reduction reinforce the unpleasant symptoms. Stuttering has lost its threat and its usefulness.

The basic concept, that some type of 'symptomatic' therapy can also be viewed a form of effective psychotherapy has been demonstrated. Our cases do not only find amelioration in their symptoms; they change as persons. We do not feel that such symptomatic therapy is at all incompatible with other forms of psychotherapy. Used concomitantly, subsequently, or prior to the traditional form of psychotherapy, it has proved extremely facilitating. In many cases, especially with those whose neurosis seems to have arisen as a result of audience penalty or verbal frustration, it can be used alone.

(From information distributed by Dr. Van Riper in class)

Without doubt, Van Riperian-type therapy for stutterers is psychotherapeutic in nature and this is certainly good. The stutterer is desensitized and motivated. But I think it is a lot more. It gives the stutterer some tangible tools for controlling his stuttering, which leads to positive therapeutic value and reinforcement from many sources. These tools will be with a stutterer for a lifetime and can be learned to fine precision.

Suggestions for Therapy VII

Examples of Preparatory Set Therapy

Objective 1

Help the stutterer learn to use a preparatory set.

Activity 1

Discuss the objective of a preparatory set and verbalize a walk-through example, then select a word in a sentence and demonstrate for the client.

Activity 2

Have the client select words/sounds and verbalize the preparation for a preparatory set. Place words/sounds in a sentence and have the client practice a preparatory set. Explain to the client that if it turns into a real block, he should use a pullout. If the pull-out is not smooth or performed correctly, he should cancel it.

Objective 2

Have the stutterer maintain a log on preparatory set activities as he did for cancellations and preparatory sets.

Activity 1

Maintain a log for therapist and stutterer to analyze the learning that took place and the reasons why.



CHAPTER EIGHT

PROPRIOCEPTIVE FEEDBACK

A very important part of the program is to teach the stutterer how to monitor his speech through proprioceptive feedback, which includes kinesthetic and tactile feedback, in an effort to maintain the ultimate control and best possible speech fluency. This is certainly part of the stabilization phase of therapy, but important enough to be studied in isolation.

In the 1960s and earlier, experts thought that humans maintain fluent speech mainly through kinesthetic and tactile feedback from the articulators and other parts of the body and that auditory feedback is secondary. This has been explained in many cybernetic theories of speech production. It is not true with the stutterer. He tries to listen to himself in an attempt to monitor his speech and at times his audition is so unpleasant and unbearable that he cannot pay auditory attention to his own speech. To escape the unpleasantness, the stutterer tunes out his own speech production and uses little feedback of any kind.

Using kinesthetic and tactile feedback to maintain fluent speech production, as it appears the normal speaker does, may be the most important tool available to the stutterer. Several techniques can help the stutterer learn this skill. We want him to minimize audition as much as possible when learning this new skill, although eliminating auditory feedback is difficult at best in practical situations. There are many studies regarding individuals with normal hearing and speech who have completely lost their hearing but maintain perfect articulation and speech. How is this done? By using other feedback channels!

When I was in therapy, the Department of Speech Pathology purchased a delayed feedback machine, which delays auditory feedback from a fraction of a second to several seconds and many intervals in between. The shorter the auditory delay, the easier it is to maintain fluency. I began using the machine with a very short delay and when I mastered that setting with some fluency, I gradually increased the delay and at the same time increased the kinesthetic and tactual feedback of the articulators. The shorter the auditory delay, the easier it is to maintain fluency.

When a fluent speaker's auditory feedback is delayed he becomes dysfluent and sometimes very dysfluent. I have seen normal speakers become so frustrated from becoming dysfluent that they actually became hostile, took their headphones off, and threw them on the floor. Others have broken down and wept out of frustration. They would not make a second attempt.

The machine has two purposes. One is to let the non-stutterer experience dysfluency. Secondly, the machine helps the stutterer decrease his dependency on auditory feedback and changes his self-monitoring process. To have any kind of self-feedback is very difficult for the stutterer and to begin to do it the right way is even more difficult.

A person learns to "beat" the machine or maintain fluency by using exaggerated speech movements at first. Most stutterers have very little movement of the articulators. Now, watch journalists reading the news on television. They have great fluency. How do they maintain it? Watch the movements of their

mouths and the observable articulators: they seem to exaggerate these movements. Now mute the sound and you can readily observe those exaggerated movements.

I started this therapy by using exaggerated movements and gradually decreased the movements as I experienced success. At the same time, I introduced this technique into my everyday speech. The more I practiced, the easier it was to do, and the more it became incorporated into my normal speech pattern.

