Commentary

Two paradoxes in stuttering treatment

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Abstract

The premise of this article is that effective communication should be a central, over-arching goal in the treatment of stuttering. Not focusing on communication may have some unintended negative consequences on treatment. The negative consequences are the result of two paradoxes that confront clinicians and clients: the listener paradox and the communication paradox. The listener paradox concerns the different ways that typical listeners and clinicians respond to stuttering. The communication paradox concerns the use of treatment procedures that may have negative consequences on communication. Clinicians and clients need to evaluate treatment procedures in terms of the effect they may have on communication. Understanding these two paradoxes and making effective communication the focus of treatment may improve the long-term treatment outcomes of people who stutter.

Educational objectives: The reader will learn about (1) why effective communication should be the central goal in the treatment of stuttering; (2) how the listener and communication paradoxes may negatively impact on communication; and (3) how understanding these paradoxes may improve the long-term outcomes of people who stutter and also improve the comfort level clinicians have in treating individuals who stutter.

Keywords: Stuttering treatment; Clinical training

It is generally agreed that stuttering is a speech disorder that has an adverse effect on communication. Communication can be defined as the process of exchanging information and ideas that involves encoding, transmitting, and decoding messages (Owens, 2002). People who are effective communicators are able to transmit their intended meanings in a manner that makes it easy for listeners to understand the
A number of factors influence how well speakers communicate their intended meanings, including the linguistic complexity of the message, the vocabulary used, paralinguistic features of the message (e.g., stress, intonation, rate, and fluency), and nonlinguistic features such as gestures, body posture, facial expression, eye contact, head movements, and proxemics. Differences or abnormalities in any of these areas can potentially have an adverse effect on communication.

Communication difficulties are a central component of stuttering. Almost all avoidance behaviors have an impact on communication. Intended meanings may not be communicated if the person who stutters avoids certain speaking situations (e.g., the telephone), chooses not to talk to a particular person, or tries to avoid using particular words or sounds. Fluency disruptions and nonlinguistic behaviors (e.g., lack of eye contact, facial tension, abnormal head movements) may also detract from transmitting intended meanings. The message may be well formed grammatically with appropriate vocabulary, but the listener may be distracted by the fluency disruptions and associated nonlinguistic behaviors. Stuttering also may evoke negative listener reactions and attitudes that affect the exchange of information.

Given the adverse effect that stuttering has on communication, one would expect that treatment approaches would explicitly target improved communication. Although improved communication is a desired outcome of most treatment approaches, treatment varies widely in how explicitly communication skills are addressed (cf. Contour, 2001; Guitar, 1998; Shapiro, 1999). In some cases, communication may not be addressed at all because it is assumed that increases in fluency and decreases in stuttering behavior will lead directly to improved communication. As people who stutter gain more control over their speech and reactions to speech, they become better able to communicate a full range of intentions and meanings in a variety of communicative contexts. As fluency increases, they are also less likely to evoke negative reactions in listeners that may lead to communication breakdowns. Directly targeting communication is thus not necessary.

It seems indisputable that communication will improve with increases in fluency and decreases in negative emotion and avoidance behaviors. But communication needs to be explicitly targeted in therapy to ensure that people who stutter understand that effective communication is the long-term goal of therapy and that fluency is just one factor, albeit an important one, that contributes to effective communication. Making communication the overarching goal of therapy also ensures that clinicians address aspects of therapy that may be inconsistent with principles of effective communication.

In this article, I discuss two inconsistencies or paradoxes that confront clinicians in their treatment of people who stutter: the listener paradox and the communication paradox. The listener paradox concerns the different ways that typical listeners and clinicians respond to stuttering. The communication paradox concerns the use of treatment procedures that may have negative consequences on communication. In the sections to follow, I discuss these two paradoxes in more detail and show how the potential negative effects of these paradoxes can be mitigated by making
effective communication the central, overarching goal of stuttering treatment. Making effective communication the focus of treatment will not only benefit clients who stutter, but may also help clinicians better understand some of the inconsistencies that exist in stuttering therapy.

