Perspectives on the past and the future: clients' views on UK service provision for adult stammering

Keywords: stammering, therapy, adults

Abstract

Client opinions are appropriate contributions to the design and evaluation of healthcare services. Adults who stammer (AWS) have previously informed discussion regarding speech and language therapy (SLT) services although contemporary UK perspectives are lacking. This study aimed to identify features of helpful and unhelpful SLT services for AWS from the client and potential user perspective. Highlighting preferred components of therapy from this standpoint can help to ensure that SLT services are client-centred. An online survey was conducted using questions largely derived from professional guidelines of minimum best practice within a UK context. Responses were subjected to both quantitative and qualitative analysis. Both positive and negative aspects of individual and group therapy for AWS were identified. Ideal service characteristics related to 'therapy and therapist' and 'service delivery issues'. Results were generally consistent with similar, previous studies. In addition, consideration of the place of remote communication methods within therapy highlighted an appetite for such practice. SLT has facilitated long-term benefits for the majority of respondents, but future service design could incorporate greater flexibility in the timing of therapy, therapeutic format, choice of therapist and the use of technology. The relevance of these findings for allied health services is acknowledged.

Introduction

The current political commitment to individualised healthcare, including that of allied health services, runs concomitantly with an emphasis on patient involvement in healthcare design and evaluation in the UK (NHS Commissioning Board, 2012; NHS Wales, 2010; The Scottish Government, 2010). Involving Speech and Language Therapy (SLT) clients in service planning can improve the quality of services, increase the emphasis on client-centredness and encourage clients to have greater ownership of their care plans (RCSLT, 2006). Evaluation of therapy benefits and its effectiveness needs to include client opinion of communication change across a variety of situations (Finn, 2003; Guntupalli, Kalinowski & Saltuklaroglu, 2006; Quesal, Yaruss & Molt, 2004) and adults who stammer (AWS) are considered good informants in generally having adequate communication skills that allow them to report on a lifelong communication difficulty (Hayhow, Cray & Enderby, 2002).

Previous studies have highlighted several aspects of therapy with which clients are satisfied (Hayhow et al., 2002; Stewart & Richardson, 2004; Swartz, Irani & Gabel, 2012). Unsurprisingly, intervention specifically targeting speech management is considered helpful (Plexico, Manning & Levitt, 2009), as is enhancing overall communication skills (Crichton-Smith, 2002) through addressing both the speech and non-speech aspects of stammering (Swartz et al., 2011; Yaruss, Quesal & Murphy, 2002a; Yaruss et al., 2002b). The clinic room has been described as a safe haven in which to discuss stammering (Crichton-Smith, 2002; Hayhow et al., 2002) with therapeutic safety further cultivated when feeling understood by a knowledgeable clinician who also has a passion for stammering, adopts client-focused clinical decision making, and facilitates acceptance and trust within the therapeutic alliance

(Plexico, Manning & DiLollo, 2010). Being with other AWS in therapy or support groups can facilitate increasing self-confidence and changing attitudes (Stewart & Richardson, 2004; Yaruss et al., 2002b).

In contrast, less helpful therapy has been recorded as that which does not facilitate transfer or maintenance of skills, does not address the emotional component of stammering, is insufficient in the amount of treatment provided or is provided by therapists who are inexperienced or do not work collaboratively with the client (Crichton-Smith, 2002; Plexico et al., 2010; Yaruss et al., 2002b). Notwithstanding the common trends that run through preferable and less preferable features of therapy, no definite conclusions have been drawn from typically heterogeneous participant samples in which a variety of therapies are often favoured (Plexico, Manning & DiLollo, 2005; Swartz et al., 2012; Yaruss & Quesal, 2004).

Small scale studies using interviews have permitted in-depth exploration of the client experience of therapy for AWS (Crichton-Smith, 2002; Stewart & Richardson, 2004), and using the membership of nationwide support associations as participant samples has permitted larger scale survey investigation of the same experience (Hayhow et al. 2002; Yaruss et al., 2002a; Yaruss et al., 2002b). Most recently, Swartz et al. (2012) surveyed American clients regarding their views on effective treatments via an online survey promoted by their Speech and Language Therapists (SLTs). Since Hayhow et al.'s (2002) UK survey, the Royal College of Speech and Language Therapists (RCSLT) has produced clinical guidelines for all communication disorders based on the published evidence base (Taylor-Goh, 2005) and whilst not a set of rules, the guidelines do set out the expected minimum standard of care. In recognition of possibly changed service user views over the past decade,

