



The effectiveness of stuttering treatments in Germany



Harald A. Euler^{a,*}, Benjamin P. Lange^b, Sascha Schroeder^{c,d}, Katrin Neumann^a

^a Department of Phoniatics and Pediatric Audiology, Clinic of Otolaryngology, Head and Neck Surgery, St. Elisabeth Hospital, Ruhr-University Bochum, Bleichstr. 16, D-44787 Bochum, Germany

^b Department of Medical Psychology and Medical Sociology, Georg-August-University Goettingen, Waldweg 37, D-37073 Goettingen, Germany

^c Max Planck Institute for Human Development, Lentzeallee 94, D-14195 Berlin, Germany

^d Institute of Psychology, University of Kassel, Hollaendische Str. 36–38, D-34127 Kassel, Germany

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ABSTRACT

Purpose: Persons who stutter (PWS) should be referred to the most effective treatments available, locally or regionally. A prospective comparison of the effects of the most common stuttering treatments in Germany is not available. Therefore, a retrospective evaluation by clients of stuttering treatments was carried out.

Method: The five most common German stuttering treatments (231 single treatment cases) were rated as to their perceived effectiveness, using a structured questionnaire, by 88 PWS recruited through various sources. The participants had received between 1 and 7 treatments for stuttering.

Results: Two stuttering treatments (stuttering modification, fluency shaping) showed favorable and three treatments (breathing therapy, hypnosis, unspecified logopedic treatment) showed unsatisfactory effectiveness ratings. The effectiveness ratings of stuttering modification and fluency shaping did not differ significantly. The three other treatments were equally ineffective. The differences between the effective and ineffective treatments were of large effect sizes. The typical therapy biography begins in childhood with an unspecified logopedic treatment administered extensively in single and individual sessions. Available comparisons showed intensive or interval treatments to be superior to extensive treatments, and group treatments to be superior to single client treatments.

Conclusion: The stuttering treatment most often prescribed in Germany, namely a weekly session of individual treatment by a speech-language pathologist, usually with an assorted package of mostly unknown components, is of limited effectiveness. Better effectiveness can be expected from fluency shaping or stuttering modification approaches, preferably with an intensive time schedule and with group sessions.

Educational objectives: Readers will be able to: (a) discuss the five most prevalent stuttering treatments in Germany; (b) summarize the effectiveness of these treatments; and (c) describe structural treatment components that seem to be preferable across different kinds of treatments.

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* Corresponding author. Tel.: +49 234 612470; fax: +49 234 509 8393.

E-mail addresses: euler@uni-kassel.de (H.A. Euler), benjamin.lange@med.uni-goettingen.de (B.P. Lange), sascha.schroeder@mpib-berlin.de (S. Schroeder), Katrin.Neumann@rub.de (K. Neumann).

1. Introduction

Stuttering treatments are shown to have a lasting effect, both for speech outcomes and for social, emotional, and cognitive outcomes, if they contain variants of slowed speech, soft voice onset, continuous phonation, self-management, response contingencies, exercises in group sessions, and transfer into non-clinical settings (Bothe, Davidow, Bramlett, & Ingham, 2006; Herder, Howard, Nye, & Vanryckeghem, 2006). For preschool children, parental reinforcement for fluent speech has also shown effectiveness (Lattermann, Euler, & Neumann, 2008; Nye et al., 2013). Pharmacological treatments have had unsatisfactory outcomes thus far (Bothe, Davidow, Bramlett, Franic, & Ingham, 2006).

