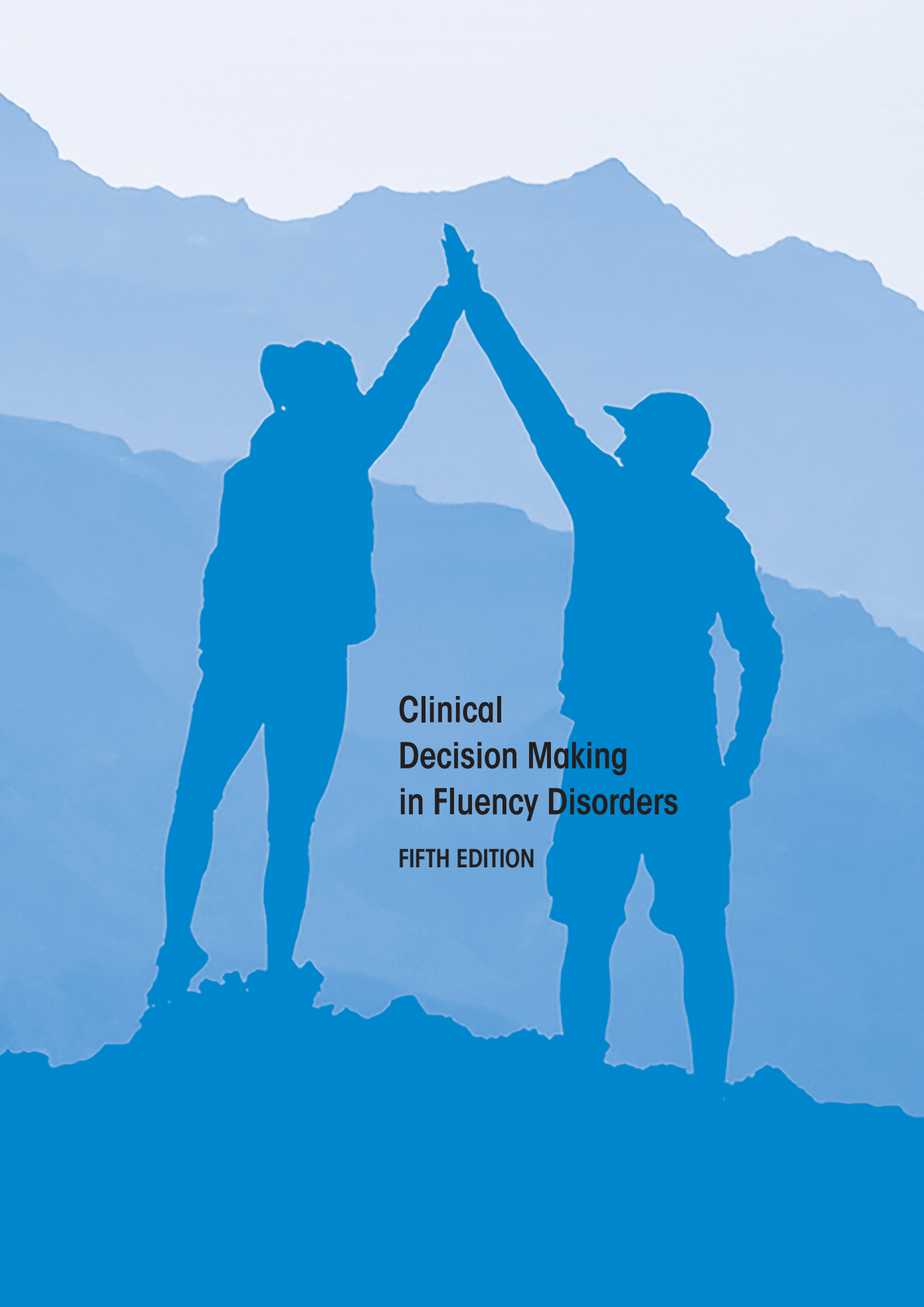

# Clinical Decision Making in Fluency Disorders

FIFTH EDITION

# Walter Harne Manning

## October 8, 1942–September 12, 2023

*"What you do for yourself dies with you when you leave this world, what you do for others lives on forever."*

