



# Communicating in the real world: accounts from people who stammer

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## Abstract

This qualitative study used in-depth interviews to explore the communicative experiences and coping strategies of 14 adults who stammer. Their accounts revealed that those participants with persistent developmental dysfluency felt that stammering had limited their lives especially in the areas of employment, education and self-esteem. All participants shared key styles of communicative management with avoidance and confrontation developing during childhood. The participants who had undertaken therapy during adulthood, relied upon a range of speech management techniques including self-evolved and therapeutic strategies. Many of the strategies regularly used by the respondents contributed to the limiting experience of stammering. This study highlights the experience of stammering on the individual, discusses the variety of strategies used to manage dysfluency and indicates the complexities of day-to-day communication. These findings are discussed in relation to speech and language therapy for adults who stammer.

**Educational objectives:** The reader will learn about and be able to give examples of: (1) the lived experience of stammering; (2) the communicative strategies used by adults; and (3) the situational management of stammering.

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## 1. Introduction

It is reasonable to speculate that people with dysfluent speech will have some qualitatively different experiences in life than people without an ongoing

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communication difficulty. Peters and Starkweather (1989) considered the changes seen in speech motor, linguistic, social, emotional and cognitive behaviour throughout five stages of the development of the individual who stammers, from the preschool period to maturity. They contrasted these with the changes occurring in the communicative life of fluent individuals and proposed that internal and external factors such as physical maturation and fluctuating social demands are interconnected and influence the development of stammering into adulthood. Blood (1993) points out that working with adults who stammer presents a unique challenge to the speech and language therapist, because they bring a lifetime of communicative experiences to the therapeutic relationship. He emphasises the role of the client in the outcome of therapy and encourages speech and language therapists to investigate the ‘baggage’ (p. 307) accumulated from a lifetime of stammering before any speech treatment is considered.

Despite much anecdotal commentary on the experience of stammering, only a few studies have been carried out that investigated this from a first person perspective. A survey by Hayhow (1999) suggested that the negative consequences of stammering start early on in life, as 56% of adults who stammer reported that school days were the most affected area of their lives. Another retrospective study (Hugh-Jones & Smith, 1999) of 276 members of the British Stammering Association (BSA), provided more detailed information about the early school experiences of adults who stammer. They found that 83% of respondents remembered being bullied at school and that such bullying had short and long-term consequences particularly on self-esteem and personal relationships. Corcoran and Stewart (1998) studied the *Stories of Stuttering* of eight adults, ages 25–50. Their in-depth interviews revealed core lifetime experiences of suffering, brought about by episodes of stammering which, in turn, resulted in feelings of helplessness, shame, fear, and avoidance. They suggested that a client’s narrative of stammering is a useful therapeutic tool, which enables the therapist to understand the client’s personal meaning of stammering. They concluded that assisting clients to reconstruct the ongoing meaning of stammering would enable them to cope with future episodes of stammering without experiencing the same negative emotions.

Some studies have considered clients’ experiences of speech and language therapy. Corcoran and Stewart (1995) described the importance of the relationship between clients and therapists. Where successful therapeutic relationships had been established, clients indicated that therapy had enabled them to gain a deeper understanding of the experience of stuttering. Stewart (1996) not only highlighted the importance of a client’s own experience of stammering, but also suggested that this may have therapeutic value in understanding individual differences in the maintenance of fluency. Stewart used repertory grids, a tool employed in personal construct psychology (Kelly, 1955), in treating two individuals who stammer to examine each client’s individual construction of fluency. She was able to identify important differences in personal meanings of fluency for clients with ‘good’ versus ‘bad’ maintenance and suggested that further investigations into this area may provide answers to why some clients find fluency easier to maintain than others.

Previous qualitative research on the lived experiences of people who stammer has focused on the meaning attached to being a person who stammers and the development of identity (Corcoran & Stewart, 1998). It is well known that secondary behaviours are common in adults who stammer and that such signs contribute to the diagnosis of a more advanced form of stammering (Guitar, 1998). These behaviours develop over many years as coping strategies for communicating with a stammer. In general, however, the mechanisms employed by people who stammer to manage communication prior to and post-therapy, are under-researched.

Qualitative inquiry is an emergent research paradigm and is ideally suited to exploratory studies that aim to understand rather than quantify phenomena (Fontana & Frey, 1994). A variety of methods have already been employed by healthcare researchers, which are applicable to the investigation of stammering (Tetenowski & Damico, 2001). The interview has been used to elicit accounts of lived experiences and coping strategies from people in a wide range of circumstances (e.g., terminal illness, chronic disease, stress, addictive behaviour, and pain management). The interview takes on particular relevance in the field of communication disorders where the freedom to answer open-ended questions breaks down the barriers presented by standard questioning. For example Parr, Byng, Gilpin, and Ireland's (1997) interviews asked people with aphasia to present their experience of living with impaired communication. This research from insiders' perspectives illuminated an area that was previously not properly understood.

