

WHAT IS STUTTERING?

stuttering from the speaker's viewpoint

Defining

Dr. Mark Irwin, Australia

WHAT IS STUTTERING?

Introduction

Written on his death bed in 1983, clinical psychologist and person who stuttered Joseph Sheehan's last statement read...*"Defining stuttering as a fluency problem ...ignores the person: it ignores his feelings about himself, it ignores the significance of stuttering in his life; it ignores ...the 'double boiler' function of maintenance of the handicap in many cases; it ignores the principle that just because an individual stutters, that is necessarily the chief problem with which a clinician need be concerned."* Perkins (90, p. 379).

Joe Sheehan died 2 years before the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM 111-R) broadened the definition of Social Anxiety to include fear and distress in most situations. (Berman and Schneier, 2004). Subsequently Social Anxiety Disorder (SAD), particularly when combined with other diagnoses, has come to be recognized as a common cause for psychiatric ill health and for major disruption of role functioning. By linking stuttering with Social Anxiety Disorder this paper seeks to provide a solution for Sheehan's concerns and to make sense of what experienced clinician William Perkins, meant when he said: *"In my*

experience those who have complained most bitterly and seemed most fearful of stuttering have been clients whom I have rarely, if ever, heard stutter. To say they do not stutter is to deny they consider themselves stutterers." Perkins (90, p. 375).

In brief this paper hopes to provide definitions and labels that enable stuttering to be defined from the speaker's viewpoint. It is hoped this will allow a differential diagnosis of stuttering as well as more accurate and effective public awareness messages.

WHAT IS STUTTERING?

THE CURRENT SITUATION

When stuttering is discussed it is variously referred to as the behavior of dysfluent speech, or as a syndrome including both dysfluent speech and the reactions to it. This creates a problem:

How should severity of stuttering be measured -- by frequency of behaviour or by the degree of reaction to it?

And there are associated questions.

Should stuttering severity be measured by the percentage of stuttered syllables only, or should it also include word substitution?

How should the syndrome be described when it is understood that increased frequency of stuttering (behavior) is not directly related to severity of internal reactions (psychopathology)?

Also given the common coexistence of psychopathology for people who stutter (figures for SAD in adults who stutter range from 50% (Kraaimaat et al, 2002) to 75% (Stein et al, 1996)), should new terminology be developed to bring awareness to this fact?

Stuttering with SAD is a different experience than stuttering without it. It could be said that it is the SAD that accentuates the situational specificity of stuttering as well as resulting in feelings of panic and loss of control. Also it is the SAD that is responsible for serious role impairment and compromise to quality of life.

But do we have the words/ terms/ labels to describe this and provide answers to the questions posed above?

Consider the following scene: Three men chat in a bar. Tom's stutter is more obvious.

TOM: I ssstutter. When I go out it tttakes me lllonger to order a bbbeer.

DICK: I ssstutter. I order a scotch because I can't say bbeer.

HARRY: I ssstutter. I'm extremely embarrassed and frustrated by it. I rarely go out. I avoid relationships.

Are these three people suffering the same disorder? Who has the severe stutter? How should they be differentiated? Would they benefit from the same therapy?

Firstly let's consider:

What is stuttering? Is it....

- a) Dysfluent speech the listener hears? (Tom)
- b) b) Dysfluent speech the listener hears and the speaker

- hides? (Dick)
- c) c) Dysfluent speech and its effects on quality of life?
(Harry)
 - d) d) All of above

The Current Problem:

A review of literature and websites would suggest the answer to "What is stuttering?" is:

- d). All of above

The fact that stuttering can be any of the 3 options creates an obvious problem in communication about stuttering. More specifically it creates a problem with discussion and measurement of stuttering frequency and severity.

Currently stuttering and its psychosocial impact are all described by the same word -- stuttering. Stuttering is the name of both the syndrome and the symptom. This is a problem since as seen by the above example stuttering can have a psychosocial impact that is not related to the frequency of dysfluencies or the severity of associated struggle behavior.

The definition problem is recognized by the American Speech Hearing Association (ASHA). In their current guidelines they give 4 definitions of stuttering, noting: "it would be a serious mistake to select any one of the stuttering definitions and assume it would apply equally well for teaching, clinical, research, consumer affairs and

third party reimbursement purposes." Furthermore they note: "the fluency area is plagued with inconsistent, confusing terminology". ASHA Guidelines (99, p29).

A Solution to the Problem: A solution is possible if language is developed to enable a clear description for the separate experiences of Tom, Dick and Harry. How to do this? Two steps are necessary.

1. Clarify the use of the term covert stuttering (specifically to distinguish escape behavior from avoidance behavior, and distinguish both from psychosocial impact.)
2. Introduce new term Stuttered Speech Syndrome (to link stuttering dysfluency with commonly associated psychopathology).