—Ken Robinson, British author and orator

The first time I met Walt, he made a comment about my Australian accent, punched me (hard) in the shoulder, and let out his loud, nasal laugh that anyone who knew him would instantly recognize! Not the image of the "highly respected fluency professor" that I was expecting! But that was Walt—always real, always himself, and always inviting you to do the same! Walt was a larger-than-life character who always filled any room he was in with his presence and laughter, which is not bad for a stutterer who grew up playing verbal gymnastics with people just to avoid stuttering on the name of the town he was from! He loved life, loved people, and was a natural scholar, teacher, and mentor.

Of course, Walt knew a lot about stuttering—he was the ultimate expert, with knowledge built from years of study as well as his own personal experiences with stuttering. But Walt's greatest gift was that he cared deeply and passionately for the people he worked with, both clients and students alike. He had a way of making you feel at ease, whether through careful, empathic listening, engaging conversation, or by being a crazy goofball, which he was very good at!! You just simply could not help but love this man!

*Clinical Decision Making in Fluency Disorders* was Walt's baby and he poured himself into the book. As Walt's PhD student, I worked with him on the third edition of the book, and then I was honored when he invited me to collaborate as a co-author on the fourth edition. As I completed the revisions for the fifth edition, my goal was to maintain Walt's voice throughout the book—a goal that I hope I have accomplished. This will always be Walt Manning's textbook and his influence will live on through the many students and individuals who stutter and who were touched by his words contained in this text!

And now I have to say "farewell," my friend! I can't believe that I will never again feel the strength of your hug, hear the sound of that laugh, or enjoy the counsel of your words. I am forever changed for the better having known you, Walt, my dear friend and mentor!

—Anthony DiLollo

# Clinical Decision Making in Fluency Disorders

FIFTH EDITION

**Walter H. Manning**, PhD, CCC-SLP

**Anthony DiLollo**, PhD, CCC-SLP

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# PREFACE

*A book is made from a tree. It is an assemblage of flat, flexible parts (still called "leaves") imprinted with dark pigmented squiggles. One glance at it and you hear the voice of another person, perhaps someone dead for thousands of years. Across the millennia, the author is speaking, clearly and silently, inside your head, directly to you. Writing is perhaps the greatest of human inventions, binding together people, citizens of distant epochs, who never knew one another. Books break the shackles of time—proof that humans can work magic.*

—Carl Sagan

Having the opportunity to write a fifth edition of this book is a privilege and a labor of love—love for a profession that has provided us with the opportunity to meet and work with some of the most amazing people, from colleagues to clients, who have inspired and challenged us in ways we could not have imagined; love for a career in which we get paid to study the complexity and beauty of the human experience through the lens of communication; and love for a friendship that began with a shared interest in stuttering and has now spanned a quarter of a century!

As with previous editions, a primary goal of this book is to convey to the reader the enthusiasm and creativity associated with assisting people who stutter. Our hope is, as Carl Sagan poetically states in the opening quote, to be "speaking clearly and silently, inside your head, directly to you" as you encounter and work with the diverse and wonderful cohort of persons who stutter and their families. We also want to provide the reader with the principles and clinical insights that enable those who stutter to improve their ability to communicate and enhance their quality of life. Although increasing fluency might be, for some, a high priority during treatment, the therapeutic journey is far more expansive and interesting. Throughout the book we emphasize the primary goals of enhancing communication and empowering clients to create an autonomous and agentic lifestyle.

The readers we have in mind as we write are graduate students who are beginning their first in-depth experience in fluency disorders. We hope this book launches them into a career-long interest in stuttering and the diverse, fascinating, and courageous people who deal with stuttering daily. We also hope that professional clinicians who want to learn more about this specialty area will find this book

to be a useful and educational resource. The information and ideas discussed in these pages might also be useful for individuals who stutter (and the parents or spouses of people who stutter), as another purpose of this book is to make stuttering less of a mystery and to provide a sense of direction for the process of therapeutic as well as self-directed change.