1. The listener paradox

Listener reactions to people who stutter are well known to people in our profession, but they are still newsworthy. Consider these excerpts from a recent article in U.S. News and World Report (Sobel, 2001):

The hardest words for Kurt Salierno to say is his own name. “Most people I meet know me as George,” he says, chuckling. When Salierno jumbled his speech as a child, his teachers decided he was mentally retarded. In some ways, it’s no easier today. When Salierno tried to order pizza a few weeks ago, the clerk thought it was a prank and hung up on him. Security guards recently surrounded him at a Wal-Mart because an employee mistook him for mentally ill. David Berger, a 26-year-old doctoral student at the University of Pittsburgh, can write eloquently about ancient philosophers but needs 10 seconds to say the word hello on the telephone. And Stephen Essman, an eighth grader in Oceanside, CA has adjusted well in middle school but still has to face classmates who call him a “scratched CD.”

Clinicians are very familiar with examples such as these as well as others. A friend of mine was recently given a breathalizer test because she stuttered when she called the police after someone broke into her house. Education level also appears to have no influence on reactions to stuttering. Shapiro (1999) provides a personal example of a university meeting at which all of the faculty had to introduce themselves. He had the slightest delay before introducing himself when the professor next to him said, “David Shapiro, Human Services. Come on. Say it!” Shapiro fought back feelings of “self-pity and worthlessness” by focusing instead on the “professional immaturity, intolerance, and impertinence” of his colleague (p. 420).

The reality of stuttering is that it evokes these kinds of comments and reactions from people. The people who make these kinds of comments and have these reactions to stuttering are not necessarily being mean, rude, or intolerant of someone who stutters. They may think the person who stutters has an emotional problem or has had too much to drink, but these thoughts may stem more from ignorance than intolerance. Remember, however, that clinicians with knowledge about stuttering still maintain unsubstantiated views about people who stutter (Cooper & Cooper, 1996). Even the professor’s behavior, though seemingly insensitive, may not have been intended to be mean spirited. Shapiro notes that the first person to introduce himself “established a quick, crisp, staccato pattern of introduction” (p. 419), so the professor’s comment may have simply been his attempt to maintain the pace of the introductions.
Stuttering also does not have to be particularly severe for listeners to be seen as reacting inappropriately when speaking with someone who stutters. It is common for listeners to avert their gaze when someone is stuttering, help when there is difficulty saying a word, interrupt when there is a break in communication or even when there is not, and show some concern. It is also not easy to focus on what is being said when speech is moderately to severely disfluent. This is not to say that all typical listeners are sensitive and tolerant of stuttering. Some listeners may be rude and insensitive, but they are probably just as rude and insensitive to people who do not stutter as they are to people who stutter. The examples I have provided in this section have all been anecdotal. There is a body of literature on gaze aversion, however, that supports the claims I am making.

1.1. Gaze aversion

One of the most common listener reactions to stuttered speech is averting eye contact. There is a rich body of literature showing that people avert their gaze not only from faces, but from any potentially distracting source of visual stimulation (e.g., Glenberg, Shroeder, & Robertson, 1998). There are also many studies showing that during a difficult cognitive activity (e.g., remembering information, thinking of an answer to a question, planning what to say, and speaking), people often close their eyes, look up at the sky, or look away from the person with whom they are talking (Doherty-Sneddon, Bruce, Bonner, Longbotham, & Doyle, 2002). In fact, the cognitive difficulty of a task has been directly linked to the likelihood that people avert their gaze from other people’s faces and that this gaze aversion often improves response accuracy (Glenberg et al., 1998). Listeners are particularly sensitive to a speaker’s gaze behavior. Any shift in a speaker’s gaze or head orientation has been found to trigger a reflexive shift in a listener’s visual attention even when the listener has been instructed to ignore the cues (e.g., Langton & Bruce, 1999). Indeed, gaze aversion is such a strong reflex that it occurs even when listeners are asked to look at the speaker as the example below illustrates.