The emphasis of the current enquiry was to explore the lived experiences of stammering and to consider the communicative coping strategies used by people who stammer. The study focused on clinical rather than theoretical issues and addressed the important area of speech management from a first-person perspective. In doing so it provides information on how adults may manage their day-to-day communication prior to, during and post-intervention.

## **2. Method**

The focus of this inductive study was to obtain rich data from a small sample of individuals who had experienced stammering in their adult lives. Fourteen semi-structured, face-to-face interviews (Robson, 1993) were carried out from a sample obtained from two sources. Eleven participants responded to a request in a regional newspaper to contact the author about their experiences of stammering and subsequently agreed to take part in the research project. The three other participants volunteered after a local support group for people who stammer was directly approached and individuals were invited to give their accounts. This voluntary sample comprised a group ranging in age from 26 to 86 years, with a mean of 56 and S.D. of 15 years. Thirteen participants were considered to have persistent developmental stammering; one reported a brief period of childhood stammering that re-occurred more than 20 years later following an accident and was considered to have an acquired stammer. Two participants had received no therapeutic

Table 1  
Gender, age and therapeutic experiences of cohort

Gender	Age	Therapy as child	Therapy as adult
F	≤55	Y	N
F	≤65	N	N
F	≤85	N	N
M	≤35	N	Y
M	≤35	N	Y
M	≤65	Y	Y
M	≤55	Y	Y
M	≤55	N	Y
M	≤55	Y	Y
M	≤55	Y	N
M	≤65	Y	Y
M	≤65	N	Y
M	≤75	Y	N
M	≤85	Y	Y

intervention for their stammering whatsoever, whereas the remainder had had a variety of experiences with different types of intervention at different stages of their lives (see Table 1). These included hypnotism, acupuncture, psychiatry, private individual and group therapy as well as individual and group speech and language therapy provided by the National Health Service in the UK.

The participants represented a range of occupations: accountant, carpenter, driver, doctor, engineering, factory worker, horticulturalist, industrial chemist, lecturer, manager in industry, nurse, sales supervisor, and solicitor. It was anticipated that common themes arising from this sample would reflect shared core experiences of a heterogeneous disorder.

The aims and a procedural outline of the study were discussed with each participant prior to the interviews taking place. All were given an opportunity to ask questions about the study, and all were assured that identifying details would be removed from the data. Written consent was obtained from each individual, and the interviews were carried out by the author at a venue chosen by the participant.

A semi-structured interview was chosen because, much like a clinical interview, it presents the same set of questions to each person but recognises that each individual will have a unique story to tell (Coolican, 1990). A schedule (see Appendix A) was developed based on the five stages of development in the life of the individual who stammers (Peters & Starkweather, 1989). All participants were invited to discuss their childhood, adolescence, employment, relationships, and speech and language therapy. Individual variations in experience were solicited by encouraging respondents to elaborate on areas of particular personal relevance. The interviews varied in length from 30 to 120 min. All were audiotaped with permission of the participants and were subsequently transcribed verbatim.

## 2.1. Analysis

The ‘Framework’ approach (Ritchie & Spencer, 1994) was employed to analyse the data. This approach accommodates the exploratory nature of this study, as it is grounded in and driven by the data. The specific aims of ‘Framework’ are to be dynamic, systematic and comprehensive and at the same time to make the analysis accessible to others. The first stage was to *familiarise* oneself with the data, which involved listening to the recordings and thoroughly reading and re-reading the transcripts. All transcripts were considered at all stages of the analysis and from this process key themes emerged. A *thematic framework* was assembled, in which codes were assigned to each area of interest, which were themselves subsumed to key themes. Each interview was indexed with its codes, then reviewed against the general thematic framework. It is here that additional themes and patterns started to emerge. Charts were constructed to reflect the themes identified from the data as well as themes of a priori interest. In this case four charts were assembled:

- Factors contributing to loss of communicative status;
- Factors contributing to re-establishing communicative status;
- Speech management options;
- Factors contributing to the disuse of a successful technique.

Index points relevant to each chart were collated across interviews, summarised and entered into the appropriate chart. Following this charting stage, the data were considered as a whole and the most salient themes are presented in the findings.

The trustworthiness of this analysis was established by two methods. Because the main analysis was carried out by the author, there was a possibility that researcher bias may have influenced the coding. Therefore, each interview was independently coded by a colleague with a background in qualitative research but no experience in stammering. There was high agreement (94%) in the assignment of codes to the data; disagreements were highlighted and discussed, and amendments were made where necessary. Following analysis of the data, the participants were asked whether the themes accurately represented their experience of stammering, and all verified the relevance of major themes arising from the analysis. This process of *member checking* is highly recommended in qualitative research analyses (Lincoln & Guba, 1985; Miles & Huberman, 1994).