During the formulation and development of the profession of speech pathology, particularly during the decades from the late 1920s through the 1960s, the area of fluency disorders was a major area of interest in our professional journals and texts. A review of the early issues of the *Journal of Speech Disorders* (published from 1936–1946) or the initial volumes of the *Journal of Speech and Hearing Disorders* (published through 1990) confirms that a large proportion of the articles addressed the nature and treatment of stuttering. As the scope of practice continues to expand in the field of communication disorders, fluency and fluency disorders have become but one of many areas that students are expected to learn about during their academic and clinical programs. Graduate students in speech-language pathology are expected to become generalists across the wide range of human communication and related problems. Because clinicians are asked to become knowledgeable about so many different communication disorders and related areas, there is concern that the qualifications of professionals for serving any one disorder are being compromised. One response to this concern, driven in part by consumer demand for better services, is the development of Special Interest Groups (SIGs) by the American Speech-Language-Hearing Association that provide enhanced professional qualifications and continuing education opportunities. One of these groups, SIG 4, focuses on fluency and fluency disorders. Other SIGs that might be of interest to those working with persons who stutter include SIG 14, which is focused on cultural and linguistic diversity, and a recently added group, SIG 20, that focuses on counseling. Interacting with colleagues in such groups is a highly effective way to grow your applied knowledge and skills about stuttering and people who stutter.

The depth of the field is also changing. Reading the volumes of literature associated with but one specialty area of the field can be intimidating, even for someone who has been a clinician and researcher for many years. It is difficult to negotiate the amount of (sometimes conflicting) information that has become available about the many aspects of stuttering. But, reading through the thoughtful and often elegant comments of those who have spent a lifetime trying to understand and explain the nature of stuttering onset and development can be an enjoyable experience. One of the most difficult choices in preparing a text is not what to include but, given the space limitations, what to omit. The citations in this text are intended not only to provide support for the ideas that are offered but also to furnish readers additional, more detailed, sources of information about a topic. There is also the desire to pay homage to the people who have preceded us—to connect to the "citizens of distant epochs" and "break the shackles of time" as Carl Sagan put it—and credit coworkers in the field for their creative and insightful clinical and research ideas.

We would like to comment on the writing style of this book. We have used the active voice throughout, with the intention of engaging the reader. The "editorial we" has been used for the main body of the text and the first person for

boxes titled *Clinical Decision Making* and *Clinical Insight*. Clinical Decision Making boxes are designed to address some of the options a clinician is likely to consider during the assessment and treatment processes. Clinical Insight boxes reflect a particular philosophical view about aspects of therapeutic change for individuals who stutter. On other occasions a third type of (untitled) box is used to provide information that in other ways supplements the text.

Some features in this edition have been revised and added to assist both instructors and clinicians. The total number of chapters in this fifth edition has increased to 15, with two new chapters, one on working with clients who are from cultural and linguistic environments different from one's own, and one on general principles of assessment that sets the foundation for the more specific assessment chapters that focus on children and adults. All chapters were revised, with new material added and some older material removed or summarized where needed. We refined and expanded the Clinical Decision Making and Clinical Insight boxes and revised the discussion questions at the end of each chapter to correspond with the new organization of the book and the fresh information included in each of the chapters. Finally, an online companion website has been (and will continue to be) developed that provides the reader with a variety of materials, including video comments by the authors, PowerPoint slides that coincide with the chapters, a test bank for instructors, and video and audio examples of various fluency problems and therapeutic approaches.

*Nothing is more dangerous than a dogmatic worldview—nothing more constraining, more binding to innovation, more destructive of openness to novelty.*

—Steven J. Gould (1995)
*Dinosaur in a Haystack*, Crown Paperbacks, New York, NY

*Perhaps the hardest of all the things a clinician must learn is how to live well. You cannot heal a person's wound if you are a dirty bandage. Unless you are a healthy, strong person, your impact will be minimal, no matter what methods you use. There have been times when I resented my clients' expectations of what I should be, but I have noticed that over the years I have become a much better man than I hoped (or desired) to be. I have found that therapy is a two-edged chisel; it shapes the therapist as well as the client.*

—Charles Van Riper (1979, p. 140)
*A Career in Speech Pathology,* Prentice Hall
Englewood Cliffs, NJ


