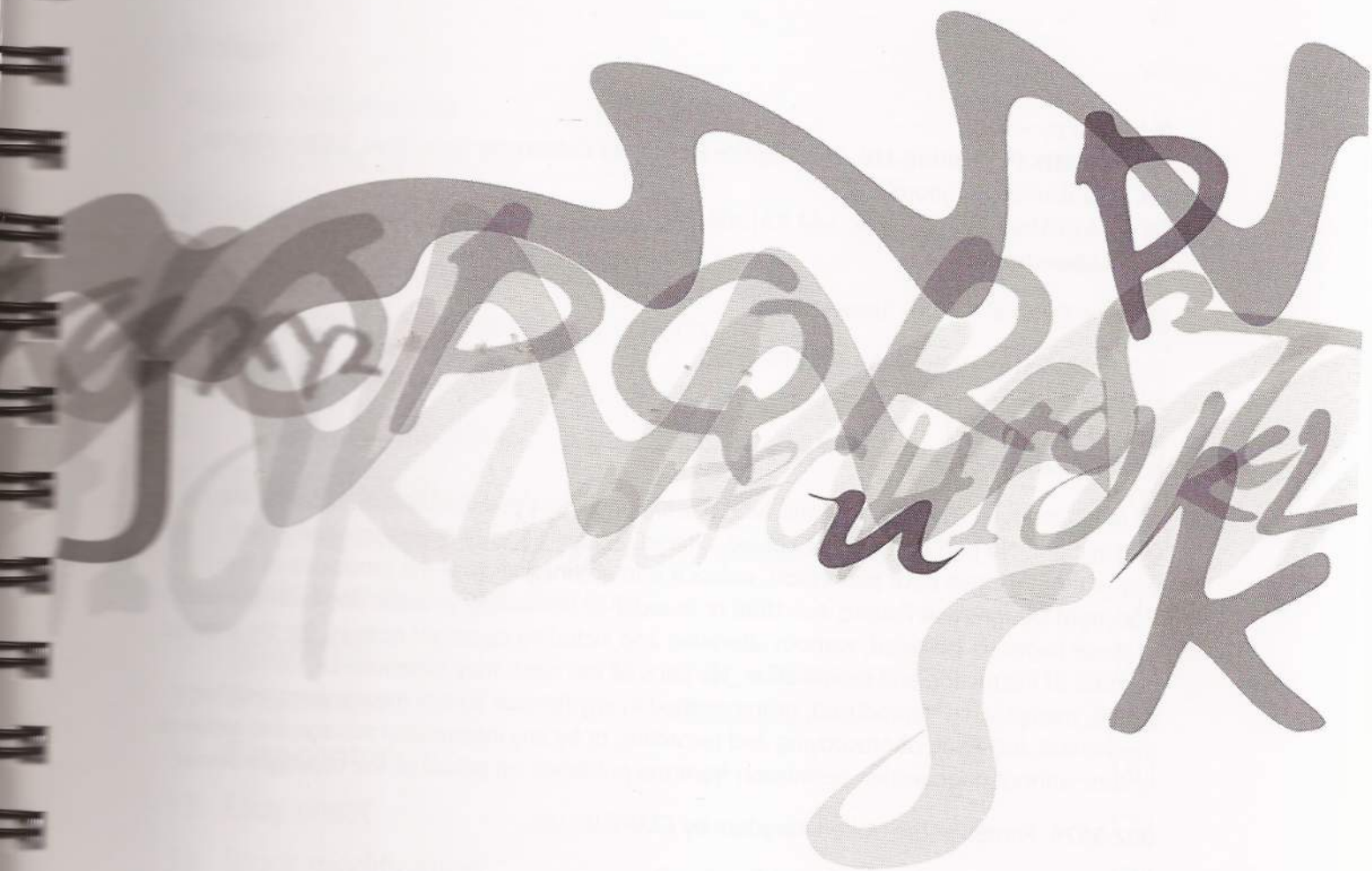
THE Dysfluency RESOURCE BOOK



JACKIE TURNBULL & TRUDY STEWART

Speechmark

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Foreword

Stuttering (or stammering) has been a baffling problem. There have been numerous unsubstantiated theories propagated over the decades and many different approaches to its treatment arising from those theories. Few clinicians and researchers have been willing to test rigorously individual treatments and fewer still have been willing to replicate. The result has been a confusing and undesirable state of affairs. This is unfortunate because stuttering can be a serious disorder for some. By its very nature it has the potential to produce barriers to successful and 'normal' verbal communication with an attached possibility of embarrassment and frustration. Few people enjoy being too different. Furthermore, social complications can arise as a result, characterised by problems ranging from shyness and avoidance to the potentially more serious such as social isolation and depression.

Given the above, it is not surprising that the treatment of stuttering has presented a difficult challenge for many clinicians working in the area. Because of the lack of replicated research we have a deficiency of treatment protocols which provide detailed treatment guidelines. A lack of available guidelines must eventually work to lower a clinician's confidence to treat stuttering. It may also encourage the futile search for the Holy Grail of stuttering, a panacea that will resolve all our treatment problems and which will cure the problem.