The final goal in this stage of therapy is to decrease the movements so they are not exaggerated and noticeable to the listener, but is only in the awareness of the stutterer. Paying attention to the movement of the articulators can be done to such a degree of perfection that this technique alone will sometimes produce all the fluent speech a stutterer needs and desires. It can be implemented very easily into all situations. Like learning to play a musical instrument, practice makes perfect. A lot of stutterers, including myself, use this technique as the primary tool to control stuttering, to produce and maintain fluent speech. In therapeutic programs for stutterers, this tool is called “monitoring.” As Thomas Kehoe (2004) states in his research regarding altered auditory feedback, “increasing the delay and/or frequency shift doesn’t improve fluency unless stutterers alter their speech motor activity.” Van Riper adds, “we train the stutterer to monitor his speech by emphasizing proprioception thus bypassing to some degree that auditory feedback system. We feel that if we can get him to concentrate upon proprioceptive feedback we can bypass these difficulties.” He is referring to auditory feedback difficulties.

Suggestions for Therapy VIII

Examples of Monitoring Therapy

Objective 1

Teach the stutterer to monitor his speech through tactile and kinesthetic feedback.

Activity 1

The therapist discusses and demonstrates the concept of tactile and kinesthetic feedback.

Activity 2

Discuss with the client this type of feedback and observe it in others.

Objective 2

Activity 1

Have the client learn to use proprioceptive feedback, first in words, then in short sentences. The stutterer must “tune into” all feelings of the movement of the articulators. An easy way to do this is to exaggerate the movements at first. Use a mirror or videotape all learning sessions so the client can see as well as feel the movement of the articulators.

Objective 3

Teach the stutterer to use a delayed feedback machine to increase his kinesthetic and proprioceptive feedback.

Activity 1

Initially the therapist, then the stutterer, must learn to “beat the machine” at different delay settings through practice, practice, and more practice. Have the stutterer verbalize how this activity will help him and its importance.



CHAPTER NINE

RESISTANCE THERAPY

Another tool, and the final one discussed here, is that of just resisting the urge to stutter. I use it, but it must be taught with great caution. Remember, our goal is not to stop stuttering but to learn to control our speech so we can speak in a more fluent manner. There is a fine line between resisting the urge to stutter in a therapeutic sense and just wanting to stop stuttering.

As stated previously, stutterers, including myself, have a need to stutter because they feel comfortable doing so, no matter how negative this communication mode may be. Stuttering is the “known,” not the “unknown.” Especially for adult stutterers, it is the way they learned to talk and have talked for a very long time, so it is easier just to continue to stutter. In spite of the fact that it is embarrassing, takes too much energy, and limits one’s ability to communicate, stuttering sometimes feels like a safe haven. However, at times, just resisting the urge to stutter is enough to gain fluency. Just by telling myself I am not going to stutter or submit to this beast in a particular situation is enough to produce some short periods of fluency, if the situational and communicative stress levels are not too high. One must be extremely careful in using this method because its effect is of short duration. The stutterer is spending some of the payback from faking stuttering and other work he has done. Every stutterer will vary in the degree that the urge to stutter can be successfully controlled. Resistance therapy should be taught very carefully by the therapist and used very sparingly by the stutterer. The stutterer must learn when to use it and for how long. It just suppresses the urge and need to stutter for a short period of time. If used too much it can become a “trick” to avoid stuttering. When this happens, it just causes more stuttering.

As a summary of various controls, in an earlier paper to stuttering therapists, Van Riper states,

As the stutterer continues to work on voluntary stuttering, he may be introduced to another fear-dosing procedure known as cancellation. This consists of learning to stop after a stuttered word and then say it again with fewer struggles or using some type of voluntary stuttering. The cancellation is not successful until the word is produced under voluntary control. Beyond the opportunity to continue to study the speech pattern through a contrast of the involuntary block and the voluntary cancellation, it is hypothesized that this technique diminishes the reinforcement of the stuttering act, which, as mentioned earlier, occurs when the person filibusters through a speech block and leaves the behavior to be reinforced because anxiety was reduced at the immediate point in time of the occurrences of the stuttering. However, when cancellation is done, the competing, altered response is reinforced also. Speaking from my own practical experience, I have found cancellation to be a rather difficult technique for stutterers to use. Thus, when the stutterer cancels 50 to 70% of his blocks in the clinic, this is judged to be proficient. Van Riper, the originator of the technique, suggests that the stutterer go on to ‘pull-outs’ after he learns to cancel. Pullouts consist of the person not allowing the speech block to run its course, but modifying the behavior as the word is spoken. Again, the reinforcement of the mal-adaptive, altered, behavior moves forward in time, and the person is able to use his experience to approach the word more appropriately in terms of a normal speech response.

Other types of behavior such as ‘delayed response’, etc., are examples of response modifications. In all of these instances, counter conditioning is being employed on the overt, final response level. When certain stimuli are present, a modified response is reinforced.

Let me hasten to emphasize that, in terms of the approach-avoidance concept of conflict, we are motivating the person to attempt these new responses after having reduced anxiety considerable by working with mediating responses, i.e. changing attitudes, feelings and perceptions. Moreover, it is therapeutically important to use a gradual desensitization approach in which responses are changed, first in the presence of stimuli, which evokes minimal anxiety, and then in stimulus situations, which have a history of producing more anxiety. One of the major contributions of therapy is that the clinician arranges a graded series of relearning situations for the client and provides guidance and encouragement in generalizing new responses to varying stimulus complex. Responses become more sure and precise as practice as continues. In summary, both stimulus conditions and response have to be manipulated in the therapeutic process.

