GUIDED BY A ROADMAP OR A SAT-NAV?

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Introduction

Over the years, much of the debate and controversy surrounding stuttering treatment appears to have centred on whether this disorder is a simple speech problem or a more complex disorder of communication. In this author's opinion, if stuttering were a simple speech disorder, treatment would be relatively straightforward, successful outcomes incontrovertible and there would be no need for International Conferences such as this one in Rome. Debates about the "right approach" would not arise and a whole industry would never have developed!

The paper will aim to reflect on some of the issues in the ongoing debate about providing the best possible clinical service – with a personal reflection on the complexity of stuttering, the current issues about evidence based practice and therapy choices. The title of the paper represents the challenges of engaging and guiding our less experienced colleagues towards becoming confident and competent in working with stuttering. It is, after all, the most intriguing and perplexing topic in the speech and language pathology basket!

So how has stuttering achieved its reputation as being such a difficult disorder to understand and to treat ?(Brisk, Healey & Hux, 1997, St Louis & Lass, 1981)

Clearly the curriculum hours in many universities have been reduced and opportunities for practical experience within the clinical setting are often minimal or lacking, but a range of other factors continue to contribute to its notoriety.

Complexity Matters

From its onset, it is a complicated disorder which is unlike other speech and language problems. The stuttering frequently arises when the child is over 3 years of age, often with no signs of any difficulty prior to this. No wonder parents panic and worry about their role in its development (Bernstein Ratner, 2010).

Stuttering can vary on an hourly and daily basis, seemingly with no pattern.

:an disappear for weeks or months at a time. Some children start to stutter
:denly and severely, while for others it arises slowly, almost insidiously. Some
:idren are unaware and unconcerned, while others have a significant
·otional reaction. There is evidence now that quite young children may
·ice the problem in a peer and begin to react unkindly – although more
:earch is needed. However it is also known that by primary school age, other
:dren do begin to notice the stuttering and treat the child differently. This is
ly to shape the child's negative cognitive, affective and behavioural
:ponses to their difficulty in speaking (Yaruss, 2010).
The high level of natural or spontaneous recovery is also a disquieting factor.
·ay feel reassuring to the clinician to be able to quote the facts and figures,
the anxious parent wants to know what the outcome will be for their child.
the problem persist or resolve? And if it persists, is there a cure?
Although these issues are well known, they are challenging for the
xperienced clinician to understand, let alone explain to the family.
There are many inconsistencies and variable "factors" which potentially
ike one child more vulnerable than another, but do not necessarily follow the
:earch findings. In the clinical setting, for each child who presents with a family
·ory of stuttering, there is another where the problem has never arisen
·ongst relatives. The preponderance of boys who stutter usually holds true,
·il there is a sudden upsurge in female referrals. Onset usually happens
·tween 2 – 5 years, but for other children stammering can start anywhere
·tween 7 – 12 years with no previous occurrences. Many children have
·ociated histories of early speech and language problems, but many others
:m to have followed the typical development. Children who have received
:cessful early treatment are referred again in later childhood or as teenagers
cause the stuttering has recurred (Bloodstein & Bernstein Ratner, 2008).
Again a real challenge for the clinician with little knowledge or experience
stuttering.
These intriguing puzzles about stuttering have occurred throughout this
·thor's 40 years of clinical experience. For every "fact" which has been
:orted from research findings, a confusing disparity has arisen within the
·ical setting.
Although the questions from clients, families and other professionals can vary,
:y usually include " Why are certain sounds, letters or words harder to say?",
·hy can I sing/act/recite fluently?", "Why are certain situations harder than
·ers?" And, of course, these reported 'difficult' situations also vary from
·ividual to individual.
Again, it is not surprising that it appears to be a challenging and

Therapy choices: the challenges of evidence based practice

Currently, and correctly, there is ongoing debate about what constitutes best practice and the need for therapy to be evidence based. Straus, Richardson, Glasziou, & Haynes defined it thus "Evidence-based medicine (EBM) requires the integration of the best research evidence with our clinical expertise and our patient's unique values and circumstances" (page 1, 2005). This definition emphasizes the importance of accounting for three aspects to implementing therapy. A skilled clinician will offer therapy that is embedded in current scientific knowledge whilst ensuring that the experiences, perspectives and expectations of the individual client are accounted for (Manning, 2010).