So far, this Foreword has been somewhat negative. While we have ample justification to be negative, there are always reasons to be optimistic. Being an optimist at heart, I believe the tide has turned and we are now seeing excellent international efforts in resolving the difficulties associated with stuttering. *The Dysfluency Resource Book* by Jackie Turnbull and Trudy Stewart is an example of why I am positive about the future. Both authors are very experienced clinicians and have conducted research into treatment issues. They therefore have a valuable resource from which they have drawn to produce this excellent workbook for stammering. The *Resource Book* provides sufficient background material on stuttering to allow professionals to grasp the problem, and the authors provide an outstanding summary and realistic description of treatment approaches from which clinicians may choose techniques. They also provide very useful exercises and worksheets that will greatly assist clinicians working with stuttering. I believe this book is a major step forward in addressing the confusion surrounding the treatment of stuttering.

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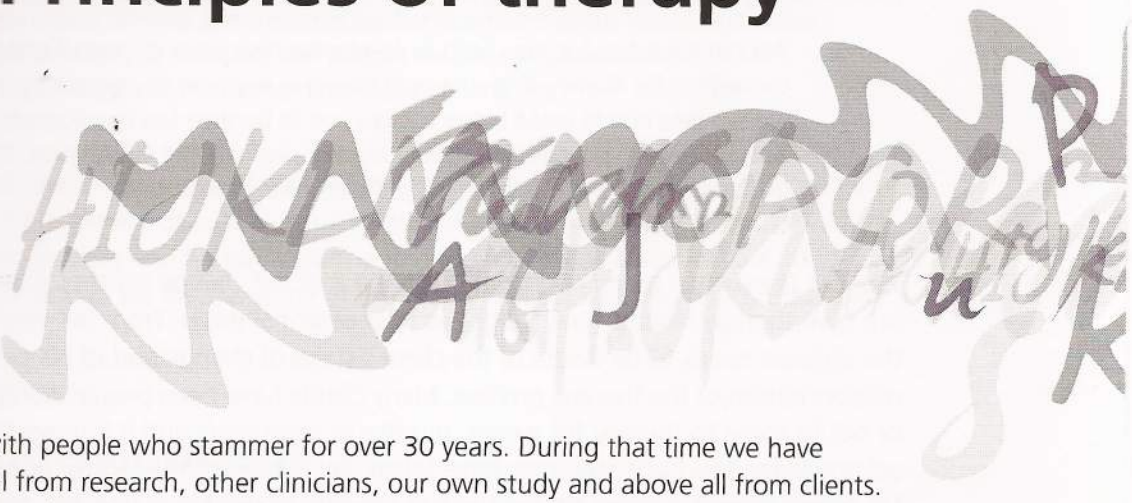
1 | Principles of therapy



We have worked with people who stammer for over 30 years. During that time we have learned a great deal from research, other clinicians, our own study and above all from clients. What any of us know about stammering is ever-changing, being challenged and redeveloped in the light of experience. This chapter represents some of our accumulated ideas and learning to date. We do not expect to feel exactly the same next month, next year or in five years' time. Indeed, we hope we do not, for it would mean that this field of study had stopped developing and that we had stopped learning.

We tell our clients that our aim is for them to end therapy being able to say what they want to say, when they want to say it, regardless of their level of fluency. How this aim is realised for each client will be unique. For some, it will involve fundamental changes in the way they construe stammering and fluency, and will entail very little, if any, change in actual speech production. For others, it will mean continuing use of techniques to control fluency and little change in their attitude to the way they speak. For most, it will be a combination of the two – a more positive approach to speaking and to the self as a speaker, reduced fear and avoidance, and the use of speech techniques in situations where increased fluency feels important. We hope that when a client ends his therapy, stammering will have become something he *does* rather than something he *is*. In other words, he will be a person first and the stammer will be just one aspect of that person.

Starting points in therapy

We work from a number of givens – attitudes, beliefs and behaviours that inform what we do.

The therapeutic relationship. There has been much discussion in recent years about the nature of the therapeutic relationship, not only in speech and language therapy but also in other caring professions (Lambert & Barley, 2001; Manning, 2000). There has been a move away from the 'medical' model in which the client comes to receive the expertise of the clinician, who has all the answers if only the client would take notice! However, we feel it is also important not to *deny* our expertise. Specialist stammering clinicians have studied their subject for many years and have learned much about its nature and about treatment approaches. Consequently, we prefer the concept of 'equal experts'. The client is the expert in his own stammering, how it affects him, how and what he wants to change and what he is prepared or able to do to allow those changes to happen. The clinician is an expert in theory and in a more generic understanding of the change process, its susceptibility to relapse and the many possible ways in which individuals experience stammering. We believe the best therapy

happens when the combined expertise of the client and the clinician is used. Manning uses the term 'leading from behind' to describe how this works in practice:

> We can assist him [*sic* the client] in developing new views of himself and new options concerning his fluency. With the right timing in response to changes by the client, we can help him to make better choices and to become less handicapped. We can also acknowledge that while we provide direction, insight, and information, the person who ultimately takes the lead in repairing the problem is the client.
> (2000, p226)

Work at the client's speed and from where he is in the change process. Experience and our own therapy failures have taught us how essential this is. From the very first session the clinician needs to be aware of the client's stage of change and of his perception or misconception of the therapy process. Many clients have been prevaricating over whether or not to come to therapy for weeks, months or even years and it is important that we acknowledge this huge step they have taken. For some a 'softly, softly' approach is needed, for others there is a desire to 'get the ball moving' as quickly as possible. Some may have been persuaded to come for help. Others will have fixed ideas about what therapy will entail: for example, Joanne thought group therapy would be like an Alcoholics Anonymous meeting, with each session starting with an 'I am a stammerer' confession.

It is important that we conduct a first session very carefully with all these (and more) possibilities in mind if we are to engage the client in the therapy process (if we both agree this is what is right for him at this point in time) and ensure he returns for future sessions. We will be saying more about this when we consider a 'stages of change' model later in this chapter.

Additionally, we must be aware that the speed at which someone is willing or able to change is not fixed and may not remain static throughout therapy. Someone who is very scared of change may find it so liberating when he starts to make changes that he wants to take on more challenges from quite early in therapy. Others will continue to need a more gentle and slow approach throughout therapy.

Move towards the client being his own therapist. From the outset of therapy we need to bear discharge in mind. We are working towards a time where the client does not need us and can be his own therapist. He will never achieve this status if we take all the responsibility in therapy. In order to foster this process, we encourage the client to take notes from the outset, to use what is helpful and abandon what isn't. We also want him to be honest, to tell us what he is feeling, to argue with us and tell us when he feels we are not helping or just don't understand.

Reconstruction of self as a 'fluent stammerer'. We believe it is our role as clinicians to help the client reconstrue himself as a fluent stammerer. To do this most effectively we need therefore to address not just his fluency but also his communication skills as a whole. It is of limited use if a person becomes more fluent but still feels inadequate in his ability to use verbal and non-verbal aspects of communication effectively. We are working with a person and his communication as a whole, not just the stammer in isolation.

Therapy must be informed by theory. What happens in therapy must be informed by theory *(Bothe, 2004). In Communicating Quality 3, the Royal College of Speech and Language* Therapists' guidance on best practice, service standard 23 states that 'The service has a strategic and systematic approach within each team to establish an evidence-based resource as the basis for provision of clinical care, organisation of services and service development' (2006, p116). Finn argues that an evidence-based framework should adhere to three guidelines:

> First, treatment selection is based on the best available, most recent, and clinically applicable research evidence. Second, the clinician is a self-directed learner with an appropriately critical attitude and a healthy level of scepticism about knowledge claims. Third, the person's values, concerns, and perspective are considered and evaluated throughout the selection and treatment management process.
> (2003, p210)

We endeavour to adhere to these guidelines wherever possible and in the light of the evidence available to us. We have already discussed the way we consider the client's feelings about himself, his hopes for therapy and his empowerment in the process as essential to a good outcome. In the next section we discuss some of the theoretical background which underpins what we do.

How change happens

We mentioned earlier that we believe it is important to know at which stage of the change process our clients are when they present for therapy and as they proceed in their therapy journey in order to ensure therapy is appropriate for each individual. We have found the transtheoretical model of change (Prochaska & DiClemente, 1992) very helpful in this respect. The model came out of an analysis of 29 systems of psychotherapy and comprises three dimensions:

1 the levels (the 'what') of change
2 the processes (the 'how') of change
3 the stages (the 'when') of change.

The scope of this text only allows us a brief description of each of these dimensions. The model and its use in stammering therapy is described more fully in Turnbull (2000).

The levels of change

The levels relate to starting from where the client is. Prochaska & DiClemente (1992) describe five levels of change: symptom, maladaptive cognitions, interpersonal conflicts, family or systems conflicts and intrapersonal conflicts. The authors suggest that therapist and client should aim to agree the level to which the problem is attributed and at which intervention is initiated. They also propose that, wherever possible, intervention should start at the lowest level.

Some of our clients come to therapy with a very specific and limited goal in mind: for example, giving a best man's speech or saying their name on the phone. For such people, starting at the lowest level of change, that is, the symptom level, is very appropriate. Sometimes, once these clients have achieved some success with their immediate goals, they discover that there are other goals they then wish to work towards, as they see possibilities opening up which they had not previously considered. So, for example, the client who has come to therapy because he is going for job interviews where he wants more speech control (symptom level) may start to realise that he needs to look at the way he perceives his and others' beliefs about himself and his speech (maladaptive cognitions, interpersonal conflicts). His avoidance behaviours may require intervention at interpersonal, family and system levels, while his lowered self-esteem may require input at the intrapersonal level. It is important for the clinician also to be aware

that levels are not independent of each other and that change at one level may well lead to change at another.