Stutterers, with whom I have worked, have a tendency, when employing a ‘bounce’ pattern, to say ‘du du du day’, rather than da da da day’. This, in my opinion, is much less effective, is incorrect. We want the person to get the feeling of the smooth transition in the consonant-vowel combination and the feeling that at any moment he wishes, he can go ahead and say the word; therefore, the proper first syllable should be practiced. I have found this approach to be very effective in helping the person to gain a greater sense of security with reference to his ability to perform the modification. In addition to this system of beginning with simplified material and smaller units and working up to more complex material, various techniques are used first in situations that evoke very little anxiety, and then gradually the client uses the procedure, such as voluntary stuttering in situations of increasing stress.” Van Riper believes that, “the theoretical foundation for this therapy is based upon two assumptions; First, that most of the abnormality of the stutterer consists of (a) avoidance responses to various phonetic, situational, and semantic cues; and (b) habitual escape and struggle responses to self-initiated TREMOR in the structures dealing with articulation, phonation, or respiration. Second, he assumes that most, if not all, secondary stutterers present the picture of neurosis.” **(by Dr. Van Riper in class)**

I will not expand upon the concept of neurosis as a component of stuttering since I am not well versed or educated in this area, although I do believe that many psychological components determine the complexity of the stuttering phenomenon. During and after therapy, many psychological changes take place in both behavior and personality. The stutterer becomes more social and extroverted. He enters speaking situations that he dared not enter when he was a severe stutterer. During speech work, the stutterer may have failed in some assignments at first, but in the majority he came out the victor.

In my own therapy, the more difficulty presented in the assignment, the more challenged and determined I was to master the task. I was very goal-oriented and generally experienced great success. The work on my speech became self-reinforcing and I met the challenges with enthusiasm and a sense of accomplishment on the majority of the assignments presented by my therapists or that I developed myself. I believe this is why I experienced success early in my therapy. My personality changed, since I was now a member of the human race for the first time in over twenty years. My shyness gradually dissipated. I wanted to show the world that I could talk and interact with others without looking like a monster.

In general, I was a happier individual and on my way to becoming a well-adjusted member of society. My basic personality would not allow me to fail.

Suggestions for Therapy IX

Examples of Resistance Therapy

Objective 1

Have the stutterer know when it is appropriate to use resistance type therapy and when it is not.

Activity 1

Discuss the principles involved in resisting the urge to stutter, why it can be used, how it can be used, and what to do if the stutterer fails in the attempt.

Objective 2

Teach the stutterer how to resist the urge to stutter when it occurs and how this is different from a “mental set” of not wanting to stutter. Not wanting to stutter is not a part of Van Riperian therapy.

Activity 1

Discuss the goals of resisting stuttering vs. the desire to stop stuttering.

Activity 2

The stutterer gives examples of when he has resisted an urge and relays the positive consequences.

Activity 3

The stutterer verbally rationalizes both positive and negative benefits of not stuttering for short periods of time.

Activity 4

The stutterer shares with the therapist when he may be able to use resistance techniques and how frequently. The stutterer should list those factors that will contribute to his successful use and how they can be controlled.

Objective 3

The stutterer will realize when he is unable to resist the urge not to stutter and recognize other courses of action available to him.

Activity 1

The stutterer, with the help of the therapist, will identify and list those signals and indicators that indicate potential failure in trying to resist stuttering, such as high emotional content, importance of communication, feared words that must be used, and the physical well-being of the stutterer. The stutterer will look for alternative methods of control and implement those chosen for the situation.



CHAPTER TEN

STABILIZATION

Stabilization is the final phase of therapy after faking or voluntary stuttering, cancellations, pull-outs, preparatory sets, and monitoring have been somewhat mastered. I use the word “somewhat,” because like playing a musical instrument, the more you practice, the better you become at the endeavor. Working on these techniques of control is a continuous, a never-ending practice that is dependent only on the amount of fluency the stutterer desires. A stutterer practices the techniques to stabilize his controls and if practiced enough, they will become automatic overtime. If practiced enough the controls will become natural and the stutterer will use them with very little energy, either mental or physical. In some cases, he may actually speak more fluently than the non-stutterer.

Some stutterers need to show off their newly acquired fluency with everyone they encounter because of the freedom from the pain of trying to speak. A stutterer can easily seek too much fluency or perfection too early in therapy. Initially the new fluency may place too much stress on the stutterer and cause the stuttering to increase.