## 3. Results

The respondents (R) who had therapy during their adult lives are referred to as group one (R1, R3, R4, R6, R7, R8, R10, R12, R14), and those who had not received therapy as adults are referred to as group two (R2, R5, R9, R11, R13). The latter group included one individual who had wanted therapy but was unaware of its availability and four adults who had chosen not to have therapy. The results are presented under the following headings:

- The lived experience of stammering;
- Communication management;
- The situational management of stammering.

### 3.1. *The lived experience of stammering*

The individual who had an acquired stammer did not have the same history of difficulties as the rest of the cohort because his adult-life experiences of dysfluency occurred after he had established a career, social life, and a relationship. This individual felt that stammering had not specifically hindered him but did disrupt his life on a daily basis and had had a profound impact on his self-esteem. All 13 respondents with persistent developmental stammering reported similar lived experiences of stammering; however, the perceived importance of the effects of these experiences varied across individuals.

First recollections of stammering were all linked to speech breakdown in social settings, such as at school, rather than within the family. Many examples of unpleasant episodes of stammering at school were recalled:

R12 But the first time that I really was aware of the stammer I must have been about five or six years old. And it was answering the register, I couldn't say yes. And I struggled, and I struggled and all the air was expelled and I still hadn't got the word out.

And it was as children that the most salient memories of receiving negative reactions to their speech was apparent:

R14 People used to say "oh come on spit it out" and of course that sort of made you worse.

R6 Because I was the only one in the class with that sort of problem, the teachers didn't actually want to make allowances whatsoever and I just had to muck in with the rest of them, we had to read plays out loud and that was a nightmare.

R10 I was reading aloud at primary school I must have been about six years old and I just couldn't get any words out, she just passed on to somebody else it was a fairly traumatic experience and of course it rather alerted me to the possibility of it happening again which of course it did.

Evidence of avoidance as a coping strategy was also apparent at an early age:

R2 Well I started having tummy ache and not wanting to go to school and that sort of thing.

Accounts of early days included feelings of exclusion, which were often brought about through respondents' strategies for avoiding speech breakdowns in public, and feelings of having had qualitatively different experiences from fluent children. The extent to which stammering was felt to have affected progress at school varied considerably. Two respondents reported leaving school prematurely, whereas one

worked particularly hard in order to achieve higher grades than the other students. A major theme emerging from these accounts of childhood was one of “limitation.” Some felt that their personal and social growth had been adversely affected, because they felt unable to participate in, or were excluded from, the full range of activities available:

R1 I missed going out in the evening and having a game of football with my mates, not necessarily because I had a stammer . . . because when it came to getting a job having a stammer was something I saw as being a problem so I had to be better than anybody else.

R14 I always wanted to be in the school play but of course I was always sort of pushed to the back.

Others felt that they had not reached their full academic potential which subsequently limited their education:

R5 I would have loved to have stayed on at school . . . you would all take turns to read at assembly or read out things of a report and the thought of doing that in front of the whole school just had me in tears and that was the reason why I left school . . . the staff they wanted me to stay on . . . but since then I just regretted it and it’s been like this for years now.

A sense of limitation was also apparent in respondents’ reflections about the workplace. All group one participants and three in group two felt that stammering had affected their working lives. It was evident that the personal beliefs of some about stammering had influenced their choice of work and left them dissatisfied with their careers:

R3 I was the geography expert and of course if you stammer you are never going to teach, are you?

Respondents who relied on avoidance as a speech management strategy in the workplace, such as being unable to make telephone calls or contribute in meetings, often found themselves limited on daily, as well as on a long-term basis:

R6 (for promotion) you have to do a lot of talking in the meetings and groups and also making our presentations to large numbers of people and I always have in the back of my mind . . . there isn’t any way that I could ever do that . . . its (stammering) acted as a brake.

For others, the limiting effect of stammering was socially imposed:

R12 I went to an interview . . . and the person interviewing me actually said ‘look I don’t think we are interested in you because of your stammer.’

Respondents also anticipated speech breakdowns in social communicative situations such as shopping, travelling, and using the telephone. The majority would avoid such situations when possible, but some went to extraordinary lengths to avoid being heard to stammer in public:

R3 I went up to the railway station with a piece of paper two return tickets to Haringey, (which read) ‘sorry but I have a sore throat’ and I handed it into the ticket office.

However, if no acceptable options to avoid existed, most respondents would confront the communicative situation regardless of the consequences.

R2 I didn’t like answering the telephone or making telephone calls . . . I was terrified but I made myself do it.