# The Effective Clinician

## CHAPTER OBJECTIVES

- To describe the importance of the clinician in the therapeutic process
- To examine the characteristics of an effective clinician
- To discuss the use of humor in the therapeutic process

## THE IMPORTANCE OF THE CLINICIAN

Beginning a book on fluency disorders by discussing the characteristics of the effective clinician is unusual. Typically, the first chapter describes the nature of stuttering, or provides the reader with historical or theoretical views of the problem—and these topics are presented in the early chapters of this book—but, because a primary goal of this book is to emphasize the ability of the clinician to make wise clinical decisions during assessment and treatment, we decided that discussing the "clinician" is the best place to begin. In earlier editions of this book, we proposed that as much as, or perhaps even more than, any other component, the clinician is central to the success of the treatment process. Clinical research in a variety of fields has continued to provide support for this idea. Not all clinicians—even those who are clinically certified, specialty certified, or have years of experience—are equally effective in assisting children and adults to address their stuttering or other fluency disorders. Having said that, we firmly believe that individuals can become effective clinicians by embracing the traits, skills, and attitudes discussed in this chapter and focusing on the person in front of them and not just the stuttering problem.

Having indicated in the Preface that another primary goal of this book is to convey the enthusiasm and excitement of working with people who stutter, we now step back a bit and place the learning process into a wider perspective. Following the intense years of formal education, you

will soon be on your own. Your role will no longer be that of a graduate student who is continually challenged by your instructors to demonstrate your knowledge and clinical skills. You will be a professional who is likely to be considered the resident expert on the topic of communication disorders in general and stuttering in particular. This change in roles may be difficult because during the years of graduate school, many student clinicians have relatively little exposure to the field of fluency disorders. Most students have the opportunity to take, at most, one (three-credit, we hope) course in stuttering and obtain clinical experience with relatively few individuals. Student clinicians typically observe the progress made by individuals for only a few weeks or months. When clients achieve success, it is often difficult for student clinicians to appreciate how much of a role they played in promoting change. Even if students are fortunate enough to take a course on stuttering that is an especially good one and the clinical experiences are instructive, it is only the beginning of learning about the experience of stuttering.

You may occasionally find yourself exhausted as you successfully negotiate the rigors of a good graduate program. Nevertheless, in order to become an effective professional, your learning must continue long after graduation. Think about it—the clinical decisions you will be making one or two decades after graduation will have little to do with much of the information you are currently learning! Reinterpretation of old data, as well as ongoing basic and applied research, continually lead to new constructs and ways of making informed clinical decisions. When people of earlier generations were students, many things they were taught—including the role of parents in the onset and development of stuttering, the linear development of stuttering through primary and secondary stages, the likelihood of spontaneous recovery in young children, the possibility of relapse following treatment, and the role of genetics in the etiology and epidemiology of stuttering—have since been shown to be partially or completely inaccurate. The evolution of information occurs in all scientific fields, and the shelf lives of textbooks are not nearly as long as authors would like them to be. Of course, your instructors are not intentionally providing information that is incorrect. It is just that the profession is still climbing the hills and mountains necessary to allow us a more accurate view of the phenomena we are investigating and the people we are attempting to assist.

Carl Sagan's (1996) caution that "One of the great commandments of science is to mistrust arguments from authority" (p. 28) is probably good advice for many aspects of life. It is also good advice for consumers of all information, including the information discussed in this text! As you expand your knowledge through years of clinical experience with many different people and your participation in continuing educational activities, you will begin to create your own style of doing things. You will choose new ideas and approaches that will spring from basic and applied research yet to be conceived or conducted. Moreover, as you continue to be a student of your field, you will achieve additional insight, wisdom, and enthusiasm for your work.

Experienced clinicians, and—perhaps more important—clients who have experienced treatment for stuttering that was more or less successful, have suggested certain clinician characteristics that are more desirable than others. If this is your first exposure to the field of fluency dis-

orders, this initial chapter may help you to determine the strengths that you bring to the clinical encounter, as well as those areas that you can work on to become the best clinician you can be.