As stated earlier, faking a block, either small or large, decreases the stutterer’s communicative stress and seems to mystically increase fluency. When a stutterer cancels a block, he is intentionally exhibiting his abnormality as a by-product of therapy and he is showing the listener that he has the intestinal fortitude to do something about it by working on his disability. This gives the stutterer great satisfaction, in addition to the cancellation technique’s therapeutic speech benefits. I do not believe the stutterer needs to give out a card, as proposed by Dr. Bernard-Thomas Hartman (2005), saying “I have a handicap with my speech. Please listen to what I am trying to say not how I’m saying it. Thank you.” A stutterer needs not be apologetic for his stuttering or ask for pity from the listener. This will not motivate the stutterer to work on his speech, but rather induce a sense of “Woe, poor me, forgive me for being different!”

Pull-outs, preparatory sets, and monitoring are sophisticated control techniques and require practice to develop. The greater the emotionality of the speaking situation, the greater the communicative stress, which increases interference in the stutterer’s ability to use his controls. This is why stabilization is necessary in a hierarchy of stressful situations, beginning with the least stressful and moving to more stressful situations.

A less stressful situation may be talking to a therapist, while a more stressful situation may be a telephone call to one’s parents or speaking to a group of people. Of course, the larger the group, the more stressful the experience. Practicing newly learned skills in the clinic with single individuals, then small groups, then large groups, and finally using the telephone may be a rudimentary example of such a hierarchy. Progressing to situations outside of the clinic, first with friends, then store clerks, teachers, restaurant employees, parents, professionals, and eventually in a classroom situation may be a hierarchy for some stutterers. Generally, with the therapist’s help, a stutterer can develop a hierarchy of stressful speech situations that he needs to work on in the stabilization phase.

I usually assigned myself ten different situations per day during the stabilization phase. Informing the listener initially that I was a stutterer, sometimes through verbal explanation or by exhibiting a few severe blocks and then working on the blocking, decreased the stress and allowed greater success during this and all other phases of therapy. It also gave me “one up” on the listener, meaning I got the jump on squelching his curiosity.

Suggestions for Therapy X **Examples of Stabilization Therapy**

Objective 1

The stutterer will develop his own therapy assignments for two easy and two difficult speaking situations.

Activity 1

The stutterer should develop therapy assignments with objectives and activities for these speaking situations, state specific goals, and indicate where the assignments will be carried out and how they will be analyzed.

Objective 2

The stutterer will objectively and accurately analyze his successes and failures and provide a rational reason for each decision he made in the above assignment.

Activity 1

After the stutterer carries out the above assignment he will report successes and failures and the reasons for each. The reason is the important part of this activity.

Activity 2

The stutterer will keep a daily log of his experiences in developing, recording, and analyzing his assignment. Entries will be made before and after the assignment is carried out. He will discuss them in detail with his therapist.

Two additional goals of therapy consist of learning to use a strong, energized voice and attempting to eliminate negative emotions. Implementing these tactics assisted in the control of my stuttering. A strong, energized voice, not a raised, angry voice, but rather one of confidence, helped me considerably. Most stutterers do not have such a voice naturally, but they do want to speak clearly, loudly, and with confidence. This type of behavior is learned after significant progress has been made in therapy; however, it is difficult to teach. Adjectives such as forceful, exertive, and confident describe the type of speech I am alluding to.

After the stutterer has made noticeable progress in therapy, he should be encouraged to take another step, while still using the controls he has learned, and move up to the next level. It is most important that he learn to decrease negative emotions, such as frustration, guilt, hostility, and shame, that result from interaction with others or that he places upon himself. A stutterer's negative emotions interfere with his ability to control his speech. They present a form of “static,” or interference that negates his ability to pay full attention to the controls he has learned.

This is a very important part of Van Riper's therapy and should not be overlooked. It encompasses ordering one's priorities and developing a plan to succeed, and lets the stutterer experience success in most endeavors. It also incorporates the premise that one should try and live a life free, as much as possible, of all negative emotions. The stutterer must identify negative emotions, with their probable causes and develop a plan to eliminate or decrease them as much as possible.

Generally, the stutterer will need his therapists help in order to make objective observations, outline a realistic plan, and receive guidance in implementing behavior changes. Realistically, one cannot live in a stress free world, but living a good life is a goal for everyone. Self-monitoring, by paying attention to the feedback of the articulators in motion, calling up the energy to speak in a forceful and confident voice, and living a life free of negative emotions have left the author with ample fluency and control over his stuttering for the past several decades, with a few mild relapses that were easily controlled.

Suggestions for Therapy XI ***Examples of Energized Voice Therapy***

Objective 1

The therapist and the stutterer identify the vocal qualities of a strong voice.

Activity 1

Tape record or videotape the stutterer speaking spontaneously using his natural voice quality.

Activity 2

Identify the stutterer's voice characteristics that contribute to his strong or weak voice.

Activity 3

Listen to a strong speaker and list those characteristics that contribute to his/her strong voice. The therapist should add characteristics to the identified list.

Activity 4

Compare the characteristics of a non-stutterer's voice to those identified in the stutterer's voice.

Objective 2

Teach the stutterer to implement into his voice quality those characteristics identified as used in a strong voice that he may be lacking.

