

Cognitive behavior therapy for adults who stutter: A tutorial for speech-language pathologists

Ross G. Menzies, Mark Onslow^{*}, Ann Packman, Sue O'Brian

Australian Stuttering Research Centre, The University of Sydney, Lidcombe, NSW, Australia

Received 5 March 2009; received in revised form 11 September 2009; accepted 12 September 2009

Abstract

This paper explores the relationships between anxiety and stuttering and provides an overview of cognitive-behavior therapy (CBT) strategies that can be applied by speech-language pathologists. There is much support for the idea that adults who stutter (AWS) may need CBT. First, approximately 50% of AWS may be suffering from social anxiety disorder. A difficult developmental history marked by problematic peer relationships and bullying may contribute to this. Stereotypes in the general community lead AWS to have occasional experiences that confirm their fears of negative evaluation. This can leave AWS with significant social and occupational avoidance and can impact on their quality of life. Second, in a recent large study of behavioral treatment for AWS, participants who had a mental health disorder, including social anxiety, failed to maintain the benefits of treatment. Available evidence supports the contention that CBT can effectively decrease anxiety and social avoidance, and increase engagement in everyday speaking situations for AWS. The components of CBT presented here are drawn from a model widely used in clinical psychology, and existing supportive data reviewed. Worksheets for speech-language pathologists undertaking CBT in this population are provided. CBT procedures, in their essentials, are straightforward to implement. Hence, the present authors suggest that speech-language pathologists who have had training in conducting CBT should be able to apply the techniques described in this paper.

Educational objectives: The reader will be able to explain: (1) the relation between stuttering and anxiety; (2) the nature of Social Anxiety Disorder; (3) why those who stutter are often diagnosed with Social Anxiety Disorder; (4) the four components of cognitive behavior therapy; (5) how cognitive behavior therapy is adapted for the management of speech-related anxiety in those who stutter. © 2009 Elsevier Inc. All rights reserved.

Keywords: Stuttering; Anxiety; Cognitive-behavior therapy; Treatment

1. Introduction

Evidence shows that efficacious speech pathology treatment for stuttering is available in early childhood (see Jones et al., 2005) however, stuttering in adults is much less responsive to speech therapy (Craig & Hancock, 1995). The strongest evidence-base for stuttering treatments in adulthood is for behavioral speech programs involving speech restructuring (for overviews, see Ingham, 1984; Onslow, 1996; Onslow, Jones, O'Brian, Menzies, & Packman, 2008;

^{*} Corresponding author. Tel.: +61 2 9351 9061; fax: +61 2 0351 9392.

E-mail addresses: r.menzies@usyd.edu.au (R.G. Menzies), m.onslow@usyd.edu.au (M. Onslow), a.packman@usyd.edu.au (A. Packman), s.obrian@usyd.edu.au (S. O'Brian).

Packman, Onslow, & Menzies, 2000). Currently, in these treatments, clients learn one of a number of novel speech patterns generically referred to as *prolonged speech*. The changes to speech production that occur with this speech restructuring enable the speaker to suppress stuttering to varying degrees. It has been suggested that these ameliorative effects may be due to reduction in the variability of speech motor activity inherent in the new speech pattern (Packman et al., 2000). Historically, speech-restructuring treatments have included shaping the new speech pattern to sound as natural as possible, with subsequent graded exposure using it in everyday speaking situations (see Ingham, 1984).

Systematic reviews have shown that while these treatments can produce medium to large effects in the medium to long term (Andrews, Guitar, & Howie, 1980), failure to maintain treatment effects remains a common problem (Craig & Hancock, 1995). AWS typically report that restructured speech sounds or feels different from typical speech and that they can be reticent to use it in some communicative contexts. Furthermore, even after gaining control over their stuttering with treatment, participants continue to regard themselves as people who stutter (Cream, Onslow, Packman, & Llewellyn, 2003).

1.1. Stuttering and the development of social anxiety

One explanation for the difficulty involved in maintaining the effects of behavioral treatments is that AWS can frequently have disabling levels of social anxiety (Craig, Blumgart, & Tran, 2009; Kraaimaat, Vanryckeghem, & Van Dam-Baggen, 2002; Menzies et al., 2008; Messenger, Onslow, Packman, & Menzies, 2004; Schneier, Wexler, & Liebowitz, 1997; Stein, Baird, & Walker, 1996). Stein et al. (1996) found that 44% of adults seeking treatment for stuttering warranted the co-morbid diagnosis of social phobia; they experienced anxiety and avoidance of social situations that were not in keeping with a realistic appraisal of threat. Subsequently, Schneier et al. (1997) confirmed Stein et al.'s (1996) finding that AWS have similar levels of social anxiety to non-stuttering adults presenting with social phobia. More recently, Kraaimaat et al. (2002) reported that approximately 50% of a large sample of AWS ($n = 89$) had social discomfort scale scores within the range of a group of "highly socially anxious psychiatric patients" (p. 319). Messenger et al. (2004) found that 34 AWS scored significantly higher on the fear of negative evaluation (FNE) scale than non-stuttering controls. Menzies et al. (2008) reported that 60% of their sample of 30 adults who stuttered and sought treatment, met the DSM-IV diagnostic criteria for Social Anxiety Disorder. Most recently, in a large study of 200 AWS, Craig et al. (2009) found that stuttering impacts negatively on quality of life, in particular on social functioning and mental health.

The development of social anxiety can relate to negative conditioning experiences in early childhood (for example Ost, 1976). Bullying has been shown to increase the risk of later anxiety disorders. Gega, Kenwright, Mataix-Cols, Cameron, and Marks (2005) compared the rate of bullying in retrospective reports of individuals in a South London dental clinic waiting room and a South London anxiety disorders clinic waiting room. Those adults waiting for treatment for anxiety disorder were six times more likely to have experienced bullying in early childhood than those waiting for dental treatment. Though this study relied on retrospective reports and the accuracy of patient memories, which of course are subject to bias and error, it points to the potentially important link between early bullying and anxiety in later life.

The finding is relevant to stuttering because of reports of negative peer responses to stuttering in children and higher than normal rates of bullying among children who stutter. This can start early in life. In an in-depth field study, Langevin, Packman, and Onslow (2009) observed instances where preschool children in the playground suffered social penalty as a result of their stuttering.

This becomes more apparent in the school-age years, including adolescence (for reviews and recent reports see Blood & Blood, 2004, 2007; Davis, Howell, & Cooke, 2002; Hearne, Packman, Onslow, & Quine, 2008; Hugh-Jones & Smith, 1999; Langevin & Hagler, 2004; Langevin, Kully, & Ross-Harold, 2007; Mulcahy, Hennessey, Beilby, & Byrnes, 2008; Murphy, Yaruss, & Quesal, 2007a; Murphy, Yaruss, & Quesal, 2007b). Hugh-Jones and Smith explored the nature and frequency of bullying among 276 respondents from the British Stammering Association. They found that the majority of participants had experienced bullying at school. Most reported immediate negative emotional effects from this bullying and 46% reported some long-term effects in functioning. The rate of bullying among children who stutter was thought to be so high that the authors developed a school-resource pack to create a more empathic school climate for the child with a stutter. Langevin and Hagler reported that primary school children who stutter are perceived negatively by their non-stuttering peers and Davis et al. showed that children who stutter have more difficulty establishing peer relationships than those who do not stutter. This finding is noteworthy, since Hugh-Jones

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