Occasionally, *total* avoidance of a situation was reported, a course of action that had the most limiting consequences. For example, one’s negative predictions about stammering resulted in her opting out of many social activities such as learning to drive:

R5 The thought if I had an accident in the car or if there was something wrong with the car and you’ve got to get out and speak to someone, I thought . . . I’d know I’d crease up, so I just keep away from cars.

Respondents frequently discussed making adaptations to their behaviour in social situations in order to avoid or minimise their stammering. It appears, therefore, that most perceived stammering as an adult in social situations as unacceptable, even though only two discussed episodes in which they had experienced overtly negative reactions to their speech as adults. For one respondent coping by social avoidance had seriously affected his ability to make friends and form relationships. References to low self-esteem were commonplace throughout the narratives, with some respondents indicating that they were fortunate to have made successful relationships:

R4 You have got to be an understanding person to take on someone with a nervous problem.

This reference to stammering as a nervous problem by R4 was a recurrent theme throughout his interview, and he cited nervousness as key to his development of stammering. In contrast, other respondents described the fear of stammering and fear elicited by certain situations as instrumental in the persistence of their communication difficulties.

### 3.2. *Communication management*

Two questions guided the analysis of the data:

1. In what ways do respondents manage their communication on a daily basis?
2. What part has speech and language therapy played in their speech management?

During the analysis a tally was made of the ways in which respondents discussed how they approached different speaking situations. Each reference was coded and



Table 2  
Total number of communication strategies mentioned per group

Strategy type	Group one		Group two		Group total	
	<i>n</i>	Percentage of strategies used	<i>n</i>	Percentage of strategies used	<i>n</i>	Percentage of strategies used
No change	5	8	2	8	7	8
Intuitive change	25	42	18	69	43	50
Taught change	17	28	1	4	18	21
Situational change	13	22	5	19	18	21

collated into main categories. Four key styles of preferred communicative management strategies emerged, which were categorized as: ‘no change,’ ‘intuitive change,’ ‘taught change,’ and ‘highlighting.’ Table 2 presents the number of communication strategies employed by each group and the two groups combined for each type.

### 3.3. No change

The ‘no change’ category of speech management represents speaking without prior planning. Examples of this management strategy were given by six respondents, all of whom were members of group one, and included: taking a chance that the outcome would be fluent speech, allowing stammering to occur in certain situations and then experiencing subsequent negative feelings, pushing on regardless of the consequences and forcing words out.

R6 you’ll be up on your feet or whatever hacking through a vital meeting or something and then wham you hit the buffers.

All of the respondents who used this strategy also spoke regularly about employing intuitive changes to their communication, such as avoidance. Three respondents relied additionally on highlighting strategies, such as disclosure about stammering, and two also used strategies taught by speech and language therapists. The ‘no change’ approach was rarely adopted in formal working situations, such as making a presentation, but was often used when the respondent felt that there was a chance of being spontaneously fluent or that stammering in front of a particular audience did not really matter. The ‘no change’ strategy was also used in the absence of any other strategy:

R12 If you haven’t learnt any tricks you just force it out.

In addition to being used as a substitute for other strategies, several respondents whose strategies could result in fluent speech commented on the apparent paradox of their using the ‘no change’ approach:

- R14 Why do we keep trying to push this sound through this blockage and keep going until we do, and then you make such a mess of it and the person says pardon and you have to say it all again.

#### 3.4. *Intuitive changes*

Comments were classified as an ‘intuitive change’ if they had not been taught, were not used as a precursor to or in conjunction with any other therapeutic technique but were purposefully instigated in order to manage communication. These strategies included: making a change to the way of talking (e.g., changing tone of voice), doing something to relax, taking a verbal run up, word and situation avoidance including getting someone else to say it, preparation, planning, and confrontation.

- R10 I often slip into a funny voice.

- R13 I might consider you know prefacing it with some words you know to get myself going.

All respondents cited occasions when they would make an ‘intuitive change.’ Avoidance of words and situations usually started at school and was the earliest strategy to appear in the accounts. It was also the most commonly cited strategy, representing over 50% of all intuitive changes made.

- R1 I will generally only avoid maybe one word in 5 minutes worth of speech.

The majority of respondents talked about avoiding situations judged to be optional. Twelve respondents commented that they would avoid speaking whenever it was possible to do so. For example they would purchase a ticket from a machine rather than at a ticket office; however, when there was absolutely no opportunity for avoidance, they would confront the speaking situation. Unavoidable situations often included tasks in their work environment, such as using the telephone. Some respondents who carried out ‘unavoidable’ tasks at work reported avoiding the same tasks at home, which again suggests a complex process of weighing the perceived importance of the situation before a communicative approach is adopted:

- R2 (at work) Answering the telephone was my biggest nightmare but I made myself get used to it (line 31).