Activity 1

The stutterer will listen to, observe and implement those factors, to strengthen voice quality, initially in words, short sentences, longer sentences, and spontaneous speech.

Objective 3

Use negative practice to help differentiate between the stutterer's voice and a strong voice.

Activity 1

Record the stutterer's speech using normal voice strength, imitating a weak voice (negative practice) and using a strong voice. Identify the factors that contribute to each.

Suggestions for Therapy X11

Examples of Therapy for Decreasing Negative Emotions and Their Influence on Using Controls

Objective 1

Identify emotions that may influence your ability to control your speech.

Activity 1

List those situations where you have exhibited severe stuttering in the past.

Discuss the relationship between your feelings regarding the situations and your speech. How did the situations make you feel prior to speech? What were your thoughts? How did you feel after trying to speak?

Objective 2

Identify the reality base for the negative emotion you experience.

Activity 1

Decide if the causal factors are realistic, how realistic or strong and if so, can they be changed? Can the perceived fears be substantiated? What is the best way to have some control in the situation ### general control and speech control? Initially the therapist will need to provide assistance to the stutterer.

Objective 3

Develop similar situations that have been identified from the above.

1. Check for a reality base and the probable consequences.
2. Enter the situation with speech assignments



CHAPTER ELEVEN

RELAPSES

A stutterer should expect a few relapses, the loss of ability to control stuttering to the desired degree, during his life. Generally a relapse is caused by a prolonged sickness, a tragedy that generates an unusual amount of negative emotions, not giving speech the attention it requires through practice, and not using controls, or excessive worry.

Realistically, relapses should be expected, but the stutterer will *not* have to start at the beginning of therapy after each one. He has learned the controls he needs and must just put them into practice again and at a highly conscious level. This is difficult to do while involved in the emotional or physical tragedy, but the stutterer will have several opportunities throughout his lifetime to practice this exercise. With each occurrence, the stutterer becomes a little more callused to emotional trauma, and re-establishing appropriate control of his speech becomes a little easier with each experience. The frequency of relapses may be greater just after the termination of official therapy and decreases as stabilization becomes stronger.

Over the years, I have observed that a common trait among stutterers is an extreme sensitivity to circumstances that elicit emotions. Stutterers appear to be a lot more sensitive to their surroundings than non-stutterers. This may be because they still continue to scan for emotionally laden situations, which are usually the behaviors of other people, but which can be an assorted list of other circumstances. These may cause the stutterer significant communicative stress, which influences speech and the ability to control stuttering. These same factors influenced their speech before they developed controls and they encourage stuttering.

Suggestions for Therapy XIII

Examples for Helping the Stutterer Through a Relapse

Objective 1

Develop a mock relapse. Have the stutterer define the parameters of the relapse.

Activity 1

The stutterer will identify characteristics of his speech during the relapse and describe the contributing circumstances.

Activity 2

The stutterer will develop a therapy plan to gain control of his stuttering.

Activity 3

The stutterer will develop a plan to change or adapt to the circumstances that were identified as causing his speech difficulties.

Objective 2

Help the stutterer develop therapy plans to regain his prior degree of control before the relapse.

Activity 1

Specifically list, discuss, and practice those factors identified above.

Van Riper and Emerick (1990) discuss the role cognitive therapy plays in helping the stutterer anticipate, analyze, and work out of relapses when they occur.

It is rather easy to get an adult stutterer to speak fluently in certain situations ### almost anyone can do it. With appropriate therapy, in many cases, the client even reduces his panic and anxiety about talking. But it is difficult to maintain these gains; relapse is a common problem in the treatment of persons who stutter. Why is stuttering so persistent? Although many variables are involved in therapeutic relapse, the most common culprit, in our clinical experience, is the client's mental attitude (Guitar and Bass, 1978)

Long after the speech and affect dimensions of a client's problem have improved, he may still have deeply imbedded negative self-defeating mental images. Sometimes, particularly when he encounters a difficult speaking situation, the stutterer unwittingly sets himself up for failure with old, irrational automatic thoughts. In short, although his speech may be relatively fluent, he still thinks like a stutterer (Eyesham and Fransella, 1985).

In cognitive therapy, we attempt to deal directly with the stutterer's incorrect premises and distorted mental imagery. Three steps are utilized: identifying the faulty thought patterns, subjecting them to reality testing, and the formulating more positive substitutes.

Identification

First the stutterer must make an inventory of his negative images, thoughts and expectations.

Reality Testing

After the client has assembled her repertoire of mental constructs, we help her assess each of them on a logical basis, we teach her to evaluate and challenge the automated thoughts rather than than blindly accept them.

Formulating Substitutes

The third and final step in cognitive therapy is the development of new, positive mental imagery. The stutterer is taught to tell himself, "Stop!" when he uses a self-defeating thought, and then to consciously shift to some alternative, more therapeutically helpful statements.

While reviewing my notes from the past, I came across some old assignments from my speech therapy in the 1960s. These provide a fairly realistic idea of therapy assignments involving some of the controls outlined above.