The processes of change

Prochaska & DiClemente describe ten basic change processes or types of activity 'initiated or experienced by an individual in modifying affect, behaviour, cognitions or relationships' (1986, p7). Research has shown that most systems of psychotherapy tend to utilise only two or three of these processes while self-changers typically employ eight to ten (Norcross & Prochaska, 1986). Proponents of the transtheoretical model argue that, in line with the current move to more integration and eclecticism, therapists should use a more comprehensive set of change processes and be at least as cognitively complex as their clients! Table 1.1 outlines these processes and some examples appropriate to stammering.

Table 1.1 Processes of change

Process	Description
Consciousness raising	Understanding more about stammering, for example, through overt and covert identification, observation and reading
Self-liberation	Accepting responsibility for change, making decisions
Social liberation	Seeking new alternatives in the environment, for example, by joining a self-help organisation, writing a letter to inform others
Counter-conditioning	Substituting more useful responses to difficulties, for example, by being more assertive, learning methods for anxiety control, voluntary stammering
Stimulus control	Restructuring the environment so problem behaviour is less likely, for example, by choosing not to mix with a group of people whose behaviour induces more avoidance
Self re-evaluation	Reappraising the problem, challenging unhelpful cognitions
Environmental re-evaluation	Reappraising the effect of the problem on others, for example, through asking questions of others, surveys, increased openness
Contingency management	Finding ways to reward self or get rewards from others for the changes they make
Catharsis/dramatic relief	Arousal of emotions which may previously have been repressed, for example, through role play, psychodrama or drama therapy
Helping relationships	Enlisting others to help in the change process, for example, by bringing significant others to therapy sessions and by being open about stammering

Different processes are helpful at different stages in the change process (these are discussed below). When clinicians introduce strategies that are not suitable for the stage of change the client has reached, then problems may occur. For example, self re-evaluation, dramatic relief and helping relationships are all thought to be useful processes during the stage of contemplation (Stage 2 of the model). If processes that are more suitable for the action phase are used instead, the client may feel threatened and cease attending.

The stages of change

The stages are described as 'specific constellations of attitudes, intentions and behaviours that are relevant to an individual's status in the process of change' (Prochaska & DiClemente, 1992, p5). The amount of time an individual spends in any one stage can vary considerably. Six stages are described, each one representing both a period of time and the completion of certain tasks. The stages and corresponding therapy strategies are summarised in Table 1.2.

Table 1.2 Stages of change and therapeutic interventions

Stage of change	Description	Therapist's response
Pre-contemplation	Client does not want to change	Empathy, active listening, give information, provide choices, use of paradox, give hope, remove barriers to change No treatment may be 'treatment' of choice
Contemplation	Client is 'thinking' about change but not 'doing'	Give time, weigh up pros and cons of change, explore implications of changing
Preparation	Client has made decision to change and may have made some small changes	Encourage, give autonomy, set goals
Action	Client is active in making changes	Encourage autonomy, teach skills, help client develop support networks, positive reinforcement for changes made
Maintenance	Client is keeping change going	Use of toolbox, relapse prevention plan
Termination	Client is confident of maintaining change in all situations	No therapy needed

Stage 1 Pre-contemplation

How clients present. A person at this stage is one whom therapists may describe as unmotivated, unwilling or resistant but who in reality is usually either unaware of a problem or, if aware, feels unable or unwilling to change it. He frequently denies there is a problem at all. We see few pre-contemplators and generally those we do see have been 'sent' for therapy, usually by employers or family members. Such clients frequently drop out prematurely.

Therapy strategies. DiClemente (1991) outlines four reasons (the four Rs) why a person may choose to remain in pre-contemplation and suggests strategies that can help. *Reluctance* is often due to the person's feeling of inertia or a lack of knowledge. Empathy and appropriate feedback are useful approaches here. A client in *rebellion* is seen as having some investment in the problem behaviour and argues actively against change (perhaps it gives him a reason not to take on some difficult tasks or responsibilities). Strategies here include providing choices and possibly some careful use of paradox: for example, the therapist might say, 'It seems that you are really quite content with your speech the way it is and there is little reason for you to want to change it'. A person in a state of *resignation* does not see change as possible. The therapist's role here is to instil hope and explore perceived barriers to change. *Rationalisation* is seen when a client argues that the problem is not a problem for him. Empathy and reflective listening are seen as the most useful interventions in these cases.

When we see people in the pre-contemplation phase we are faced with some ethical dilemmas. We have to weigh up the likelihood of being able to move such clients to contemplation (the next stage of change) when we also have well-motivated clients on our waiting lists and targets to be achieved. Kuhr considers that a therapist's decision to recommend 'no treatment' can sometimes be warranted, stating that this 'requires considerable courage and the conviction that this constitutes the best course of action, given the particular circumstances' (1991, p19).

We suggest that when we are presented with a pre-contemplator and feel that attempts to move him on are likely to fail, we should consider terminating therapy but make it clear we are there to work with him if and when he *is* ready.