- R2 (at home) I’ll avoid doing things on the phone if I can (line 407).

It was noticeable that those respondents who felt that they had experienced successful speech and language therapy cited more examples of adopting ‘intuitive’ communicative changes than ‘taught changes.’ Interestingly, comments about avoidance as a strategy were often made in conjunction with remarks indicating that avoidance was not viewed as an acceptable way of managing dysfluency:

- R8 I know I shouldn’t avoid, but I do.

### 3.5. *Taught change*

On the whole, members of group one were able to name their therapy or describe key identifying components, which indicated that they had undertaken a variety of therapies commonly available in the UK. These included ‘stutter more fluently’ techniques (e.g., [Van Riper, 1973](#)) and ‘speak more fluently techniques,’ such as syllable-timed speech ([Andrews & Harris, 1964](#)). Often respondents had experienced more than one type of therapy and reflected on the merits of different experiences. Some members of group one were currently undergoing therapy, whereas the remainder felt that they were able to manage their speech post-therapeutically either alone or in a support group. All respondents reported that enhanced fluency was their main goal of therapy and all had been told that there was no cure for stammering. The category of ‘taught change’ refers specifically to strategies that were either identified in the accounts by the respondents as learnt during speech and language therapy or were identifiable in the transcripts as common therapeutic strategies such as cancellation. When mentioned at all, specific techniques were reported as being used at certain times, such as immediately after completion of therapy or with particular people such as with a therapist or in a support group. Many respondents commented on useful techniques and theories that they had learnt in speech and language therapy yet did not cite them as current functional management strategies:

R10 Of course, you don’t use that sort of technique in every day speech do you?

R14 It’s quicker to get the word out using syllabic speech... but for some strange reason up there in your head you fight it.

One explanation for the lack of examples of fluency maintaining behaviour in respondents’ accounts could be their conceptualisation of the need to be fluent. It is possible that respondents were actually comfortable with the amount of dysfluency in their speech, having re-constructed their feelings about stammering post-therapeutically. To account for this, group one members were specifically questioned about what they wanted their speech to be like and whether speech and language therapy had enabled them to achieve this. All of them had wanted to eliminate their dysfluency prior to therapy, and all continued to view elimination of dysfluency as the ultimate, desirable outcome for successful speech and language therapy. Additionally, all reported that their experiences with therapy had enabled them to gain more control over their dysfluency and that they had become more fluent when they put therapy into practice as a result:

R1 What I used to do before (therapy) to avoid getting blocks I would take a great big lungful of breath, breathe all that breath out and then start to speak... it was very uncomfortable... learning to speak on a proper lungful of air made all the difference.

The idea of what constituted valuable therapy was discussed with both groups. Beneficial effects of therapy varied across individuals. Some reported that therapy

had equipped them to produce fluent speech, providing them with a new sense of control. Others described less quantifiable outcomes, such as raised confidence levels, increased insight into their difficulties, and chances to meet other people who stammer. Of particular note was the number of comments about therapy providing the only real opportunity to talk about stammering, which was viewed as very beneficial. Respondents from group two reported that they had not had a chance to openly discuss stammering with anyone except for being told by others how to manage their speech. The one respondent who clearly stated that speech and language therapy had not been beneficial, later added that his therapy experiences had, in fact, equipped him with the skills to help himself.

The use of techniques post-therapeutically was explored with group one in order to understand why individuals continued to report dissatisfaction with the amount of dysfluency in their speech. Although members had found techniques that enabled them to produce fluent speech, many reasons were cited for not using them. All group one respondents felt overloaded by either the effort taken to think and control speech at the same time or the responsibility of transferring fluency into their daily routine.

R7 If I think about it I can (control speech) but when you talk you don't think about it you talk.

Some respondents gave additional reasons for not using fluency maintaining strategies. Many of whom cited themselves as responsible for their current dysfluency due to their lack of dedication to practice and preference for habitual ways of talking.

R8 I actually think all the time yeah I should practice this because then that would get rid of it.

Only a few respondents singled out ineffective or inappropriate speech and language therapy, or therapists, as having contributed to their current communicative status. One mentioned that he felt a lack of confidence with the therapeutic technique, and another cited dissatisfaction with the speed of change following therapy. Only one respondent concluded that the effort required to achieve fluency was not worth it and that he had made a conscious decision to abandon fluency techniques preferring to use disclosure.

### 3.6. *Highlighting*

The final communicative strategy mentioned by respondents is described here as 'highlighting.' These changes include being open about stammering, such as informing communicative partners about the stammer and making light of any communication breakdown (e.g. by swearing or humour):

R14 If I do get stuck for a long, long time I just swear 'sod it' or something like that it puts the person you are talking to at ease as well I think.