and possibly changed SLT practice in response to professional guidelines, this study intended to gather contemporary views of SLT services for AWS from the client or potential service user perspective. Capturing nationwide views could allow for some comparison of UK data from that previously published (Hayhow et al., 2002) and could contribute to the design of local and national services that achieve clinically significant outcomes for all stakeholders (Finn, 2003). The present study used an internet-based survey to seek the perspectives of AWS in the UK regarding their past experience(s) of National Health Service (NHS) SLT services and their preferences for future therapy. To achieve a comprehensive overview of stammering therapy, consideration was given to helpful and unhelpful aspects of SLT, the effectiveness of SLT to facilitate maintenance of new communication skills, characteristics of an ideal service, preferred structure of both individual and group therapy, and preferred location, timing and intensity of appointments. Soliciting opinion about future service design provides a long-term perspective of stammering management not included in previous studies.

Method

Participants

The respondents (n=74) were AWS from the UK and were predominantly male. Ages ranged quite widely and just under half of the sample was educated to university level. Demographic characteristics are shown in Table 1 below.

Respondents were asked to rate the severity of their stammering on a 10-point rating scale. The scale identified 0 as 'none', 1–3 as 'mild difficulties', 4–6 as 'moderate difficulties' and 7–9 as 'severe difficulties'. The mean severity rating was 4.41 (SD=1.89, range 1-8).

Table 1 about here please

Materials and Procedure

The questions in the survey were developed from those used in previous surveys of AWS (e.g. Hayhow et al., 2002; Yaruss et al., 2002a). Additional questions were included to reflect changed provision of SLT since earlier studies and the contemporary emphasis on user involvement in healthcare service design. The survey included both closed and open questions, was distributed via a weblink posted on the British Stammering Association's website. To increase awareness of the study and thereby increase response rates, SLTs in the UK, who were members of a Dysfluency Special Interest Group, were invited to promote the survey to their adult clients who stammer. Online surveys are advantageous in reducing costs of production and distribution, as well as facilitating data collection and management. Furthermore, the anonymity provided by internet surveys can reduce the likelihood of socially desirable responding (Leong & Austin, 2006).

Frequency counts were computed to quantify responses to the closed questions. Where appropriate, quantitative data were further analysed by means of discriminant analysis, chi-square test of goodness-of-fit, and chi-square test of association. Thematic analysis, as outlined by Braun and Clark (2006), was used to code individual meaning units within the responses to the open ended questions. Coded responses were grouped into themes, none

of which had been pre-determined prior to data collection. Groups of similar responses qualifying as distinct themes were identified collaboratively by the first and second authors. A small number of responses were uncodeable (e.g. “I honestly don’t know” or where respondents named individual therapists or therapy programmes) and so were excluded from analysis.

Results and Discussion

Despite the recognised benefits of online surveys, the sample (n=74) was smaller than anticipated, and in comparison with previous studies. Due to the anonymous nature of the study, it is not known what percentage of the BSA membership or how many current SLT clients responded. The majority of respondents (83.8%) indicated that they had attended SLT for their stammering as an adult while 16.2% reported that they had not. This latter subsection of the sample did not answer questions regarding previous experiences of therapy. As is typically the case, the response rate varied across the survey.

Past Therapy Experiences

Respondents were asked to state how many blocks of SLT they had received as an adult. A block of SLT can be understood as a series of therapy sessions commencing with assessment and concluding with discharge. The number of sessions within a block will vary according to the structure, demand and resourcing within local services. Of the respondents who had received SLT, 37.5% received one block, 27.1% two blocks, 12.5% three blocks, and 22.9% four or more blocks.

Table 2 shows the percentage of respondents receiving specific types of therapy. A high percentage of respondents reported experience of stuttering-modification strategies, specifically managing feelings associated with stammering, reducing avoidance, voluntary stammering, and Van Riperian block modification. It is less clear whether any respondents had been exposed to fluency-modification techniques alone. The high percentages relating to slowing the speech rate, breathing exercises and soft contact may indicate this; alternatively, these strategies may have been incorporated as part of an integrated therapy approach together with stuttering-modification (Guitar, 2006). Under the 'Other' category, responses included personal construct psychology, hypnotherapy, speaking circles and private stammering therapy courses.

Table 2 about here please

Notably, nearly three-quarters of respondents cited relaxation as a type of therapy received, but it would be surprising if this historical technique was part of the modern stammering therapist's repertoire. Although speaking in a more relaxed manner is a meaningful eventual goal, practised relaxation techniques aimed at producing fluency have long been regarded as counterproductive (Bloodstein & Bernstein Ratner, 2008; Sheehan, 1984; Van Riper, 1973).

