OBJECTIVE PSYCHOTHERAPY IN THE TREATMENT OF DYSPHEMIA

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Since many speech therapists feel that dysphemia is already "the disorder of too many theories," they regard outside opinion as an intrusion and a usurpation of their rights. Others, imbued with a need for therapeutic teamwork, (a high-sounding concept which rarely works in practice) often err by accepting contradictory and fragmentary views which only further confuse and complicate the issue. The present paper is an endeavour to increase the scope and range of the speech therapist's role by offering an objective rationale for the inclusion of certain behaviour therapeutic* techniques into the sphere of logopedics.

The study of dysphemia may be conveniently divided into three parts:

(i) The actual stutter (i.e. the analysis of clonic and tonic spasms associated with phonation, articulation and respiration which disturb the flow of speech. This would include accompanying tics and allied patterns of dysrhythmia in various areas of psychomotor activity).

(ii) The onset and underlying causes of stuttering. (In this connection, it should be emphasized at the very outset that attempts to reveal the genesis of stuttering through biochemical analyses, psychometric investigations, medical and neurological examinations, EEG recordings and the like have all proved nonspecific for any stutterlike pattern).

(iii) The stutterer's psychological responses, with special reference to his attitudes and feelings in various speaking situations.

In dealing with the problems associated with (iii), the speech therapist is handicapped by a paucity of effective techniques. On occasion, the anxieties which often exacerbate dysphemic responses are glossed over. In general reassurance or mild emotional support is offered, while relaxation and specific "assignments" are used as therapeutic adjuncts. On the other hand, many problems are left alone on the assumption that it is highly dangerous to dabble in psychotherapy. This is a crucial gap. In most practical essentials the speech therapist is willy-nilly a psychotherapist and the treatment of specific neuroses which have a bearing on the mechanisms of speech, may legitimately be placed within the province of logopedics. The present article outlines two techniques which, in time, may conceivably form an integral part of the therapeutic "**modus operandi**" of every speech therapist.

Although it has not been established that dysphemia is essentally a manifestation of unresolved conflicts and anxiety, even the pure organicists cannot deny that a stutterer's speech pattern usually deteriorates in anxiety-generating situations. It is empirically demonstrable that attitudes of hypersensitivity and self-consciousness tend to further inhibit the stutterer's verbalization and result in "secondary blocking." Some stutterers, burdened by pervasive anxieties, find the mere thought of speech terrifying. The desensitization technique outlined below is not for them; it is indicated in cases where the individual is overwhelmed by anxiety and tension in **specific** speaking situations. It must be understood, however, that neither of the therapeutic techniques* dealt with is intended as a "cure" for dysphemia. When working towards a cure, the emphasis should be on a **synthesis** of different therapeutic procedures, so that consideration is given to the entire speech mechanism **perse** and to the socio-psychobiological features. But at the present stage of our knowledge, the complete elimination of a confirmed stutter is generally a therapeutic ideal rather than a practical objective. Therapeutic idealism often results in objective nihilism and fails to achieve even those modest therapeutic goals which are well within the limits of our practical skills. Those theorists (such as the pschoanalysts) for example, who insist on treating the so-called "total personality" are often so absorbed in the intricacies of their amorphous task, that they rarely achieve results comparable with

*We are following Eysenck's example of subsuming the theoretical concepts and practical methods of treatment derived from modern learning theory under the heading "Behaviour Therapy."

*The practical application of learning theory to the treatment of tics which often accompany stutterlike patterns is dealt with towards the end of this paper. Speech therapists will easily recognize the different emphasis which is placed on the well-known technique of "negative practice."

those attained by therapists who use only simple vocal exercises. Thus, on the assumption that it is wise to proceed with scientific humility and caution, we shall now outline two techniques which aim to **alleviate** rather than to **eliminate** the problem of dysphemia.

(i) SYSTEMATIC DESENSITIZATION BASED ON RELAXATION*

Wolpe[2] has shown that specific anxieties can be eliminated if they are progressively opposed by muscular relaxation. Thus, if a stutterer becomes anxious each time he answers the telephone, this response (anxiety) must be opposed by a new response (e.g. relaxation) which is physiologically incompatible with anxiety. The bond between the specific speaking situation and the anxiety will then be broken. This fact was clearly demonstrated in the case of a 19-year-old pharmacy student whose mild stutter became extremely pronounced each time he had to answer the telephone. "As soon as the 'phone starts ringing I begin to feel butterflies in my stomach," he explained. "As I get near the 'phone my fears get worse and by the time I lift the receiver to my ear, I just know that I'm going to stutter . . . By then I can't even open my mouth." He added that the **mere thought** of speaking on a telephone made him feel ansxious. Systematic desensitization was applied as follows:-

He was first trained in an accelerated version of Jacobson's[3] progressive relaxation. While fully relaxed, he was asked to imagine the sound of a telephone ringing in the distance. (He was told to signal to the therapist if he experienced any feelings of anxiety while visualizing any of the given situations). As this failed to provoke any anxiety, he was asked to imagine the sound of a telephone ringing in the same room. This image also failed to generate any anxiety, but the thought of a telephone ringing right next to him provoked a fair measure of anxiety. His anxiety was opposed by relaxation again and again until he was able to tolerate, with complete tranquillity, the idea of a telephone ringing right beside him.