## The Critical Importance of the Clinician

First, let us re-emphasize that the clinician plays a vital role in a successful therapeutic process. A number of authors have considered this concept specifically in the area of fluency disorders (e.g., Cooper & Cooper, 1985c; Emerick, 1974; Guitar, 2006; Hood, 1974; Plexico, Manning, & DiLollo, 2005, 2010; Shapiro, 1999; Van Riper, 1975) and provide convincing arguments indicating that the clinician is a critical part of the therapeutic process. For example, regardless of the treatment strategy and the associated techniques, Cooper and Cooper (1985c) maintained that the person who is administering the treatment is the most important variable in creating the process of change. Murphy and Fitzsimons (1960) contended that during counseling, the "most important single variable affecting the success in the treatment of stutterers is—the clinician" (p. 27). Even if treatment takes the form of an archetypal program of behavioral modification, Cooper and Cooper (1985b) proposed that "it does matter who is doing the conditioning" (p. 21). Regardless of the treatment strategy, authors have consistently found that the clinician plays a critical role in orchestrating a successful treatment program (Emerick, 1974; Hood, 1974; Reeves, 2006; Shapiro, 1999; Van Riper, 1975; Yaruss, Quesal, & Murphy, 2002). In Chapters 8 and 10 we discuss empirical evidence supporting the importance of the clinician in the therapeutic process, not only for our field, but also in related fields such as counseling and psychotherapy.

### Clinician Attributes

Although there is no exclusive set of attributes that define the ideal clinician, many authors have attempted to define such a set, with at least some level of agreement across the varied opinions. For example, Crowe (1997c) cited the American Psychological Association (1947) as recommending the following personal attributes for counselors and psychotherapists: resourcefulness, versatility, curiosity, respect for the integrity of others, awareness of one's own personality traits, humor, tolerance, ability to relate warmly to others, industry, responsibility, integrity, stability, and ethics. Similarly, Van Riper (1975) provided the first comprehensive description of the desirable attributes of clinicians who help children and adults who stutter. He described personality characteristics of *empathy*, an authentic sensitivity for the client; *warmth*, a respect or positive regard for the client; *genuineness*, openness, and the ability to disclose oneself as a real person; and *charisma* (perhaps the most enigmatic one), an ability to arouse hope, appearing confident yet humble, frank yet tactful. As Van Riper (1973) wrote, "Like fishermen, good therapists are optimists. Most of them have come to have profound respect for the latent potential for self-healing that exists in all troubled souls" (p. 230).

Another description of desirable clinician characteristics was proposed by Zinker (1977), who considered therapy a creative process of changing awareness and behavior. He suggested that a common malady among therapists is that they fail to see themselves as artists involved in a creative process. As the clinician

becomes involved in the dynamic and shared process of change, the opportunity for creativity becomes more apparent. The experienced clinician can be seen as a guide who has a map of the territory. The clinician has a sense of direction about where the client may benefit from traveling and a notion of when it might be appropriate to initiate an exploratory trip off the main path. The challenge for the clinician is to "establish an adequate cognitive map which includes the client's experience of himself and then to point to action steps to make the solution possible for the client" (Zinker, 1977, p. 11).

In order to guide a person through successful therapy, Zinker proposed that the clinician possess several thought-provoking characteristics that nurture the creative process:

1. Creativity that is facilitated by a child-like wonderment and excitement
2. Patience for change without forcing
3. A love of play
4. A sense of humor
5. A positive attitude about risk taking
6. Willingness to experiment with different approaches and techniques
7. The ability to distinguish the boundaries between the clinician and a client
8. Willingness to push, confront, persuade, and energize another person to accomplish the work that needs to be done
9. A lifestyle that promotes a rich background with a range of life experiences

Zinker proposed that blocks to creativity lead to the clinician becoming stuck in a particular theoretical or professional stance or holding to the view that science and art do not mix (a science vs. art dichotomy). Other blocks to creativity include a fear of failure (playing it safe and not taking risks), a reluctance to play (fear of experimenting with ideas and techniques and of looking silly), overcertainty concerning a particular school of thought (a rigidity concerning the nature of the problem-solving approach), giving up too soon when an approach or a technique does not appear to be "working," a reluctance to push hard enough to help others, or an inability to accept contrasting ways of interpreting things and events (believing that there is only one way or a single best way to define success during therapy). It is also worth considering that clinicians should not be exhibiting these blocks to creativity to their clients, who might already be experiencing them. Zinker's views are similar to those of David Luterman, an experienced counselor and author in the field of communication disorders. Luterman (2001) suggested that professional growth is severely limited by the clinician's fear of making mistakes and an unwillingness to assume risks during the therapeutic or counseling process.