This clearly reflects practice at its best but is it likely that less experienced clinicians can provide this?

In September 2011, Nan Bernstein-Ratner presented an excellent and thought provoking keynote address at the Oxford Dysfluency Conference (Bernstein Ratner, 2011) where she raised many of the topical questions in relation to providing the best possible clinical practice which is evidence based cost effective and accounts for individual differences. She emphasised that there is a considerable and growing body of published research (Bloodstein & Bernstein Ratner, 2008), which is readily available to clinicians about stuttering but that this largely relates to the nature of stuttering rather than treatmen outcomes. However, she also reported that rather than looking for the evidence base for current treatment approaches, many clinicians are more likely to return to traditional textbooks written by 'experts' or to seek advice directly from colleague. She raised some key questions: - Who qualifies as an "expert"? Wh is current published research apparently not transferring to the therapy room' Do the subjects in the research studies represent the real client in the therap room? Is the evidence-based therapy practicable? Are there institutionc constraints which prevent particular choices?

Bernstein Ratner went on to conclude that there are significant challenges fc clinicians in providing "best practice" for clients, including whether EBP is the righ and only choice for all. She discussed the potential limitations of adhering to 'manualised', step by step programme of therapy with set goals related to th research findings rather than considering the needs of the individual client an family.

Bernstein Ratner introduced the possibility that Practice Based Evidenc (PBE) could make an important contribution to everyday clinical services. Brief PBE requires clinicians to collect the 'evidence' in their everyday clinic practice to demonstrate that the therapy is genuinely making the differenc that fits with the client's needs and expectations. She emphasised th

portance of the relationship between the client and the therapist and made ne point that there may be different goals in therapy for different clients: clinicians should ensure that they fully understand the real life goals of clients.

Bernstein Ratner proposed that quality of life issues, the more subjective goals that clients might aspire to, can, with constructive questioning, be turned into quantifiable and objective measures of change. For example, "What exactly in this therapy is working well for you?", "In what specific ways is this is making a difference?", "What seems to be working less well and what needs to be different?" "What are you doing now that you were unable to do before?" "What difference is therapy making to your life specifically?" Bernstein Ratner re-iterated the importance of the partnership with the client in making sure that the therapy does resonate with the client 's expectations and have credibility and fidelity for the individual.

Developing clinical skills

The title of this paper "The therapeutic journey: guided by a roadmap or by Sat Nav (GPS)" was inspired by the discovery that the exclusive use of satellite navigation systems for guiding drivers could result in very real narrowing of a person's competence in planning and navigating a journey. Of course, the Sat Nav often successfully guides a person from one location to another by the shortest route. On these occasions there are no barriers to progress, no roadblocks, no unexpected changes and no challenges to face. All that is needed is a qualified driver who can follow instructions and who doesn't (usually) question the route by unexpectedly seeking alternatives. If minor challenges arise, the Sat Nav system competently re-callibrates and offers a new instruction "turn around where possible", or "at the next junction, turn left". No fuss. No stress. No arguments.

But when the driver is asked "Where did you actually go?" Or "How did you get there?", the answer is the postcode or address rather than any detail.

However was this route the most efficacious? Could there have been more interesting options? Would another destination have proved more successful? Could the driver find the same place again without the technology? What would have happened if the device had failed? What if the Sat Nav provided a route that was too narrow and became impassable?

This analogy fits with the challenges faced by a clinician with limited knowledge and skill in providing stuttering therapy. This clinician has received some basic training and possesses a manual for the treatment of stuttering. The goal of the treatment is clear and fits with the assessment of the severity of stuttering – the research has shown this 'route' to be the shortest and i tested. It works well and both client and clinician are satisfied that they reached the right goal. But taking the analogy a little further. What if the cl problem was actually much more complicated and it was difficult to an the severity and complexity of the problem from the available test? Perhc number of different potential goals were identified but there environmental factors which complicated matters. It could be that this the had been tried before but the progress had not been maintained or the did not match up to the expectations. Therapy would not be successful there are no options.