In my undergraduate survey class on communication disorders, I begin my class on stuttering by telling the students that I am going to demonstrate some stuttering behaviors and I want them to look at me and write down the characteristics of these behaviors. The students typically do a nice job of identifying the various kinds of disfluent behaviors and secondary symptoms, but the vast majority report that they have difficulty looking at me when I am stuttering. Follow-up queries reveal that most of the students did not look at me because I was not looking at them. Some reported that they were able to look at me until my eyes began to blink. One of the more interesting responses came from a student who did maintain eye contact. She said that it wasn’t hard to look at me because she knew I wasn’t “a real stutterer.” In other words, it is possible to look at someone stutter if you know they are only pretending.

It should be apparent that gaze aversion is a natural and communicatively appropriate behavior in speakers as well as listeners. It is often assumed that people
who stutter avert their gaze because of the negative emotion associated with stuttering or the possibility of a negative listener reaction. Gaze aversion may become associated with negative emotions over time, but the incipient cause of gaze aversion and what makes it difficult to eliminate is more likely to be the high cognitive load associated with speech in people who stutter. It is also generally assumed that listeners who avert their gaze when someone is stuttering are being insensitive or rude. Although some listeners may be insensitive or rude, most are not. They avert their gaze either as a reflexive action to a speaker’s shift in gaze or as a response to the distracting visual and auditory stimulation associated with stuttering. In both cases, gaze aversion is a predictable response to the communicative situation.

1.2. Clinician reactions to stuttering

In Section 1.1, I have tried to show with anecdotes and empirical studies that most typical listeners respond in predictable, appropriate ways to stuttering and people who stutter. It is very important to make this point because there seems to be a widespread belief in our profession that many typical listeners respond in inappropriate ways to stuttering and people who stutter. Perhaps some clinicians have forgotten that they once had to be taught how to respond to people who stutter.

Every clinician is familiar with the basic rules of what to do and what not to do when speaking with someone who stutters. The Stuttering Foundation of America (2001) even has a publication (#46) entitled “How to React When Speaking with Someone who Stutters.” The first three rules below are adapted from this publication. The fourth rule is one that I have often heard in my professional career.

Rule 1: Maintain natural eye contact even during moments of stuttering.
Rule 2: Wait patiently and naturally until the person is finished. Do not finish sentences or fill in words.
Rule 3: Let the person know by your manner and actions that you are listening to what he or she says — not how they say it.
Rule 4: Try not to show any discomfort, empathy, or pity for someone who stutters.

What is noteworthy about these rules is that people rarely react to someone who stutters or stuttering in these ways. As I showed in Section 1.1, gaze aversion is a common reflexive action to a shift in eye gaze. Filling in words, interrupting when there is a break in communication, and showing some concern are also common listener reactions to stuttering. It is also not always easy to focus on what is being said if the stuttering is relatively frequent or accompanied with other struggle behaviors. Because it is not readily apparent how one should respond to someone who stutters, most listeners need some specific instruction and guidance in the rules for what to do and what not to do in speaking with someone who stutters.

Not coincidentally, these rules are one of the first things clinicians learn when they begin to work with clients who stutter. Knowing how to respond to stuttering and the person who stutters is an important part of the therapy process. Consider, for example, how responding to what the person is saying puts the focus on
communication rather than on fluency or how maintaining eye contact and waiting for the person to finish a thought focuses attention on the person as a communicator and indicates that one cares about what the person is saying. Although these listener reactions may be difficult to learn, they are important for everyone who interacts with people who stutter on a regular basis. Note that clinicians are often faced with the additional burden of trying to focus on what the person who stutters is saying while at the same time monitoring and providing feedback about fluency.

Because most listeners are not familiar with the rules for speaking with people who stutter, clinicians need to be careful not to create unrealistic expectations in their clients about how listeners should react to stuttering. They should help people who stutter learn to differentiate the few rude and insensitive listeners from the vast majority of listeners who are trying to be sensitive, but are not familiar with the rules for reacting to stuttering. Clinicians also need to make sure their clients recognize that the way they are responding to stuttering does not represent typical listener behavior. They may consider simulating typical listener reactions to reduce the negative emotions and reactions that these reactions might cause.