The analysis showed that highlighting could occur either before a communicative exchange or after communication had broken down. Four respondents used such disclosures at work before high-pressure situations, such as presentations, whereas a less formal approach was often adopted with friends and family, such as commenting on the stammer after it had occurred. Two respondents commented on using disclosure in such formal social situations as making appointments on the telephone.

R7 Now I've got to the stage where now I admit if it happens, I say 'look I've got a problem with my speech, this might happen' and it tends to calm me down. If I feel the other person knows about it, it's less of a problem.

These comments by R7 and R14 suggest that an important function of disclosure is to put the person who stammers and the listener at ease. Twelve respondents used highlighting, eight from group one and four from group two. This set of strategies could have been classed as 'taught changes,' because similar types of disclosure are encouraged as a desensitisation technique, as recommended by [Turnbull and Stewart \(1999\)](#). However, the occurrence of these strategies in the behaviour of group two members indicates that these strategies can also develop independently of therapeutic intervention. Additionally, there were no suggestions that the idea of disclosure had come from a speech and language therapist. Although it is possible that these strategies may have arisen during therapy, such as personal construct therapy or counselling, it was decided not to categorise them as a 'taught change.'

### 3.7. *The situational management of stammering*

An examination of when respondents used specific strategies to manage their communication indicated that strategy use was influenced by a number of internal and external variables. These included the content and structure of the message, the presence and status of the interlocutor, the familiarity and formality of the communicative situation, the perceived need to talk, one's physical or emotional state, and past memories of stammering. Predictions about the communicative partner were commonplace throughout the interviews:

R5 If I come up to somebody who I feel they're above me, that they've got a better job or they're more qualified, I feel when I speak to them my stammer comes back, I feel as though my self-esteem is low again.

R10 I didn't feel comfortable with it (the use of slowed speech in public), I don't mind using it with you.

Respondents often commented that speech was worse in situations where they felt it should not be a problem, such as with partners and friends:

ICS . . . so you can go home and speak fluently?

R6 Yeah, on my own . . . often the words to her (wife) will be, are the worst (most dysfluent) of all because I guess . . . I just relax you know and I don't concentrate.

For employed respondents, speaking at work was a key issue. Stammering in the work place, when managed by avoidance, was felt to have negative consequences, preventing them from displaying their full potential, which in turn could limit their opportunities for promotion:

R8 The way I feel about it sometimes stops me from saying things I would like to say and in turn that makes me feel as if some people might think that I'm not good at what I'm doing . . . that I shouldn't be in that position.

Therefore, confrontation in the work place was often viewed as a necessary if daunting and unrewarding prospect.

R13 There were things I would avoid doing . . . there were other things which I would take on against my better judgement and make a mess of. It was a very fraught time really.

Sometimes, confrontation had beneficial consequences:

R1 My boss asked me to find out about a particular product which involved ringing round various companies . . . I was fairly nervous and I would try to put this off as much as I could and eventually I would just have to get on with it . . . when I did I actually felt as though I did better than I thought I would.

R2 I made a big effort with that (telephone) and in the end it was OK.

Patterns emerged for each respondent, in which different situations prompted different strategies, such as using an 'intuitive change' in public and formal situations (e.g., at work or socially) and employing a 'no change' strategy at home:

R2 (In public) I avoid where I can, I get my daughter to do it for me.

Individuals' preferred mechanisms for speech management were frequently cited as being disrupted by internal responses as well as external factors. Respondents felt that their emotional state was often key to the communication choices they made and that their internal responses could not be explained.

R7 It happens but I can't predict when it's going to happen, just that sometimes I just feel I can't handle it and other times I can, I'm not sure why.

ICS Can you use, actually use what you've learnt in therapy to your own benefit?

R8 It depends on my level of stress I think. I can't sometimes but if I can, I feel good.

#### 4. Discussion

The qualitative nature of this study facilitated a reflection on different individuals' experiences of stammering. It revealed that key experiences are shared both by adults who have and have not received therapy. [Corcoran and Stewart \(1998\)](#) suggested that the core experiences of stammering are suffering, helplessness, shame, and stigma. This study's findings concur with these key elements but found that individuals experienced varying amounts of these elements at different stages of their lives. For some, suffering was acute in childhood but had dissipated gradually over time, whereas suffering was still a key part of their lived experience for others. However a strong theme of limitation emerged from the cohort. This experience of limitation began in childhood and continued into adulthood. The four respondents who chose not to have therapy as adults reported feeling the most limited in their social lives, whereas work was singled out as a key area of difficulty for the respondents from group one. The extent of workplace limitations varied considerably from those who felt that their initial choices of a career had been influenced by stammering, to those employed in a career of their choice who expressed very specific issues concerning their communication at work. These findings are supported by the results of a survey of members of the British Stammering Association by [Hayhow \(1999\)](#), who found that social lives were reported as being least affected by stammering.