Assignment: Stutter with a long silent block with tremors on one word to a stranger for fifteen toe taps.

Response: I started with project seven and worked backwards to see if any fear would come from easier assignments to more difficult ones. This project I did in the city park while talking to a middle age lady and her little boy. Both were sitting on a bench. I asked the lady where the Burdick Hotel was located. I had my block on the word "hotel." I had no fear or anxiety, for I was more concerned with his or her

reactions than myself. The little boy just looked at me and smiled while the lady looked away the whole time. I don't think she knew what I was doing. She didn't know whether to sit there or get up and run. My emotions were barely aroused.

Assignment: Stutter repetitively with tension to a member of the opposite sex and of your own age on one word for ten toe taps.

Response: I did this assignment in Penney's Department Store. I chose a colored (remember this is in the early '60s) girl, for I don't remember that I've ever worked on my speech with a member of the opposite sex who was colored. The girl was arranging gloves in the women's department. I asked her if she could tell me where the men's gloves were located. I stuttered on the first word, "could." She neither looked up nor paid any attention to me, but simply went on with her work. When the ice broke and the word finally came out, she told me and I went on my way. I had no fear of anxiety in this situation. Yet, I wondered why she never looked up when I approached her.

Assignment: Stutter with vocal fry over the telephone on almost every word of a conversation but the individual moments of stuttering need be no longer than five toe taps.

Response: This experience was new to me, for I've never used the vocal fry much and I have never used it on the telephone. I called the train station asking when the next train left for Detroit. The man said nothing, but waited until I completed my sentence. I could tell by his stern, short answers that he was disturbed somewhat by my speech. I really had to work to make myself do this assignment right, but I walked out of the phone booth laughing because of the man's attitude shown in his reply.

Assignment: Interrupt a five-toe tap fixation of a silent mouth posture with a gasp, a head jerk and a facial contortion. Do this to three university students.

Response: I did this to girls who worked in Woolworth's, for I knew they were students at Western. The first girl I asked for shoestrings. She gave a sign of amusement and wonder while looking at me for the entire duration. This did not disturb me, but on the next two it did. The second girl I asked where the Halloween suits were for my twelve-year-old sister. On this particular assignment I turned a little red, for I felt sorry for her when she looked away. I wanted to apologize and explain, but I didn't. I just said thank you and walked away. The third girl I talked to was at the record counter. The first time I asked her for a record with a mouth posture and a gasp and a head jerk she looked away. I tried it a second time trying to win her and have her not look away and sure enough she kept eye contact. This I liked for I had won my point in two different directions.

Assignment: Use three different postponement devices before words beginning with a p, k, or t.

Response: I did this in the public library while asking a girl about renewing my membership card. The postponement devices I used were one, using such words as "uh" and "um"; two, scratching my face before I said the word; three, I dropped my pencil and card on the floor before I said the word. These were all words that began with a t. This was not new and not a challenge for me and the girl had no reaction at all. I did gain something by the conversation. I wanted to know if I had to pay to renew my card or could I do this free? After a lengthy conversation while working on my speech and after the girl had brought two or three higher authority figures into my conversation and with my arguing, I found out I had to pay two dollars to have it renewed.

Assignment: Avoid speaking any word beginning with an s in a conversation by using synonyms.

Response: I asked a man sitting in the park for directions to the Kalamazoo Arts Building. I avoided all words that started with an s or started with the [s] sound. I also avoided words that ended in an s. This

was hard to do at first and then the hang of it came back. The man started filling in words for me until I caught up to his rate of thinking. It disturbed me until I got the hang of it. It has always disturbed me. I've never been any good at it.

Assignment: Have a conversation while using the delayed feedback apparatus.

Response: I had a conversation with L.T. This also disturbed me at first for the machine was beating me. The more I concentrated on my thoughts the more fluent I became. I need more work on this, for I don't like the idea that a non-stutterer can beat a stutterer or have more fluency while talking on a machine.

Assignment: Describe what it is like to stutter.

Response: In other words, the question is, what is it like to stutter and be a stutterer. The best way I know for a person to obtain this feeling would be to put a blindfold on and walk out into the middle of a busy highway and stand there for a minute or so and then walk back to safety. A person could get a very good picture of a stutterer's feelings while he is having a block. As far as a stutterer's personality goes, he has almost none of his own except for the usual stutterer's personality. You could compare this personality to the winters we find here in Michigan. Usually cold, miserable, and unpleasant, but now and then a little warming might occur, but the colds of winter return soon with no sight of spring. The stutterer's attitude toward other people may be thought of as a warrior duck in hunting season. Such a duck as being wise with many wounds, one who is smart enough to keep away from hunters for fear of being shot at again or being permanently wounded. The wise duck avoids as much as possible, so does the stutterer. The stutterer's attitude toward his speech could be compared with a person sentenced to prison for a life term. No hope in sight and you hate your life for what lies ahead, yet this is what you were sentenced to for life. Now and then one such person may be told by an authoritative figure that if he is good and works hard he may be set free.