Becoming aware of the listener paradox may have the added benefit of making clinicians reflect on the difficulty they may have had or still have in maintaining eye contact and following some of the other rules. Numerous surveys (e.g., Cooper & Cooper, 1996; Yaruss, 2003) have shown that speech-language pathologists are less comfortable treating stuttering than other disorders, even though most clinicians have many of the skills and knowledge necessary to provide effective treatment. It is not unreasonable to speculate that the listener paradox may contribute to this discomfort. If this is the case, then understanding the source of the paradox may have the added benefit of increasing the comfort level clinicians have in treating stuttering.

2. The communication paradox

The communication paradox refers to the use of a treatment approach that may have negative consequences on communication. Although improved communication is clearly an important component of the two major approaches for treating stuttering (fluency shaping and stuttering modification), some of the techniques used in these approaches have the potential of adversely affecting communication. For example, with fluency shaping, individuals usually are taught to speak in a slow, prolonged nonstuttered manner (e.g., Shames & Florance, 1980; Shapiro, 1999; Wingate, 1976). Although natural-sounding spontaneous fluency is the goal of fluency shaping programs, some individuals may not achieve high levels of spontaneous fluency. Fluency is achieved, but it is a controlled fluency that requires considerable attentional resources to maintain. More importantly, this controlled fluency often sounds artificial and may evoke more negative listener reactions than stuttering does. Increased fluency thus might come with a cost — an increase in negative listener reactions due to the artificial quality of the fluent speech.
Voluntary stuttering is another example of an aspect of stuttering treatment that may have negative consequences on communication. Voluntary or fake stuttering is one of the techniques used in the desensitization phase of therapy that is common in stuttering modification approaches (e.g., Shapiro, 1999; Van Riper, 1982). In this treatment phase, a variety of procedures are used to reduce the avoidance behaviors, fears, and negative attitudes associated with stuttering. By intentionally stuttering, the client weakens the association between stuttering and negative emotion and also gains a feeling of control over stuttering. In some cases, however, voluntary stuttering, like controlled fluency, may sound very artificial and elicit more negative reactions from listeners than stuttered speech. Although the benefits of voluntary stuttering are clear, it may be important to make sure clients are aware of the possible negative consequences of fake stuttering.

Eliminating the avoidance behaviors, fears, and negative attitudes associated with stuttering is an important phase in the treatment of stuttering. It is just as important, however, to recognize that the maze behaviors people who stutter use to avoid stuttering, such as substituting words, paraphrasing, circumlocuting, pausing, and using interjections, do not necessarily detract from effective communication. In fact, these behaviors are not only used by typical speakers, but they are also commonly recommended for other individuals with communication disorders. In these cases, they are referred to as “compensatory communication strategies.” For example, individuals with word retrieval problems or other expressive language problems are often encouraged to do whatever it takes (substitute words, paraphrase, circumlocute, pause, etc.) to communicate their ideas and intentions. With people who stutter, there is good reason to view these behaviors as inappropriate because they are one of the manifestations of the avoidance behaviors and fears associated with stuttering. But these compensatory strategies are not the problem; the problem is the fear and negative emotion associated with stuttering that leads to the ineffective use of these strategies. Once the avoidance behaviors and fears have been eliminated or significantly reduced, people who stutter can actually be encouraged to use certain maze behaviors (e.g., pausing, paraphrasing, and verbal placeholders) because they have the potential to enhance communication.

2.1. Targeting effective communication

The benefits of making effective communication the primary, overarching goal of stuttering treatment should be clear. Focusing on communication will benefit people who stutter by placing less emphasis on increasing fluency and reducing stuttering behaviors. People who stutter need to learn that effective communication involves more than just being fluent or being able to modify or eliminate stuttering behaviors. As Williams (1957) stated more than 40 years ago, “treatment procedures should not focus on stopping or controlling an entity called stuttering; rather, the changes should be in the positive direction of doing more things that normal speakers do” (p. 397). People who stutter need to learn about the factors that contribute to effective communication. The competent communicator is able
to “conceive, formulate, modulate, and issue messages and to perceive the degree
to which intended meanings are successfully conveyed” (Owens, 2002, p. 12).
Fluency is just one factor that may influence communication.