The limiting effects of stammering can be attributed to two factors; those that are socially imposed and those that individuals placed on themselves, sometimes from a very early age, by their adaptations to stammering. [Peters and Starkweather \(1989\)](#) proposed that individuals who stammer start making adjustments to their speech as early as 6 years old. They continue to refine their communicative behaviours into adulthood in order to minimise any signs that might be detected by their audience and viewed as abnormal. Therefore stammering may appear less severe, in early adulthood, yet the strategies used to achieve this appearance may actually increase the burden of stammering for that person. Respondents' narratives indicated that part of this 'burden' is the fact that living with a stammer limits the life of the individual.

In the accounts of stammering during childhood all of the adults referred to episodes when a third party, usually a teacher or a parent, had negative reactions to their stammering. However, there were only two narratives that contained explicit references to similar negative reactions from adults in adulthood. These narratives were elicited by general questioning, and it is possible that some respondents may have experienced a variety of reactions to their stammering as adults but did not discuss them during questioning, because adult experiences may be more difficult to discuss than are childhood experiences. An alternative explanation suggested by this study's findings is that others' reactions to stammering, whether negative or positive, are few and far between, because stammering is predominantly managed by avoidance in formal situations. Thus, many of the limiting experiences reported by members of both groups may be

associated with the consequences that follow a member's chosen speech management strategies.

The respondents' highly elaborated and complex systems of speech management not only varied in method but also across situations. Decisions to reveal or conceal their stammering appear to be driven by multiple influences, predominantly based on the perceived consequences of revealing their stammer. When stammering was concealed through avoidance, a personal gain was made, because the objective of 'not being heard to stammer' was achieved. However, losses, which are also limiting, might occur as well. Such losses may be either internal personal losses, such as feelings of inadequacy, or external losses, such as not being considered for a promotion. Therefore, the limitations experienced by people who stammer may be equally attributable to self-imposed restrictions as well as to the barriers encountered in society. This view is supported by the narrative of the individual with acquired stammering who had an established career, social life, and family prior to the onset of his dysfluency as an adult. This respondent openly confronted speaking situations and did not associate stammering with being limited.

As [Blood \(1993\)](#) points out, adults who stammer present a unique challenge to the speech and language therapist, because as adults they have invested years in developing their character but as people who stammer, they want to change. This study has indicated that these adults will feel limited in their lives. As ongoing feelings of limitation may be self-imposed it is important that the therapist investigates the management strategies already used by the client as it could be these strategies that are the maintaining source of the limitation.

This study additionally provided information as to what the therapist may find in the highly elaborated system of speech management used by the adult who stammers. Regardless of the presence or absence of therapeutic input, adults who stammer shared common strategies for coping with the threat of communication breakdown. The strategies were grouped into four key areas: no change, intuitive change, taught change, and highlighting. Respondents used an amalgam of strategies to manage their communication rather than favouring one method. As suggested by [Peters and Starkweather \(1989\)](#) these strategies are likely to be refined over time. Evidence of this ongoing revision of strategies was particularly apparent in the accounts of group one. Following speech and language therapy, the respondents from group one were managing their speech on a daily basis in a variety of ways including a heavy reliance on intuitive strategies such as word and situation avoidance. Respondents however indicated that they felt that avoidance was not a desirable way of managing their communication, indicating a mismatch between what they believed and what they practised. Further examination of this belief showed that this is what they had been told by a speech and language therapist. Additionally, respondents indicated that intuitive strategies were inferior to taught strategies and therefore the continued use of the former inferred some amount of failure on their part. Nevertheless, avoidance for these respondents evidently continued to play a functional role in their communicative repertoire.



The finding that speech management strategies were employed variably across different situations indicates that taught strategies would also succumb to this pattern. Most respondents felt they were more comfortable stammering at home with their friends and with their therapist, than at work. Although, without further evidence, the findings from this study cannot be generalised to the wider population of adults who stammer, the fact that different communicative situations are construed in different ways is of interest to the clinician. Without a thorough knowledge of how the client behaves in their individual communicative environment, the clinician will be unable to set up a realistic therapy program. If the client perceives work as the only situation where fluency is key, as did respondents in group one, it may be that this is where opportunities for change will be focused. The client may not indicate that they are experiencing significant episodes of stammering behaviour at home or in social environments perhaps because these are situations where there is minimal perceived limitation from stammering or where the client has a more supportive communicative environment. However, it could be that those are still occasions when the client is significantly dysfluent or using a significant number of intuitive strategies. Such situations would then serve as the arena for intermittent reinforcement of pre-therapy behaviours. Behaviours that are intermittently reinforced are notoriously difficult to replace with new ones. Luper (1996) highlighted this as being one major obstacle to the maintenance of fluent speech.