The road map (provided it is modern) in this analogy equates to experienced therapist who knows how important it is to take all factors consideration before embarking on the therapeutic journey. The client have a clear goal in mind, but has also identified a number of high expecta about the final destination. He or she is not quite sure what the journey invc and does not want to risk getting stuck anywhere. This experienced clini recognises the importance of getting to know the client well, to have emp with the current challenges they face, their strengths and needs, the bas their expectations and their readiness to embark on the journey. The "roadm therefore represents the options that are available in therapy and the var of destinations that might be possible. This therapeutic journey or 'roadma based on scientific evidence as well as observations and data from ot clients' experiences in therapy. Some therapeutic journeys may be short challenging, while other options offer the possibility of going slowly enough discuss issues as they arise, examine the pros and cons of certain directi experiment with strategies or techniques, discard ideas that seem less hel and retain ideas that are proving more beneficial. The clinician has the "mc shares it with the client who examines the options, selects possible routes c engages in a partnership with the clinician to select a likely destination.

It is not necessarily an either/or decision in selecting whether to travel guic by Sat Nav or by roadmap –a combination may be the best approa However the Sat Nav will certainly be very useful technology for the novi driver who wants to concentrate on developing driving skills, but it will soon important for this driver to take independent responsibility for journeys, discover new routes and alternative destinations. In the same way, the novi therapist will develop confidence by being trained in a particular – eviden based – therapy programme with a manual in the early stages, but a creati and enthusiastic therapist will quickly discover that there are other routes whi fit individual client's needs more closely. The analogy works too in relation working in partnership with the client, the novice clinician will also find the re

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The road map (provided it is modern) in this analogy equates to the experienced therapist who knows how important it is to take all factors into consideration before embarking on the therapeutic journey. The client may have a clear goal in mind, but has also identified a number of high expectations about the final destination. He or she is not quite sure what the journey involves and does not want to risk getting stuck anywhere. This experienced clinician recognises the importance of getting to know the client well, to have empathy with the current challenges they face, their strengths and needs, the basis of their expectations and their readiness to embark on the journey. The "roadmap" therefore represents the options that are available in therapy and the variety of destinations that might be possible. This therapeutic journey or 'roadmap' is based on scientific evidence as well as observations and data from other clients' experiences in therapy. Some therapeutic journeys may be short but challenging, while other options offer the possibility of going slowly enough to discuss issues as they arise, examine the pros and cons of certain directions, experiment with strategies or techniques, discard ideas that seem less helpful and retain ideas that are proving more beneficial. The clinician has the "map", shares it with the client who examines the options, selects possible routes and engages in a partnership with the clinician to select a likely destination.

It is not necessarily an either/or decision in selecting whether to travel guided by Sat Nav or by roadmap –a combination may be the best approach. However the Sat Nav will certainly be very useful technology for the novice driver who wants to concentrate on developing driving skills, but it will soon be important for this driver to take independent responsibility for journeys, to discover new routes and alternative destinations. In the same way, the novice therapist will develop confidence by being trained in a particular – evidence based – therapy programme with a manual in the early stages, but a creative and enthusiastic therapist will quickly discover that there are other routes which fit individual client's needs more closely. The analogy works too in relation to working in partnership with the client, the novice clinician will also find the real

benefits of helping the client to find their own routes for maintaining progress and dealing with setbacks.

A finial thought about the "roadmap", the novice clinician will become experienced through further training, expert supervision and joint working. Confidence and competence are the hallmarks of an expert, the "journey" to expertise should be challenging and inspiring.

Summary

The best possible therapeutic service will be grounded in evidence based practice which has three key strands: empirical evidence, the clinician's knowledge and skills and the clients' needs and values. This offers the possibility that the clinician must be able to resist the pressures of adhering to research findings based on studies which have been carried out on a population which is different to the individual client who is seeking help. A selected therapy approach should have an evidence base, it must have a justified reason or focus which fits with the client's particular experiences and concerns. The therapy approach must be monitored carefully – and if positive change is not evident or reported by the client, a new direction should be considered with the client's agreement.

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