One of the most important findings regarding stuttering treatment effects, particularly in the study of Bothe, Davidow, Bramlett, Franic, et al. (2006) and Bothe, Davidow, Bramlett, and Ingham (2006) and most saliently in Nye et al. (2013), is that only a minority of studies fulfill methodological quality criteria of modern evidence-based research. Bothe, Davidow, Bramlett, Franic, et al. (2006) and Bothe, Davidow, Bramlett, and Ingham (2006) required as inclusion criterion that four out of five quality criteria (random assignment to groups or qualified single-subject design; blind or independent observers; both pre-treatment and post-treatment data; beyond-clinic data; controls for speech rate and naturalness) had to be fulfilled. The authors identified 39 out of 162 studies published between 1970 and 2005 that fulfilled their relatively lenient inclusion criterion. Nye et al. (2013) meta-analyzed the reports about treatment effectiveness in children and adolescents between the ages of 2 and 18 years, first excluding single-subject studies, pharmacological studies, and studies which did not report fluency measures, with a stricter methodological inclusion criterion provided by the Downs & Black, 1998 Downs and Black Checklist (1998). This checklist assesses five categories of methodological quality (reporting, external validity, internal validity bias, internal validity confounding, and power) and yields an overall methodological quality rating by expert raters. With a relatively moderate and compliable cut-off (14 out of a possible 26 points) the authors could include only nine studies, from 312 citations that fulfilled the first inclusion criteria.

Studies reported in German journals were not included in the above-mentioned reviews. To our knowledge there is at least one German study (Euler & Wolff von Gudenberg, 2000) which probably would have otherwise been included in the Bothe, Davidow, Bramlett, Franic, et al. (2006) and Bothe, Davidow, Bramlett, and Ingham (2006) review. An effectiveness comparison of German treatments in order to inform German prescribers is needed, but is not available. However, it is not given that the effectiveness and efficiency of treatments performed by experts under selected and often ideal circumstances, such as reported in the above-mentioned systematic reviews, compares to the effectiveness and efficiency of the same kind of treatments delivered in everyday domestic contexts (Langevin et al., 2006).

Persons who stutter (PWS) or whose parents search for stuttering treatment have the right to get the most effective and evidence-based treatments recommended by professionals (Yaruss, 2001) which are locally or regionally available. Therefore, a Germany-wide retrospective questionnaire-based study on the rated effectiveness of stuttering treatment is reported in this paper. It can be expected that some of the results are generalizable to countries other than Germany, depending on how access to stuttering treatments differs between Germany and other countries where stuttering treatments are provided. Therefore, the treatment situation in Germany is described first, followed by the situation in a few selected countries. We omit the North American countries, assuming that most readers are relatively well informed about stuttering treatment in the United States and Canada.

1.1. Access to stuttering treatments in Germany, Australia, and Eastern Europe

In Germany, parents who are concerned that their child might stutter most often consult a physician (pediatrician, phoniatrician/pediatric audiologist, otorhinolaryngologist) who prescribes a treatment and refers the child to a logopedist (the most common Continental European occupational title for a speech-language pathologist) in a private practice or, less frequently, to a stuttering treatment center. Adult PWS who seek treatment also consult a physician in order to obtain a medical referral. The latter is required for health insurance coverage. Health insurance, which is obligatory in Germany (either public or private), covers the costs for unspecified logopedic treatments in private practices and, in most cases, partly for selected specific treatments, such as fluency shaping treatments or stuttering modification treatments (Peters & Guitar, 1991), provided in centers. Other therapies, such as breathing regulation or hypnosis-based treatments, have to be covered by the patients or parents themselves.

In Australia, as an example of an English-speaking country, speech pathology services for stuttering are provided in hospitals, schools, health centers, and private practices. A medical referral is not required. Services in the public sector are free of charge and optional health insurance covers part of the costs in the private sector. Financial support is also provided by the government for a limited number of sessions with a private practitioner. As stuttering has quite a high profile in Australia, parents of preschoolers who start to stutter will often contact a speech pathologist directly for a consultation (A. Packman, personal communication, May 15, 2013).

In most Eastern European countries (Fibiger, Peters, Euler, & Neumann, 2008), stuttering treatment for children is offered in kindergartens, schools, or health services and is usually free of charge. Coverage of treatment is provided by educational systems, health services, or social/health insurance. In many Eastern European countries, but not in Bulgaria and Russia, adults receive free treatment through the public health system or get full or partial reimbursement from their health insurance. Many different kinds of therapeutic approaches are reported, but fluency shaping treatment is dominant,

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