The majority of respondents (75.5%) reported that they had found therapy helpful, while 5.7% indicated that therapy was not helpful, and 18.9% were unsure. This figure is consistent with that reported in previous studies in the US (Krauss-Lehrman & Reeves, 1989) and the UK (Hayhow et al., 2002). A discriminant analysis was conducted with helpfulness of

therapy as the dependent variable and level of severity, and level of experience with therapy as predictor variables. Forty three cases were analysed. Univariate ANOVAs showed that those finding stammering therapy helpful and those finding it unhelpful did not differ significantly on severity or therapy experience. The value of the discriminant function was not significantly different for the two groups (χ^2= 0.997, df = 2, $p > 0.05$).

In the absence of a precise definition, it is likely that respondents in the present study had differing conceptions of the term 'helpful' so, although generally encouraging, the present finding is of course open to some interpretation. Respondents were asked to specify what they had found helpful in therapy. As shown in Table 3, a number of consistent and independent themes emerged under three broad categories: process of therapy, outcome of therapy, and types of therapy / specific techniques. Although there was more of a focus on therapy process, the heterogeneous collection of responses highlights again that individuals who stammer tend each to value different aspects of the SLT experience (Plexico et al., 2005; Yaruss & Quesal, 2004). Four responses we uncodeable and so were discarded.

Table 3 about here please

Interestingly, none of the individual responses about helpful aspects of therapy related specifically to the process of working directly on fluency, or fluency as an outcome. This would suggest that participants appreciated successful therapy would deal in no small part with the hidden cognitive and affective aspects of stuttering, rather than just the surface behavioural features of the disorder (Conture, 2001; Sheehan, 1975; Yaruss & Quesal, 2006). This finding may reflect the possibly informed nature of the sample; around two

thirds of respondents had had experience of two or more blocks of SLT. As such, it is less likely that they held the misconceptions and unrealistic expectations about therapy still witnessed in clients with no prior experience of therapy (Van Riper, 1949). Also, the proliferation of information about stammering and its treatment on the internet in recent years has enabled people who stammer to become 'educated consumers' (Packman & Meredith, 2011). The consequent increase in knowledge may be moderating stammerers' expectations relating to the attainment of fluency.

Respondents were also asked to report what they had found unhelpful in therapy. Again, some specific themes emerged and these are detailed in Table 4. Five responses we uncodeable and so were discarded.

Table 4 about here please

The majority of responses on what had been unhelpful in the process of therapy related to service delivery issues and negative clinician characteristics. Issues with service delivery included limited therapy options and available appointments. Among the negative therapist characteristics were inexperience, lack of tact and poor understanding of the everyday experience of stammering. In terms of therapeutic outcome, respondents cited as unhelpful the lack of transfer of techniques beyond the clinic and the lack of lasting effect of therapy. These issues have been identified by AWS in earlier studies (Hayhow et al., 2002; Plexico et al., 2010; Yaruss et al., 2002b).

A perennial issue in stammering therapy has been that many aspects of therapy create gains which are short-term in nature. By contrast, long-term positive outcomes are more difficult to achieve (Bloodstein & Bernstein Ratner, 2008; Conture, 2001). This study sought to determine more precisely which outcomes, from the client perspective, might have been achieved in the short and long term. Table 5 lists 11 statements of therapy outcomes described as minimum best practice by the RCSLT (Taylor-Goh, 2005). Respondents were asked to indicate whether or not therapy had helped them achieve these outcomes. Chi-square goodness of fit statistics were significant for the distribution of responses on 8 of the 11 outcome statements.

Table 5 about here please

Six good service outcomes were achieved in the long term. These were: understanding stammering behaviour, dealing with negative feelings and attitudes towards speaking, making changes to the stammer, becoming more assertive, maximising potential to communicate more effectively, and developing strategies to reduce the amount of stammering. This encouraging finding suggests that stammering therapy for these clients had been 'robust' enough that therapeutic gains have been maintained beyond the short term. Some caution is required, however, as there is no way to verify that these positive outcomes were solely as a result of SLT and were not influenced by factors outside of therapy, such as self-help (Yaruss, Quesal & Reeves, 2007), or self-therapy (Fraser, 2010; Plexico, et al., 2005).

There was reasonable agreement that the other 3 outcomes were met for a considerable percentage of clients, but there was no consensus on whether gains were short- or long-term in nature. These were: developing strategies to reduce the number of dysfluencies experienced, developing strategies to reduce the severity of stammering, and maintaining skills learnt in the clinic. Again, these findings point to the long-recognised difficulty some people who stammer have of maintaining therapy gains after formal treatment has ceased (Boberg, 1981).