Cooper and Cooper (1985b) also provided a description of several desirable attributes of the effective clinician. Many of the attributes described by these authors coincide with their view of fluency treatment as an interpersonal (communication) experience. The Coopers suggested that, especially during the early stages of treatment, the client–clinician relationship should be a major focus. They stated that the clinician should be *genuine* and able to openly express both negative and positive feelings to the client. However, as the clinician is expressing these feelings, it is important that she also indicate a belief in the worth and potential of the client (what Carl Rogers

## CLINICAL INSIGHT

On a few occasions throughout this book, we will include comments from Daniel Goleman's (2006) book, *Social Intelligence*. Goleman provides a wealth of supporting data from studies in neuroscience when discussing the concept of *primal empathy*, the ability of individuals to unconsciously employ a "low road" to rapidly scan and interpret another individual for such issues as safety and trust. Neural circuitry connecting such areas as the sensory cortices, thalamus, and amygdala, as well as multiple systems of mirror neurons, allow some individuals to "bridge brains" (p. 43). The "high road," which involves the prefrontal cortex (the brain's executive center) is not involved. Goleman describes how mirror neurons fire in such a way that observing someone else being hurt also feels like being hurt to the observer. People develop an emotional contagion and synchrony as they resonate with another. As the synchrony occurs, individuals' moods begin to match, the timing of verbal and nonverbal communication becomes more coordinated, and participants become more comfortable with silences. The process must be spontaneous and unconscious rather than preplanned and intentional. Fortunately, as Goleman explained, the process is described as "eminently trainable" (p. 99).

[1957] termed "unconditional positive regard"). As treatment becomes challenging and the client is asked to make behavioral, attitudinal, and cognitive changes, the clinician should be continually *honest* in reinforcing the client's feelings of self-worth. Such honesty, the Coopers noted, is much easier to manifest when the clinician enjoys working with the client, something that might not always be the case. They warned that the clinician also needs to resist the urge to tell clients how they should feel. As Luterman (2001) cautioned, there is a great temptation to try to get the client to feel as we do—something to be avoided if we are to be helpful.

Importantly, Cooper and Cooper (1985b) also suggested that the clinician should be "devoid of dogma" and have the ability to adapt the therapeutic approach to the client's uniqueness and needs. This is a good way of saying that good clinicians are client directed rather than treatment directed. The clinician must be able to recognize subtle client responses that provide cues for direction and indicate progress. Effective clinicians are not daunted by a client's negative response to the suggestions and challenges of the therapeutic process. They are, in short, able to be a constant ally and to persevere along with the client when the process of change slows or becomes difficult. Effective clinicians inform the client by providing information about the client's progress and direction of treatment.

Undoubtedly, the characteristics we have discussed would be desirable for any clinician working with a person for any reason. And, of course, they would be valuable characteristics to have in a friend or colleague. Moreover, just as it is possible to be successful as a friend or colleague without being adept at all of these attributes, it is possible to be a successful clinician without possessing a high level of skill at each. Personal and professional growth, however, is something all

## HIGHLIGHTS

The clinician is a vital component in facilitating effective therapeutic change.

Desirable characteristics for an effective clinician include the following:

- Empathy
- Warmth
- Genuineness
- Charisma
- Honesty
- Creativity
- Patience
- Humor
- Playfulness
- Willingness to experiment
- Devoid of dogma

clinicians should strive for—at all levels of experience and expertise—and can lead to increased skill in both areas of strength and relative weakness. Clinicians are encouraged to engage with workshops, journal articles, books, conference sessions, and other development activities to enhance your knowledge and skill in the various attributes described in this chapter, and thereby increase your effectiveness in treating clients.

