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Recent advances in the treatment of stuttering: A theoretical perspective

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Abstract

Prolonged speech and its variants are widely used in the behavioral treatment of stuttering. Unlike these approaches, which depend on clinician-prescribed speech pattern changes, two behavioral treatment regimens, one for children and another for adults, recently developed at the Australian Stuttering Research Center, promote self-monitoring of speech as a means of controlling stuttering. In these programs, the clients themselves modify their speech in subtle and variable ways to gain control over stuttering and, in that, they appear to be similar to a well-known experimental technique for suppressing stutters known as response contingent stimulation. The present paper provides an integrated explanation for the effectiveness of both clinician-directed as well as client-initiated speech pattern modifications and, in the process, develops a new model of stuttering. It also shows why client-generated speech patterns changes potentially produce faster and more lasting improvement than those changes prescribed by a clinician.

Learning outcomes: The reader will learn about: (1) two hypothesized methods of preparing utterance motor plans—speech concatenation and speech construction; (2) how behavioral treatment programs make use of speech construction to promote fluency in persons who stutter; (3) why therapy procedures based on cognitively driven speech construction produce faster and superior results than those based on motorically driven speech construction; and (4) the empirical evidence that suggests that speech concatenation is the source of stuttering.

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1. Introduction

For over half a century, primarily influenced by Johnson's (1942) diagnosogenic theory, speech–language pathologists had shown great trepidations about offering direct treatment for stuttering in young children. Recently, however, work carried out at the Australian Stuttering Research Center, which is based on a path-breaking study reported by Martin, Kuhl, and Harlodson (1972), has shown that stuttering in children can be treated safely (Woods, Shearsby, Onslow, & Burnham, 2002), efficaciously (Harris, Onslow, Packman, Harrison, & Menzies, 2002; Onslow, Menzies, & Packman, 2001), and economically (Jones, Onslow, Harrison, & Packman, 2000) with a home-based operant treatment regimen called the Lidcombe program. In the Lidcombe program, parents are trained to: (1) administer verbal praise and occasionally tangible rewards contingent on fluent utterances; (2) request in a nonthreatening manner that stuttered utterances be replaced with fluent utterances; and (3) rate stuttering severity on a daily basis on a 10-point scale (Onslow, Menzies, et al., 2001; Onslow, Ratner, & Packman, 2001). The most striking feature of the Lidcombe program is that neither the clinicians who work with the child while training the parents in the clinic nor parents who, for the most part, administer the treatment outside of the clinic attempt to modify the child's speech either through instructions (e.g., "speak slowly" or "draw out words," etc.) or by way of modeling. Onslow, Stocker, Packman, and McLeod (2002), after failing to find consistent acoustic timing differences between pre- and post-treatment speech of a group of children who successfully completed the Lidcombe program, concluded that no satisfactory explanation exists for the success of the program.

In another study, O'Brian, Onslow, Cream, and Packman (2003) described a treatment regimen for adults called the Camperdown program that initially and briefly required participants to adopt a slow (70 syllables/min), prolonged speech pattern modeled in a videotape. In later stages of treatment, participants were only required to produce speech that was rated 1–2 on a 9-point stuttering severity scale and 1–3 on a 9-point speech naturalness scale without having to meet any specific targets for speech modification such as speech rate, gentle voice onset, continuous vocalization, etc. Sixteen participants, out of the original group of 30, who completed the program met and maintained the stuttering severity and speech naturalness criteria and achieved a satisfactory rating on a lay listener based social validation measure 12 months post-treatment. Prolonged speech based stuttering treatment typically involves "shaping" speech systematically by requiring participants to meet specific criteria for rate and an assortment of related speech modifications such as gentle voice onset, continuous vocalization, and soft articulatory contact in small, incremental steps (Ingham, 1984; Onslow, 1996). The Camperdown program demonstrated that people who stutter (PWS) could develop natural-sounding, nearly stutter-free speech without specific clinician instructions with regard to speech modifications although they do require consistent and reliable feedback concerning stuttering severity and speech naturalness.

The success of the Lidcombe and the Camperdown programs appear to suggest that many children and adults who stutter are able to produce nearly stutter-free and natural-sounding speech by: (1) developing a cognitive set to speak without stutters and (2) monitoring their speech, initially with the help of clinicians or family members, to verify

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