Stage 2 Contemplation

How clients present. A person in the contemplation phase accepts he has a problem and is thinking seriously about doing something to change it. Contemplation is characterised by ambivalence in which a client experiences both a fear of staying the same and a fear of changing. It can last for months or sometimes years. The shift from pre-contemplation tends to happen because of developmental or environmental events (for example, job prospects, relationships or the birth of a child), but unless there is also a consequent intentional change, relapse is very likely to occur.

Therapy strategies. Contemplation is not about 'doing' but about 'thinking'. It is important not to try to move the client on too quickly, but instead to give him time to weigh up the pros and cons of change. Moving the client into action too early can bring about what appears to be resistance to change and may lead to premature termination of therapy. 'Resistance' may in fact be a lack of current readiness to change, which if handled more carefully can be used to form the basis for more lasting change.

Processes found to be particularly useful at this stage include consciousness raising and self re-evaluation. Self re-evaluation techniques include encouraging a client to explore the implications of change and to weigh up the advantages and disadvantages both of staying the same and of changing. For example:

- an advantage of change: new opportunities may be opened up
- a disadvantage of change: others may expect more of the client
- an advantage of staying the same: it's safe and known
- a disadvantage of staying the same: continuing low self-esteem.

Stage 3 Preparation

How clients present. This is a short-lived stage. It combines intention and behaviour and is like a window of opportunity that will only remain open for so long; the client either has to move forward to action or back into contemplation or even pre-contemplation. The person at this stage has made a decision to change and may have initiated some tentative changes. The person who stammers may, for example, try to speak more slowly, reduce avoidance, or will tell someone about the problem. It is important that the therapist asks about any changes the client is already making in order to recognise when he is at this stage and to encourage him and so capitalise on his resolve.

Therapy strategies. Self-liberation is seen as a vital process during this stage. A client needs to believe he has the autonomy to effect change, but also to be aware that the environment can be powerful in exerting pressure on him to stay the same. Goal setting is another important strategy in the preparation stage.

Stage 4 Action

How clients present. This is where behaviour change happens. In order for change to be maintained, a client must have spent sufficient time in contemplation. However, if he stays in contemplation for too long he can lose the momentum to change. The therapist's role in the action stage is to help the client develop a sense of autonomy and take more responsibility for his own progress.

Therapy strategies. Action involves learning skills which will vary according to the level of change at which the person is: for example, if he is working at an interpersonal level he may benefit from communication skills training; if he is working at a symptom level, then specific technique work may be indicated.

It is important that clients have the support of others in their efforts to change. Some of this support can be found in group therapy, but environmental support will also be very important. Self-liberation, counter-conditioning (desensitisation, relaxation and assertiveness training), stimulus control (greater openness about stammering and enlisting friends to remind clients to act in the way they want) and contingency management (rewards for the changes that are made) are seen as necessary processes at this stage.

Stage 5 Maintenance

How clients present. A client in maintenance has made the changes he needs to make but this stage is not necessarily about keeping the status quo (see Chapter 15 'Maintenance: a continuing process of change'). It is an active stage in which change continues in order to prevent relapse. If appropriate strategies are not used in this stage relapse will occur.

Therapy strategies. Goals may change as the client realises that the changes he originally wanted to make are not those he now wants. A client can be encouraged to create his own 'toolbox', which will be essential in helping him maintain the changes he has made after therapy has ended (see Chapter 15).

Stage 6 Termination

How clients present. Termination is a more stable stage in which a client feels able to resist relapse. Four criteria are said to distinguish termination from maintenance: a new self-image,

no temptation in any situation, solid self-efficacy and a healthier life style. We would argue that this stage is rarely, if ever, achieved by people who stammer and that they are likely to remain in maintenance for life.

While we have described the change cycle in a linear way, we all know that change rarely happens like that. We are sure you can think of your own examples of something you have tried to change and may have succeeded in changing: smoking, drinking, taking exercise and so on. Usually, we make lots of attempts before the change is established. We all know too of the smoker who gives up for many years and then returns to smoking at a time of stress or maybe even at a social event where the pressure to return to the old behaviour is just too much.

Typically, change occurs not sequentially but in a spiralling pattern in which there are relapses, with recycling of one or more stages. Indeed, one or more periods of relapse are seen as the norm rather than as the exception. Such relapses can be useful therapeutically as they are used to help a client be realistic and develop strategies for managing difficult times.

Theories informing psychological approaches to stammering treatment

We have said earlier that we consider ourselves to be eclectic in our approach to treatment. We draw from three particular psychological approaches, broadly based in the cognitive group of therapies, to inform our therapy approaches.

Personal construct psychology (PCP; Kelly, 1991)

Kelly proposed that a person makes sense of his world by anticipating events, using a system of personal constructs. Constructs are described as bipolar: they have two extremes that help to give them meaning. For example, someone may construe 'night' in opposition to 'day' or 'stammering' in comparison with 'fluency'. Kelly saw people as being rather like scientists who make hypotheses which they may validate or invalidate in the light of the outcome of their experiments.