Assignment: Verbalize a stutterer's feelings from three different standpoints, as he is about to give a speech.

Response:

a. The Way He Feels. Right now you are feeling some hostility towards me for asking you to do this. Also you are feeling some anxiety and fear. Your increase in heartbeat has been caused by your fear, as you probably know. You are probably having two types of fears that you aren't aware of at the present, but maybe you are aware of these. These are word fears and fear of the actual situation. You're probably also having fear of just wondering how bad of a time you'll actually have. Along with this comes anxiety that is caused by waiting for your turn to give the speech.

b. The Way I Felt. I had already had speech therapy a few months before I gave my first speech, yet I still had a lot of anxiety and fear. I didn't have any word fears; I suppose it was the situation. I remember the night before. I lay in bed and wondered just what was going to happen. I also practiced over and over in my mind what I was going to say. The next day came and I had so much anxiety that I couldn't eat and I surely thought my fluency would break down in the morning before I gave my speech in the afternoon, but it didn't. I worked all the more to keep my fluency while the anxiety and fear grew.

c. What Happened to Other Stutterers? I remember I was talking to one fellow who stuttered just before he gave his first speech. We were laughing and joking and then suddenly he became awful quiet and I saw the fear and anxiety come. This poor fellow took about ten trips to the bathroom in five minutes. He felt the same way you do right now. Every person to some extent and all stutterers feel the same way before giving their first speech. They are worried about it, they want to hurry and get it over with and get the hell out and be gone.

THOUGHTS FOR THE THERAPIST

1. A former client returns to you while experiencing a relapse and asks for help. What would you say or do to help him? Is it appropriate to see him again for formal therapy?
 2. A former client of another therapist who is no longer in the area comes to you seeking assistance while experiencing a relapse. What do you do? Be detailed and specific.
 3. Verbalize in your own words the definition of a cancellation, pull-out, preparatory set, and monitoring. Verbalize to someone how they are taught.
 4. Design a different therapy session to teach cancellations, pull-outs, preparatory sets, and monitoring. Practice teaching someone who is unfamiliar with stuttering therapy. You will have to be able to do them yourself before you can teach them to someone else.
 5. How would you teach a stutterer to resist the urge to stutterer? Be careful and wise!
 6. Design a lesson to discuss with a stutterer the concept of using a strong voice and a lesson to actually teach this concept to a stutterer.
 7. Design a straightforward lesson to help a stutterer identify the negative emotions that he is currently experiencing in his life. Which emotions are caused by other people or situations and which are self induced?
 8. Design a lesson to help a stutterer decrease the negative emotions he is experiencing.
 9. What is controlled stuttering? Do not use words like “normal” or “better than,” but be specific. Describe.
 10. Stutter, repetitively, with tension to a member of the opposite sex and of your own age on one word for a duration of ten toe taps. Do not smile!
 11. Interrupt a five-toe tap fixation type block with a gasp and a head jerk. Do this to someone about your parents’ age.
 12. Use three different postponement devices before a word beginning with a p, k, and t in a conversation.
 13. Avoid speaking any word beginning with an s in a conversation by using synonyms.
 14. List as many flaws as you can identify in this type of therapy for stutterers. What can you do to improve upon the therapy?
-



CHAPTER TWELVE

FINAL WORDS OF WISDOM TO THE THERAPIST

Most stutterers can be helped, a few cannot. Those who cannot are beyond the reach of the speech therapist's expertise, perhaps beyond the help of any professional at this point.

To succeed in helping a stutterer decrease his dysfluencies and acquire those skills needed to control his speech for both social and communicative gains, you as a therapist, must go beyond your traditional mind set and level of comfort. You must take personal pride in your desire to be inquisitive and adventurous and take yourself and your client, the stutterer, into areas where they have not been before. While aiming for and anticipating a positive outcome, you must develop ingenuity and a sense of creativity and excitement that will motivate both yourself and your client.

Never be afraid to try new and different ideas and sound techniques in therapy. You will surprise yourself by stumbling across something that works and affects the stutterer in a positive way.

There is no greater feeling of accomplishment than to bring another human being, an adult, into the race, both human and otherwise, and see his personality blossom into its full range of potential.

To succeed in giving therapy to the stutterer, you must reach out with creativity to learn about your client and to develop and administer the right therapy at the right time. Don't be afraid; be concerned, but not worried. It's an enjoyable and fascinating challenge that can be met and conquered through knowledge and learning.

Having been a young stutterer and now an older stutterer in my 60's, I have had some experience working with stutterers and know from where I speak. Dr. Charles Van Riper's therapy does work.

Good luck in helping the stutterer change his behavior and perhaps yours. Never give up!



My Creed

I expect to pass through this life but once.
If, therefore, there is any kindness I can show,
or any good I can do to any fellow human being,
Let me do it now,
For I shall not pass this way again.