The patient was seen three days later. He reported that he no longer experienced any anxiety when he actually heard the telephone ringing . . . "the butterflies are completely gone in that situation." He was then desensitized to the thought of approaching a ringing telephone. It required four sessions before he was able to contemplate picking up the receiver with no feelings of anxiety. At this stage he reported that his phobia for telephones had greatly diminished. "I don't panic any longer," he stated, "but I still stutter very badly over the 'phone . . . It's worst of all when I try checking an order over the 'phone." After nine additional desensitization sessions, there was no apparent difference between his telephonic speech and his verbalization in face-to-face situations. At the time of writing, he has maintained his improvement for over four years.

Equally good results were achieved in the case of a 19-year-old student whose stutter incapacitated her while out on a "date," while speaking in class and when answering the telephone. These three anxiety areas were treated concurrently and required 22 sessions for their complete elimination. The patient also reported an improvement in many general aspects of her speech. The follow-up in this case is also over four years.

Similarly, a 42-year-old business executive who had experienced great difficulty when talking to important clients and when ordering in a restaurant stated that "my new business contacts don't believe me when I tell them that I am a stutterer." He required only 13 desensitization sessions to effect this improvement.

A case reported elsewhere[4] was that of a 34-year-old engineer who received desensitization therapy for a speech disturbance characterized by lengthy and frequent "word blocks" accompanied by considerable tension and facial grimaces. When first interviewed he stuttered on about 12-25% of words, with "blocks" averaging 3-4 seconds. His attitude towards speaking situations was poor. He received 30 hours of therapy over 9 months. Therapy sessions were usually held once a week. Training in progressive relaxation was followed by systematic desensitization. Among others the following anxiety-situations were treated: time pressures (especially speaking on the telephone as he conducted many of his occupational affairs by long-distance calls), telling jokes, public speaking, difficult 'audiences' i.e. specific people who provoked added speech difficulties. Progress was gradual, but at the termination of therapy a substantial gain in speech fluency had been achieved.

One of the principal skills in the administration of systematic desensitization is to proceed at a pace which is in keeping with the patient's level of anxiety. No harm seems to ensue from proceeding at a pace that might prove too slow for a patient, but too rapid a pace can prove extremely antitherapeutic and lead to increased levels of anxiety. The desensitization procedure

*For a complete practical and theoretical exposition of systematic desensitization based on relaxation see Wolpe[2] Chapter 9.

can be used with children[5] but, as yet no one seems to have administered it to dysphemic children.

(ii) THE USE OF MASSED PRACTICE IN THE TREATMENT OF TICS ASSOCIATED WITH DYSPHEMIA

Yates[6] deduced a method of eliminating neurotic tics by building up a habit of "not performing the tic." According to Hullian theory[7 8 9] massed practice of a motor activity (e.g. a tic) causes reactive inhibition (Ir) to build up. When Ir reaches a certain critical point the subject requires rest i.e. he experiences a need not to perform the tic. The habit of not performing the tic becomes associated with drive reduction and is therefore reinforced. Repeated massed practice will therefore build up a negative habit ("not-doing-the-tic") which will militate against the positive habit of doing the tic.

Yates's theoretical model was applied in the case of an 18-year-old youth with an extreme stutter who invariably twisted his mouth, screwed up his eyes and jerked his head forward and back during a "block." Twelve years of intermittent speech therapy had been of no avail. He was referred to the writer for vocational guidance and was advised first to undergo therapy for the pronounced spasms and tics which seemed to impede his speech. The tics were treated concurrently but independently. Each tic was given five one-minute periods of massed practice, with one minute's rest between each period. The same order of massed practice was employed throughout the treatment. He was first required to practice the jerking of his head for five trials. After three minutes rest he was asked to perform the mouth twisting movements and finally reproduced the eye-movements. The patient was instructed to carry out two sessions daily. He was supervised by the therapist twice a week. The tendency to screw up his eyes during a "block" was eliminated in less than three weeks. The mouth-twisting response and the head-jerking required more than a month of massed practice before they entirely disappeared. To date, there has been no apparent symptom substitution, nor have any of the original tics or spasms returned. The overall improvement in his speech is really quite remarkable. His blocks are now far more infrequent and they are usually so momentary that they often pass completely unoticed by untrained observers. A prolonged follow-up of this case is being undertaken.

DISCUSSION

It is premature at this stage, of course, to assess the value of the techniques outlined above in the treatment of dysphemia. The preliminary findings, however, are most encouraging and warrant further investigation. This introduces the query: "Who should carry out the treatment, speech therapist, psychologist, or both?" We therefore return to the consideration of therapeutic teamwork. In the opinion of the writer, therapeutic teamwork is tenable only where there is a clear-cut division of the skills involved. In the case of a therapeutic liaison between doctor and psychologist, for instance, the collaboration is usually fruitful. This is because the doctor remains responsible for the **physical** health of the patient and the therapeutic lines of demarcation are reasonably obvious to patients and therapists alike. It is difficult to decide whether therapeutic teamwork between speech therapist and psychologist is advisable — so much depends on their respective theoretical orientations, their therapeutic objectives, the patient's level of adjustment and so forth. By and large, it is our view that the speech therapist, given the necessary training,* would be adequately qualified to "go it alone" when confronted with cases similar to those presented above.

*It must be understood that the desensitization technique is a highly specialised procedure. The therapist who employs desensitization requires tuition in (a) the construction of the relevant anxiety hierarchies (b) the application of hypnotic and ordinary relaxation procedures (c) the handling of anxiety which is aroused during a session (d) in assessing the optimal number and duration of the stimuli which should be presented in any given session.

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