### *Clinician Attitudes About Stuttering and People Who Stutter*

Our attitude about those who come to us for help and our understanding of their communication problems have a fundamental influence on how we approach them as people during both assessment and treatment. What the clinician has learned and understood about the stuttering experience and what he or she has been able to observe about people who stutter will determine whether he or she will even have the desire to work with such clients.

One unique characteristic of the field of fluency disorders is that a substantial number of people who stutter (or have a history of having stuttered) have gone on to become professional clinicians, often specializing in stuttering and related fluency disorders. Assuming that clinicians with a history of stuttering have also acquired the necessary academic and clinical knowledge, their life experiences may provide some understanding about a client. The experience of having traveled within the culture of stuttering and survived the many tribulations along the way tends to promote the insight and empathy necessary for guiding others through the process of therapeutic change. It is generally easier to understand and relate to another's situation if we have shared the same or a similar experience (e.g., undergoing surgery, losing and searching for a job, loss of a loved one, experiencing a divorce). There are many examples of this understanding in the helping professions. For example, people with a history of substance abuse are often extremely effective therapists in alcohol and drug rehabilitation programs. They understand from their experience the nature of the problem and the many tricks that people use to deny the problem or avoid change.

This does not mean, however, that people who stutter or who have stuttered in the past will be more effective as clinicians or will necessarily have a greater understanding of the stuttering experience. With good preparation and experience, clinicians without a history of stuttering can have equal understanding and do not have to acquiesce when individuals who stutter offer the challenge, "How can you understand? You don't stutter!"

## CLINICAL INSIGHT

One summer, I was contacted by a colleague from the Psychology Department at the university at which I was working. He had a 14-year-old nephew, Luke, coming to town for the summer and was hoping to get some help with Luke's stuttering. I agreed to see Luke at his house, and was then told that Luke was not a big fan of speech therapy and would not be told I was coming. When I arrived, Luke and I met in the basement of the house and I could tell from the start that Luke was not happy to meet me! His first words to me were, "I don't need any help with my speech, so you are wasting your time!" I responded, "Well, I promised your uncle that I would come and see you, so would it be okay if we just hung out for an hour, so I can at least say that I tried?" Luke agreed, so we just hung out and talked about what he liked and what life was like in his hometown. I didn't try to do any "treatment," but I did ask Luke about how he handled his stuttering, and I suggested a few things he could read if he wanted to (he was an avid reader). At the end of the hour, as I was preparing to leave, Luke said, "So, maybe you could come back a few times while I am here." I told him that if I did, we would need to do some work on his speech, but that we would do it in a way that would be more like the conversations that we had just had and less like his school experiences of speech therapy (which involved primarily naming pictures). I saw Luke a number of times over that summer and the subsequent two summers. The important aspect here is that, rather than pushing my agenda as the speech pathologist or the agenda of Luke's uncle, I was able to engage Luke where he was at and build a relationship that then allowed us to move forward in working on his stuttering. (AD)

(Manning, 2004b). It may be that one day a client will challenge you by asking such a question. If a client does, will he or she be correct and how will you respond?

## HIGHLIGHTS

You don't have to be a person who stutters to appreciate the experience of stuttering—but you do need to learn to not be afraid of stuttering, be willing to engage in challenging behaviors (e.g., pseudostuttering, making difficult phone calls, etc.) with your clients, and seek out stories that elaborate on the experience of stuttering.

### *How Clinicians Interpret the Disorder*

If stuttering is presented to students as a mysterious disorder, when those students become clinicians, they will naturally be wary about treating these clients. Stuttering may indeed be an enigma, for, as we describe in succeeding chapters, the problem is complex and many of the features lie under the surface. When responding to the suggestion that stuttering is like a riddle, Van Riper (1982) stated that "[it] is more than a riddle. It is at least a complicated, multidimensional jigsaw puzzle, with many pieces still missing" (p. 1). Sheehan (1970) frequently argued that stuttering is like an iceberg, with only small portions of the problem visible to