Constructs are individual but can also be shared: I may have a bipolar construct of 'interesting speaker' versus 'boring speaker', which may be similar to my friend's or may be quite different. For example, the 'interesting' pole of this construct for me may mean that the person I am describing is vivacious and uses a variety of non-verbal behaviours, while the 'boring' pole may imply someone whose non-verbal repertoire is limited. My friend on the other hand may use this construct in terms of the content of the person's speech. Constructs may be 'tight' (fixed and not open to change) or loose (fluid and frequently changing). Either extreme can be seen as problematic. Constructs that are too tight can make change very difficult and frightening, whereas very loose constructs may make it hard to make any valid predictions.

PCP and stammering therapy

PCP was first used in relation to stammering by Fransella in 1972 and has been developed since by many clinicians, notably Evesham & Fransella (1985), Hayhow & Levy (1989), Fransella & Dalton (1990), Williams (1995), Stewart (1996), Stewart & Birdsall (2001). PCP is used in stammering therapy to help a client identify his constructs and, where these are unhelpful,

to experiment with alternatives. Some of the processes used in therapy are too involved to describe in detail here, for example, the use of repertory grids, self-characterisations and fixed-role therapy. Information about these can be found in mainstream PCP texts. We outline here a little about how PCP can be used in the process of change.

Change is seen in PCP as involving a process of loosening (thinking about and experimenting with alternative ways of construing) and then tightening (choosing from a variety of available options to explore more helpful ways of construing). Take the following example: Sam was a man of 40 who had struggled to find employment after being made redundant. He had a construct of 'needs to talk fluently' (versus 'fluency is irrelevant') with regard to prospective employers. When he stammered at interviews and did not get the job, his construing of himself at the 'needs to talk fluently' pole became even more entrenched. He was invited to consider other ways of construing his lack of success; for example, it was a difficult economic climate, he had few qualifications, he had not sufficiently prepared for the interviews, and so on. He carried out some experiments: he phoned for feedback after his next interview, he mentioned his stammer at the start of the interview, he honed his interview style through role play and advice from friends. He began to see that his original construct was in fact invalid, and that interview success was based on a range of factors, of which fluency was only one.

Cognitive behavioural therapy (CBT; Beck, 1993)

CBT was developed by Aaron Beck in the 1960s, initially as short-term therapy for depression, and has been developed since for a wide range of emotional problems. It has much in common with PCP and Beck himself talked of PCP as a forerunner of CBT. Fundamental to CBT is the view that it is our interpretation of the world that affects how we feel and behave. It is not the event that causes emotional problems per se but the meanings we give the event. So, for example, one person might think of a listener's lack of eye contact as embarrassment while another might think of it as rudeness.

CBT is a talking treatment which aims to help the person to identify and reality test unhelpful cognitions which underlie repeated negative patterns of behaviour, and to develop and test new, more adaptive cognitions that can give rise to a more positive experience of the self, others and the world (Bennett-Levy *et al*, 2004). It is structured, goal-oriented and collaborative with its emphasis on changing unhelpful thoughts and replacing them with more helpful ones. It is more concerned with how problems are maintained than on how they are caused and, wherever possible, the focus of therapy is in the present rather than the past.

CBT helps people make links between thoughts, emotions, physiological reactions and behaviours. Therapy starts with an individual formulation which the clinician and client work out together to make sense of what is happening for the client.

CBT and stammering therapy

A very simple formulation, taking a specific situation of asking for a bus fare, is illustrated in Figure 1.1.