1. Clarification of term "Covert Stuttering"

Covert is a term with many meanings in stuttering. In the literature it is used to refer to:

- a) speech deliberately hidden by the speaker, (word omittance and substitution)
- b) situation avoidance by the speaker,
- c) what is unobservable about the speaker (attitudes and emotions)
- d) what is unknown or not widely appreciated about stuttering.

The multiple meanings create confusion and cause problems with accurate communication. One solution is to

only regard covert stuttering as the speech deliberately hidden by the speaker (otherwise described as the speech event of *escape* behaviour after sentence formulation). The speaker (in this case Dick) omits, substitutes or circumlocutes as a way to hide what he recognizes would otherwise be an overt stutter. This is distinct from situation *avoidance* behaviour (as demonstrated by Harry). It is necessary to make this distinction if we are to restrict our definition and measurement of stuttering to dysfluent speech events as experienced by the speaker. (Note: Escape and Avoidance are established psychological terms.)

In any case the strict definition of the word covert is secretive or *deliberately* hidden as opposed to the simple meaning of hidden. Describing emotional/attitudinal responses as covert introduces potential inaccuracy. They may be covert if they are secretive or deliberately hidden, but they cannot be regarded as covert simply because they are not on view or their existence is not often appreciated.

This has clinical implications. Irrespective of presence of psychopathology a person with minor *overt* dysfluency may be experiencing frequent *covert* dysfluency.

With this new terminology attention can be drawn to the fact that children who stutter should not necessarily be denied therapy simply because they have minor *overt* dysfluency. They may well have frequent *covert* dysfluency.

2. Introduce new term Stuttered Speech Syndrome

(stuttering with social phobia)

The negative emotional, behavioural and attitudinal reactions (also known as affective, behavioural and cognitive reactions) to stuttering are not always present, or certainly not always significant enough to warrant a diagnosis of psychopathology. Clearly they don't affect Tom but are extremely significant in Harry's life. Of course Tom has some frustration but there is no significant life impact.

One way to clarify and describe this difference in life impact is to relate stuttering to Social Anxiety Disorder (also known as Social Phobia). Social Anxiety Disorder is a separate disability that can either be specific to certain social situations or generalized to most. The vast majority of individuals with SAD report their career, academic and general functioning has been seriously impaired by their fears. 70-80% of sufferers meet criteria for additional diagnoses and in most cases SAD predates the co-morbid condition.

Also SAD most commonly begins in early childhood. (These facts make for speculation on the cause of stuttering that is best left to future research and discussed in a later online conference! Which came first, the anxiety disorder or the stuttering? Interestingly Selective Mutism is a social anxiety disorder in which anxiety symptoms make speech impossible.

Clearly, anxiety symptoms impact on speech production.

Since one of the negative behavioral effects of social embarrassment about stuttering is increased dysfluency and more social embarrassment, then a separation of stuttering from social anxiety disorder is difficult. Instead it is necessary to create a new term, say Stuttered Speech Syndrome, which refers to symptoms experienced by those with the twin disabilities of dysfluent speech and social anxiety disorder. That is two people may stutter but only one has Stuttered Speech Syndrome (stuttering plus social anxiety disorder.)

Of course some may argue that SAD could be associated with other disorders in which symptoms are subject to social display eg. shaking in Parkinson's disease, and that therefore there is no need to make a separate case of the link between SAD and stuttering. But the counter-argument is that a term denoting the link is valuable because firstly the association is not universal and a new term draws attention to this. Secondly the link is so common (50 -- 75%) that language is made more efficient by having one term for both conditions.

A linking term like Stuttered Speech Syndrome brings understanding to stuttering in the same way that Anorexia Nervosa brings understanding to low body weight.

To explain this point further "low body weight" means one thing, "distorted body image" means another. Anorexia Nervosa refers to the coexistence of both conditions.

The existence of Stuttered Speech Syndrome, has clear implications for treatment. It has previously been recognized that people with phobias like Social Anxiety Disorder are unable to think clearly. Lorberbaum et al (2004) reported phobics react more with automatic emotion and less with reasoning. With too much anxiety, phobics may be unable to think clearly enough to follow rational advice. Simply providing speech technique instruction to a person who stutters with coexisting SAD is to give advice this person is incapable of using under anxiety provoking conditions. These people are functioning more on conditioned emotional responses and are therefore unable to act on advice no matter how logical.

The other issue is that SAD (also known as social phobia) can be overcome even if it is difficult to remove all stuttering behavior. Stein, Baird, and Walker (1996) pointed out that SAD should not be overlooked as a potentially remedial source of distress and disability for people who stutter.

Diagnosis of Stuttered Speech Syndrome

Stuttered Speech Syndrome would be diagnosed when both disabilities of stuttering and Social Anxiety Disorder (SAD) coexist. While overt stuttering is obvious to the listener and both overt and covert stuttering are obvious to the speaker, the coexistence of SAD can be confirmed by using a self-report measure such as the Liebowitz Social Anxiety Scale questionnaire (LSAS). The LSAS is a

standard diagnostic instrument in the psychiatric world that has been shown to be sensitive to the interventions of pharmacology and cognitive behavioral therapy (Fresco et al., 2001).