To place communication in a more prominent position in the treatment hierarchy
and follow Williams’ suggestion about doing more things that normal speakers do,
clients who stutter should be taught how to be disfluent like a normal speaker. This
means that clients should be taught to use whole word and phrase repetitions rather
than syllable or sound repetitions, prolonged interjections (e.g., “well . . .”) rather
than prolonged sounds or words, and silent pauses at appropriate junctures in the
communication exchange. And as long as the negative emotion associated with
stuttering has been eliminated or significantly reduced, the taboo against using
other maze behaviors (e.g., word substitutions, rephrasings, and circumlocutions)
should also be removed.

As clients who stutter learn to be disfluent like a normal speaker, they should also
be observing the frequency of disfluencies and maze behaviors in typical speakers
and the effect these behaviors have on communication. It is common in therapy to
have people who stutter observe and analyze the disfluencies in typical speakers.
Less common is focusing on the impact these disfluencies have on communication.
From their observations of typical speakers and listeners, people who stutter should
find that gaze aversion occurs in response to the speaker’s shift in gaze. When
the speaker maintains eye contact during a disfluent moment, most listeners do
not avert their gaze. They should also notice many examples of listeners helping
speakers find words and finish thoughts. Observations such as these should help
people who stutter recognize that listeners respond in predictable ways to gaze
aversion and communication breakdowns and that their behavior as a speaker thus
has a considerable influence on listener behavior.

Understanding the communication paradox may also help clinicians resolve
some questions they may have had about inconsistencies in procedures used to
facilitate fluency and those used to facilitate communication. With communication
as the primary goal of treatment, every approach to enhance fluency and modify
stuttering can be weighed in terms of how it impacts on communication. Some
clinicians might choose to use a particular approach because it is an important step
in the treatment process, even though in the short-term it might negatively impact
on communication. One would expect that in these instances, clinicians will discuss
the benefits as well as the negative consequences of the approach with their clients.

3. Conclusion

In this article, I have attempted to show why effective communication should
be a central, overarching goal of stuttering treatment. Not focusing on communi-
cation may have some unintended negative consequences on long-term treatment
outcomes. The negative consequences are the result of two paradoxes that confront
clinicians: the listener paradox and the communication paradox. The existence
of the two paradoxes seems undeniable, even if they are rarely acknowledged. Clinicians do respond to stuttering differently than typical listeners and they do occasionally use treatment procedures that have negative consequences on communication. It is also true that effective communication is not always an explicit goal in stuttering treatment. Becoming aware of these paradoxes and making effective communication the focus of treatment can only help in the long-term treatment outcome of people who stutter.

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References


CONTINUING EDUCATION

Two paradoxes in stuttering treatment

QUESTIONS

1. What factor does not influence effective communication?
   a. complexity of the message
   b. vocabulary used
2. Why does communication need to be explicitly targeted in therapy?
   a. Because people who stutter are poor communicators
   b. To ensure that fluency is not the only long-term goal of treatment
   c. To help people who stutter improve their language abilities
   d. To make people who stutter better listeners
   e. Because working of communication improves fluency

3. What is the listener paradox?
   a. Differences in the way listeners and people who stutter respond to stuttering
   b. Differences in the way listeners and parents respond to stuttering
   c. Differences in the way listeners and clinicians respond to stuttering
   d. Differences in the way clinicians and parents respond to stuttering
   e. Differences in the way clinicians and people who stutter respond to stuttering

4. What is the communication paradox?
   a. The use of treatment procedures that have negative consequences on fluency
   b. The use of treatment procedures that improve fluency and improve communicative effectiveness
   c. The use of treatment procedures that decrease fluency but improve communicative effectiveness
   d. The use of treatment procedures that improve fluency but decrease communicative effectiveness
   e. The use of treatment procedures that decrease fluency and communicative effectiveness

5. Which is not one of the rules for speaking with someone who stutters?
   a. Maintain natural eye contact
   b. Wait patiently until the person is finished
   c. Show empathy for the person who stutters
   d. Do not fill in words
   e. Listen to what the person is saying