-Anonymous-



REFERENCES

1. Bryngelson, B., Chapman, M., Hansen, O, *Know Yourself: A Workbook for Those Who Stutter*, Burgess Publishing Company, Minneapolis, MN, 1960, p. 112-113.
 2. Foundas, A., DAF in Stuttering: A Potential Anatomical Link, *The Stuttering Foundation*, Winter 2005, p. 1.
 3. Gottlieb, Sheldon, Making Changes: What Does It Take?, *Diabetes Forecast*, October 2004, p. 37.
 4. Guitar, B and Peters, Theodore, Stuttering: An Integration of Contemporary Therapies, Publication No. 16, *Stuttering Foundation of America*, Memphis, TN, 1999, pp. 15-22.
 5. Hartman, Bernard-Thomas, Straight Talk About Stuttering, *ADVANCE for Speech -Language Pathologists & Audiologists*, May 9, 2005, Vol. 15 No.19, pp.10-11.
 6. Helliesen, G., *Forty Years After Therapy: One Man's Story*, Apollo Press, Inc. Newport News, VA, 2002.
 7. Kehoe, Thomas, Safety and Effectiveness of Anti-Stuttering Devices, *ADVANCE for Speech-Language Pathologists & Audiologists*, May 10, 2004, Vol. 14 No. 19, p. 15.
 8. Massie, Larry, *Brown and Golden Memories: Western Michigan University's First Century*, Kalamazoo, MI, Western Michigan University, 2003, p. 100.
 9. *The Stuttering Foundation*, Genetic Studies Gain Ground, Summer 2004, p. 7.
 10. *The Stuttering Foundation*, New Research on the Roots of Stuttering, Fall 2004, p. 1.
 11. Van Riper, C., *Speech Correction Principles and Methods*, Prentice-Hall, Inc., Englewood Cliffs, N.J., 1963. p. 311.
 12. Van Riper, C., *WMU Journal of Speech Therapy*, Vol. 1, No. 2, September 1964.
 13. Van Riper, C., *Speech Correction Principles and Methods*, Fifth Edition, Prentice-Hall, Inc., Englewood Cliffs, N.J., 1972, p. 284.
 14. Van Riper, C., *The Treatment of Stuttering*, Prentice-Hall Inc., Englewood Cliffs, N.J., 1973, p. 204.
 15. Van Riper, C., *Charles Van Riper's Notes on Speech Correction Principles and Methods*, Sixth Edition, Prentice Hall, Englewood Cliffs, N.J., 1978.
 16. Van Riper, C. and Emerick, L., *Speech Correction: An Introduction to Speech Pathology and Audiology*, Prentice-Hall, Inc., Englewood Cliffs, N. J., 1990, pp. 351-352.
 17. Van Riper, C. and Erickson, R., *Speech Correction: An Introduction to Speech Pathology*, Ninth Edition, A Simon and Schuster Company, Needham Heights, MA, 1996.
-

18. Van Riper, C., To the Stutterer As He Begins his Speech Therapy, Information distributed by Van Riper in class.
 19. Weber-Fox, Christine and Smith, Anne, Stuttering Involves Complex Interactions *ADVANCE for Speech-Language Pathologists & Audiologists*, August 2004, Vol. 14. No. No.31, page 17
-



SUPPLEMENTARY READINGS

Goven P. and Vette, G., *A Manual for Stuttering Therapy*, Stanwix House, Inc., Pittsburgh, PA., 1966.

Shames, G. and Rubin, H., *Stuttering Then and Now*, Chapter 15 Modification of Behavior, Part One, Part Two, Part Three, Charles Van Riper, Charles E. Merrill Publishing Co., Columbus, Ohio, 1986, pp. 363-379.

Van Riper, C., *The Nature of Stuttering*, Prentice-Hall, Inc., Englewood Cliffs, N.J., 1971.

Van Riper, C., Therapy for Those Who Stutter, Publication No. 0010, *The Stuttering Foundation of America*, Memphis, TN, 2002, p. 45-73.



ABOUT THE AUTHOR

Mr. Helliesen is a speech pathologist by profession. He has stuttered for over sixty years. Out of desperation, as a young man, he sought help for his severe speech disability. His search for help took him to Western Michigan University. There, under the expert guidance of world-renowned clinician in stuttering therapy, Dr. Charles Van Riper, he learned to control his impediment and become a productive member of society.

He has taught speech pathology at several universities, developed a major in Communicative Disorders and directed the first speech and hearing clinic at a university. He has also served as both a local and regional director of special education in programs for various public school divisions, and as a public school speech pathologist.

Before his retirement in 1998, he was licensed by the Commonwealth of Virginia as a speech-language pathologist in the public schools and as a supervisor of special education. He was also licensed as a private speech-language pathologist.

Mr. Helliesen believes in the therapy practices developed by Dr. Van Riper. This therapy can free a severe stutterer from his disability, allowing him to achieve a good degree of fluency and a meaningful and productive life.

Contact the author at

mrh@tm.net