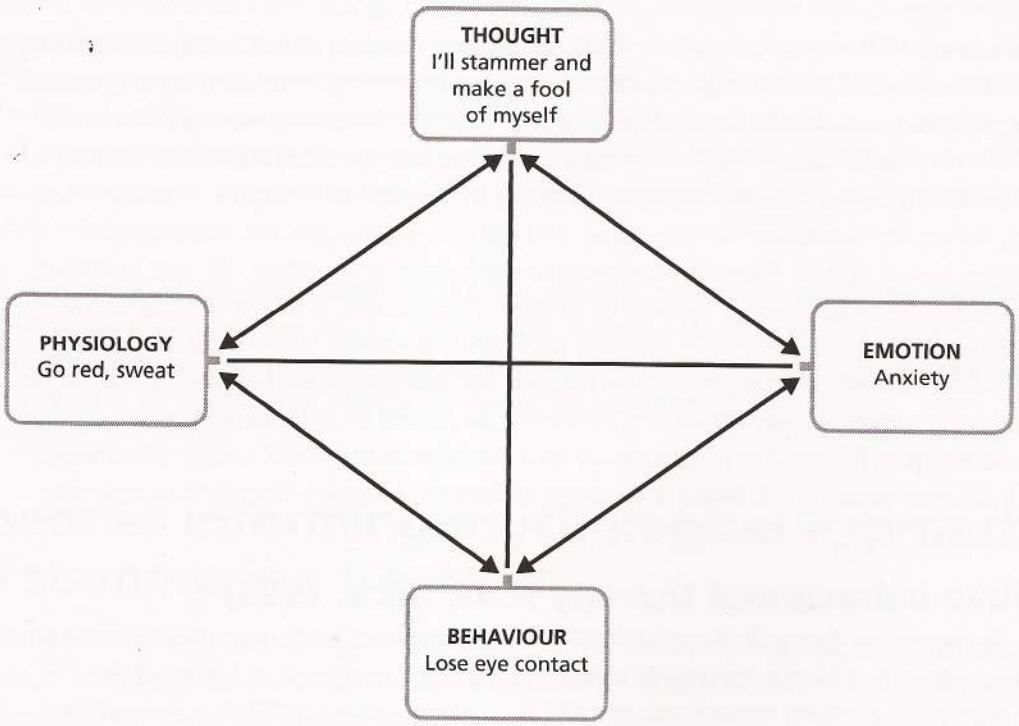


Figure 1.1 A simple formulation

In this situation the thought 'I'll stammer and make a fool of myself' leads to the emotion of anxiety, the behaviour of lost eye contact and the physiology of sweating and blushing. A vicious circle ensues: the more the person thinks he will make a fool of himself, the more anxious he gets, and the less he looks at the person, and so on.

Therapy involves helping the client first to notice unhelpful thinking and then to challenge it. The clinician uses 'Socratic questioning' in order to facilitate this process; these are questions which are open, collaborative, non-confrontational and asked with a spirit of enquiry and curiosity. Such questions do not aim to persuade the client to the therapist's point of view but rather they are used to guide discovery in the client. Below are some of the sorts of questions that can be useful in helping a client to notice and/or challenge his unhelpful thinking:

- Can you give a specific example? Who? What? Why? Where?
- How did you feel?
- What did you do?
- How is this a problem for you?
- How does 'x' go with 'y'?
- What do you mean when you say ...?
- What is the evidence that ... is/is not true?
- What is the worst thing that could happen if it is true?
- If it did happen, what then?

- What does this mean about how the other person thinks or feels about you?
- What does this mean about people in general?
- What would you tell a friend in a similar situation?
- What do you make of this?
- What would someone who cares about you say if they knew this?

Other questions can be used to help a client find alternative ways of thinking, for example:

- Are there any alternative explanations?
- Is the thought helpful?
- What other possibilities are just as or more valid?
- Is this thought a typical thinking error of yours?
- How can you test the thought?

CBT also uses behavioural experiments to test the validity of thoughts. Bennett-Levy *et al* (2004) divide such experiments into two types:

1 Active: once a client has identified an unhelpful cognition, he deliberately acts or thinks differently in the problem situation. This can be in a real situation or in a role play.
2 Observational: used if action is too anxiety-provoking or if more information is needed.

Experiments may be *indirect* (for example, watching a therapist voluntarily stammering in a shop) or *direct* (for example, taking part in a survey on stammering).

To summarise the main components of CBT we quote from Blenkiron:

> I think there are ten main ingredients, which are summarised below using the acronym 'CHANGE VIEW'.
>
> **C**hange: thoughts and behaviour
>
> **H**omework: between sessions
>
> **A**ct in collaboration: therapist & client
>
> **N**eed for structure: within sessions
>
> **G**oals & problems: clarify them
>
> **E**vidence based approach
>
> **V**isualise: a formulation diagram
>
> **I** can do it: self help philosophy
>
> **E**xperiments: test out beliefs
>
> **W**rite it down: to remember progress.
>
> (2007, p2)

Solution-focused brief therapy (SFBT; de Shazer, 1985, 1988)

SFBT, as its name suggests, is a forward-looking therapy based on working to a preferred future rather than on analysing problems. The term 'brief' may be confusing as in practice it really means 'as long as it takes, but not one more session than is really necessary'.

SFBT is based on a number of premises, as follows:

- Clients have resources and strengths to resolve complaints.
- Change is constant.
- The therapist's job is to identify and amplify change.
- It is usually unnecessary to know a great deal about the complaint in order to resolve it.
- It is not necessary to know the cause or function of a complaint to resolve it.
- A small change is all that is necessary: a change in one part of the system can affect change in another part of the system.
- Clients define the goal.
- Rapid change or resolution of problems is possible.
- There is no one 'right' way to view things; different views may be just as valid and may fit the facts as well.
- Focus on what is possible and changeable, rather than what is impossible and intractable.

(Adapted from O'Hanlon & Weiner-Davis, 1989, pp34–49)

In its simplest form, therapy is based on the answers to the following three key questions:

1 What does the client want?

2 What can the client do to get what he wants?

3 What needs to happen in order for the client to get what he wants?

Therapy follows a process which looks on paper to be deceptively simple and uses the following techniques:

- problem-free talk and compliments
- miracle question
- exceptions
- scaling
- what else questions
- 'getting-by' questions.

The client groups for whom SFBT is felt to be suitable include the following:

- those who have come to solve a specific problem
- those who report spontaneous recuperations
- the 'worried well' (those who have anxieties about their health which may be ill-founded)
- those with support systems
- those fed up with feeling 'stuck'.

SFBT and stammering therapy

Our training has rightly taught us a lot about analysing 'problems'. However, this approach can sometimes seem overwhelming and make the client feel that there is so much wrong that his

problems are insurmountable. An approach which emphasises what a client *can* do, and helps him believe that he has the resources to make changes, can be very liberating.