Back to the bar.....

By clarifying the old term “Covert Stuttering” and introducing the new term “Stuttered Speech Syndrome”, it is now possible to provide a succinct differential diagnosis for Tom, Dick and Harry.

TOM: My speech pathologist has diagnosed I have an overt stutter with no covert stuttering or associated psychopathology. Retraining of speech muscles, breathing instruction and rate control are proposed.

DICK: My speech pathologist has drawn attention to my covert stutter. I understand I need to overcome my fear and embarrassment of overt stuttering or else it may build to the psychopathology of Social Anxiety Disorder. If this happens I will be diagnosed with Stuttered Speech Syndrome.

HARRY: My speech pathologist has diagnosed severe Stuttered Speech Syndrome. I need to do something about both my stuttering and associated Social Anxiety Disorder. Cognitive behavioural therapy and participation in self-help groups are two of the treatment modalities that have been suggested. Referrals have been arranged.

In a future fantasy world all might live happily ever after.

Tom continued to stutter because old habits die hard and, because stuttering had minimal impact in his life, he lacked motivation to change.

Dick worked hard on his attitudes, perceptions, beliefs, and emotions and overcame his covert stuttering. While he occasionally overtly stutters he is able to order the beer he wants.

Harry received cognitive behavioral therapy and is now actively socializing and enjoying life. He is stuttering more because he is speaking more and saying the first word not its substitute. His stuttering is more frequent but it is no longer associated with feelings of panic and loss of control. His Stuttered Speech Syndrome has been cured.

Conclusion:

Since not everyone who stutters suffers social phobia or uses the covert strategy of word “omittance”, substitution and circumlocution, then distinctions are needed in stuttering terminology. Leaving aside questions of cause and neurological, genetic and biochemical events, it can be argued the definitions that make most sense are:

Stuttering (synonymous with stammer) --to produce dysfluent speech characterized in overt form by repetitions, prolongations and blocks, or in covert form by avoidance, substitution and circumlocution.

To explain this further: Overt Stuttering is repetitions, prolongations and blocks: Covert Stuttering is omitting certain words, substitution and circumlocution aimed at hiding what the speaker recognizes would be an overt stutter.

For those who would like a more academic definition, then the following is most accurate:

Stuttering --*temporary inability either overtly or covertly to move forward fluently with linguistically formulated speech.* Perkins (84, p. 431).

The link of stuttering to the post-1985 definition of social phobia, is best made by creating a new term: Stuttered Speech Syndrome - defined as *symptoms resulting from coexistence of stuttering and social anxiety disorder (social phobia)*. Specifically these symptoms are behaviours of stuttering with feelings of panic and loss of control, situation avoidance, attitudes of low self- confidence and low self-esteem, and emotions of frustration and anxiety.

The support of leading speech pathology professionals in the development of the ideas expressed in this paper is greatly appreciated.

References

American Speech-Language-Hearing Association Special Interest Division 4: Fluency and Fluency Disorders (1999 March) Terminology pertaining to fluency and fluency disorders: Guidelines. *Asha*, 41(Suppl. 19), 29-36

Berman, R.M. and Schneier, F.R. (2004) In Bandelow, B. & Stein, D.J. (eds) *Social Anxiety Disorder*. N.Y. Marcel Dekker, Inc.

Fresco, D. M., Coles, M E., Heimberg, R.C., Liebowitz, M.R., Hami S., Stein , M. R., Goetz, D. (2001). The Liebowitz Social Anxiety Scale: a comparison of the psychometric properties of self-report and clinician administered formats. *Psychological Medicine*, 31, (6) 1025 --1035.

Lorberbaum, J.P., M. R., Klose S., Johnson, M. R., Arana, G. W., Sullivan, L. K., Hamner, M. B., Ballenger, J.C., Lydiard, R.B., Broderick, P.S., George, M. S., (2004). Neural correlates of speech anticipatory anxiety in generalized social phobia. *NeuroReport* 15, 18.

Kraaimaat, F.W., Vanryckeghem, M. & Van Dam-Baggen, R. (2002). Stuttering and Social Anxiety. *Journal of Fluency Disorders*. 27. 319-331.

Perkins, W.H. (1984). Stuttering as a Categorical Event: Barking Up the Wrong Tree -- Reply to Wingate. *Journal*

of Speech and Hearing Disorders, 49, 429-441.

Perkins, W. H. (1990). What is stuttering? *Journal of Speech and Hearing Disorders*, 55, 370-382.

Stein, M.B., Baird, A., & Walker, J.R. (1996). Social Phobia in Adults With Stuttering. *American Journal of Psychiatry*, 153(2), 278-280.