Relapse following therapy came under scrutiny over two decades ago at the Banff Conference (Boberg, 1981). Despite this focus, relapse continues to be an issue in the treatment of stammering (Bloodstein, 1995; Craig, 1998), and with the distinct possibility that clients' own strategies may reoccur, there is a real opportunity for them to experience a sense of failure and further limitation. Taking the findings of this study into consideration, clients' ways of managing communication pre-therapy merit special attention throughout the therapeutic process. Word and situation avoidance, postponement, use of fillers and run-ins, have functioned for years as escape mechanisms from the painful and stressful situations that cause the suffering felt by many who stammer (Corcoran & Stewart, 1998). However, in the same manner that these mechanisms have a positive immediate effect, they are also directly linked in respondents' narratives about the long term, limiting experiences of stammering. Therapists are, therefore, faced with the difficult task of helping clients to find more effective ways of communicating when it is likely that they have a strong sense that the strategies that they developed and use are effective to some extent in achieving the primary aim of concealing stammering (Sheehan, 1982). Therapists need to help such clients realise the true consequences of their daily communicative behaviour. Therefore, in addition to discussing the possible advantages and disadvantages of certain ways of managing their dysfluency with clients, it appears that approaches which advocate experimentation or reality testing, such as personal construct psychology (Dalton, 1983; Hayhow & Levy, 1989; Kelly, 1955), would be beneficial. This would give clients the opportunity to compare the real life efficacy of their

pre-existing coping mechanisms with the efficacy of the strategies introduced by the therapist.

The process of recording the type, place of occurrence, frequency of use and the perceived efficacy of a client's pre-therapy coping strategies may be a useful therapeutic tool. It would entail a thorough evaluation of speech management strategies including what the client already does, acknowledging the advantages and disadvantages of using individual strategies in a variety of situations and identifying which strategies are most likely to return. This would aid the identification of the most limiting strategies and would enable therapy to be focused on their replacement. With this in mind, it seems that clients should leave a therapeutic encounter prepared for the possibility of speech breakdown (Turnbull & Stewart, 1999) taking with them a plan for dealing with the old ineffective coping strategies when they reoccur.

This study has identified that the experience of stammering has a limiting effect on the life of an individual. As the findings are drawn from a sample with a mean age of 56 it would however be beneficial to replicate these findings in a younger cohort. Further investigations into the communicative choices that people who stammer make following therapy would also be of clinical interest. This study has provided an insight into the way that people who stammer communicate on a daily basis and suggests that people who stammer rely on a variety of strategies in a variety of situations. It should be a priority of the speech and language therapist to identify and minimise any ongoing limitation felt by a client particularly focusing on those limitations, which may be self-imposed. A successful therapeutic intervention would therefore have enabled the client to recognise and act upon any limitations they place on themselves in communicative situations and equip them with the most functional strategies to use in different areas of their lives.

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## **Appendix A. Interview schedule**

- (1) Can you tell me about your earliest memories of stammering?
- (2) Were you offered any help with your speech when you were younger?
- (3) In what ways did stammering affect your life when you were a child/teenager?
- (4) As you have got older do you feel that your stammering has changed in any ways?
- (5) What have your experiences of speech and language therapy been as an adult?
- (6) How do you manage your speech on a day-to-day basis?

- (7) In what ways has stammering affected your adult life?  
 (8) Please describe your experience of stammering to me.

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**CONTINUING EDUCATION****Communicating in the real world: accounts from people who stammer****QUESTIONS**

1. The respondent who reported a different lived experience of stammering was:
  - a. female
  - b. a person with an acquired stammer
  - c. a person with a persistent developmental stammer
  - d. an unemployed person
  - e. a clutterer
2. All of the respondents with a persistent developmental stammer recall their first memory of stammering as occurring:
  - a. in a family setting
  - b. when seeking employment
  - c. in a social setting (e.g., school)
  - d. when making friends
  - e. during therapy
3. The lived experience of the group can be summarised as:
  - a. inspiring
  - b. depressing
  - c. stigmatising
  - d. positive
  - e. limiting
4. Two reasons for respondents preferring NOT to use taught changes are:
  - a. feeling overloaded and not bothering to practice
  - b. taught change was unsuccessful when tried and received a negative reaction
  - c. feeling conspicuous and ashamed
  - d. not liking the therapist and never trying the change
  - e. inadequately explained by the therapist and taught change made dysfluency worse
5. Respondents managed their communication by:
  - a. following the advice they were given by a Speech and Language Therapist
  - b. speaking normally regardless of the consequences
  - c. always warning others of the possibility they might stammer
  - d. using a variety of strategies dependent on external and internal variables
  - e. always using fluency enhancing techniques