Looking to a preferred future helped George, a client who had had many years of therapy throughout his life, look at what he wanted and discover new ways in which he might achieve it. Using the 'miracle question' (de Shazer, 1988) showed that what he wanted was to be more confident, assertive and less fearful of starting interactions. Looking at 'exceptions' showed him that there were indeed times when he was able to be all of these things, and 'scaling' helped him look at small stages to becoming how he wanted to be more often. He started to realise that, while he might always stammer, he did not have to let his stammer determine what sort of a person he was. These processes can direct the therapist in formulating a management plan based on the client's preferred solution.

Examples of the use of all these approaches will be seen throughout the book. We advise clinicians to undertake at least some basic training in any of the approaches they are interested in using with clients.

Process and progress of therapy

The vast majority of clients who refer themselves for therapy have both overt and covert aspects to their stammering. We believe that it is essential for most clients to do at least some work on their covert issues before they are introduced to fluency-controlling techniques. Change in behaviour without a consequent change in attitude may work in the short term but is rarely maintained. In addition, when fluency-controlling techniques are taught too early in therapy they may be used by the client as a way of covering up the stammer even more.

The principal areas we address in therapy are as follows:

- identification
- desensitisation
- avoidance reduction
- fluency-controlling techniques and communication skills
- maintenance and relapse management.

Although we invariably start therapy with identification, then desensitisation and avoidance reduction, and move on later to introducing techniques, there will be times when we will additionally introduce techniques or skills training quite early in therapy. Reasons for this include the following:

- A client may have such severe overt symptoms or be so anxious about his stammering and so desperate to gain some fluency that he needs a 'carrot' to keep him engaged in the therapy process.
- There are particular overt symptoms for which more practical intervention can quickly make a difference to the person's communication, for example speaking rate, breathing patterns and the use of fillers.
- The person is at a stage of pre-contemplation or contemplation and in order to move on needs some concrete evidence that his speech can be changed through therapy.
- The nature and amount of any previous therapy and the client's attitude to it will be an important point to consider in therapy planning. If someone has had copious amounts

of previous therapy, then repeating stages already undertaken will be unhelpful and unnecessary.

Although it might seem that maintenance and relapse prevention work are the final phase of therapy, in fact gathering strategies to ensure skills are maintained is a continuous process throughout therapy. For example, identification is a tool which will serve the client well after therapy when he needs to carefully monitor and analyse his speech and his attitudes in order to maintain his progress. Identification will therefore also be a part of the client's maintenance plan or toolbox.

We illustrate the individual process of therapy with some brief client examples.

Client A: This young man had an extremely overt stammer. He had had a lot of previous therapy elsewhere and had learned to accept and live with his stammer. He came for therapy because he wanted some techniques to make his life easier, so that it took him less time to say what he wanted and he could keep his listener's attention. His therapy involved identification, work on breathing and fluency-controlling techniques.

Client B: This young woman's stammer was very covert. We rarely heard her stammer in the first few weeks of therapy. She needed a very gradual approach to change and to be able to make changes when she was ready, without coercion. It was important for her to spend quite some time identifying the covert aspects of her stammering, at a pace that would not feel catastrophic to her. Once she had done this she began to recognise that she needed to allow her stammer to be seen and not hidden. The process of desensitisation and avoidance reduction that followed was a long and difficult one for her which needed careful management in order to keep her engaged in the therapy process. At no point in the therapy did she work on fluency control. Her toolbox comprised ways in which she could maintain her new-found positive attitude to speaking.

Client C: This man came wanting to make sense of his stammering, not to change it. He was able to do this in individual therapy, using a PCP approach.

Client D: This man in his thirties had had some therapy elsewhere in the past. He had found it helpful and was now returning to see if there were any new techniques for him to try. He was at the stage of contemplation and used the therapy process to help him come to the decision that he did not want to move into action at present. His therapy involved mainly identification work and SFBT. The latter helped him to acknowledge that his preferred future was not dependent on increased fluency.

Client E: This student had both overt and covert aspects to his stammer. He had had no previous therapy. He worked through the stages of change in a mostly linear way, starting with identification, moving on to desensitisation and avoidance reduction. Ongoing work on identification helped him to see that some of his difficulties were not about his stammering but more to do with his verbal and non-verbal communication skills. At the action stage he therefore worked on his posture and eye contact and also on conversational skills such as greetings and turn taking. As a student, he would return home for holiday periods and he would frequently relapse at these times. He was encouraged to use his lapses to work on relapse prevention in a very practical hands-on way and to build up a repertoire of skills which reduced his dependence on therapy to help him return to action.

Client F: This man in his forties returns to therapy every few years. He moves between action and maintenance, returning to therapy when he is ready to take on more challenges and then leaving therapy when he is ready for a further period of consolidation.

In this chapter we have described the principles that underlie our approach to stammering therapy. We go on now in the remaining chapters to describe how these approaches are realised in practice.