In addition, it was found that a statistically significant percentage of the sample did not achieve two of the RCSLT's outcomes. The first of these was helping friends/family/partner to support communication more effectively. A number of clinicians (e.g. Beilby, Byrnes, Meagher & Yaruss, 2013; Manning, 2010) have advocated recruiting the support of friends and family in the course of therapy to usefully acknowledge and reward the client's efforts beyond the clinic. Many respondents in the present study seem either to have had no experience of this type of support, or have found it to be unsuccessful.

The second RCSLT outcome not achieved was the development of attention and listening skills to enhance communication. An apparent explanation is that these general communication skills had simply not been part of the respondents' therapy. As presented in Table 2, however, a very high percentage (90.2%) of the sample indicated that communication skills, including listening skills, had indeed been part of their previous therapy. It is not clear why a considerable proportion of respondents indicated that this outcome had not been achieved, but it is worth noting that sub groups of people who stammer with concomitant problems may benefit from enhanced communication skills.

Guitar and Peters (2003) offer the examples of the stammerer who overcame his fears of speaking only to find he did not know what to say, and another who gained fluency but annoyed his listeners by dominating conversations. These authors argue that stammering therapists could do more to address such deficits in communication skills when they arise.

Future Therapy Preferences

Of 55 respondents, 40% indicated that they would undertake SLT in the future, 14.5% indicated that they would not, 20% were unsure, and 25.5% reported that they were presently attending SLT. A discriminant analysis was used to assess whether level of severity and/or level of experience would predict the likelihood of undertaking therapy in the future. Thirty cases were analysed. The discriminant function revealed no significant association between the two groups and the predictors (χ^2= 0.988, df = 2, $p > 0.05$).

Respondents were asked about aspects relating to the content of individual and group stammering therapy, rating each of these as 'very important', 'important', 'slightly important' or 'not important'. For summary purposes, 'very important' and 'important' responses were combined and aspects of therapy were ranked according to reported importance, as in Table 6. Respondents agreed closely on the overall outcomes of individual and group therapy that are most important to them. Ratings were closely comparable across the two types of therapy suggesting that respondents may have anticipated or desired similar benefits from individual and group therapy.

Table 6 about here please

Respondents were asked to rate the importance of structural aspects of individual and group therapy relating to planning, goals and practice. Again, for descriptive purposes, 'very important' and 'important' responses were combined. The percentage of respondents rating the importance of each statement is shown in Table 7.

Table 7 about here please

Individual therapy

The UK professional standards for SLTs state that therapeutic goals should be specific to the needs of individuals and formulated in conjunction with clients (RCSLT, 2006). Respondents here agreed largely with this in that they favoured joint goal setting between therapist and client over therapy that is planned solely by the therapist. A similar viewpoint has been expressed by AWS reflecting retrospectively on the clinician characteristics which promoted change (Plexico et al., 2010). A more collaborative way of working is advocated by many in the wider clinical and rehabilitation community and has been distinguished as 'doing something *with*' clients as opposed to 'doing something *to*' them (Geller & Foley, 2009, p 6).

A considerable percentage of respondents also ranked highly the need for individual therapy to make use of weekly practice tasks and for sessions to have set plans. It seems then that there is a strong appetite for structured activities both within and outside of the stammering clinic.

Group therapy

A preference for collaboration in individual therapy was reinforced by the preference for a common goal for group therapy. Weekly practice tasks were less popular within groups than for individual therapy and may hint at differences in function for the two therapy formats. The personalised nature of individual therapy may mean participants are more focused on specific outcomes that require regular attention between sessions whilst meeting other AWS in group therapy may be beneficial as a discrete experience in itself, without the need for identified practice tasks. As shown in Table 6, however, such specific practice was still rated as important in group therapy by around two-thirds of respondents.

Individual vs. group therapy

When asked to indicate their preference for type of therapy, 18.5% chose individual therapy, 25.9% chose group therapy, 11.1% were not sure, and 44.4% chose both types. It may be that greater benefits were expected from combined therapy compared with either individual or group therapy alone. Based on his decades of clinical experience and experimentation, Van Riper (1973) advocated as a minimum requirement for most adult stammerers 'one hour of individual therapy and one hour of group therapy three days a week and as much daily self-therapy as we can get for a period of three to four months' (p205). Other SLTs have noted the advantages of a combined individual and group approach from the clinician's perspective. For example, Conture (2001) notes that, among other things, group attendance allows the therapist to monitor the progress of clients concurrently engaged in individual therapy.

Ideal service

Respondents were asked what three things would be part of their ideal SLT service. A total of 147 responses were made and were frequently framed in terms of 'have more…', suggesting that participants had identified gaps in provision rather than confirming that ideal practice currently exists, and some comments regarding an ideal future service certainly related to aspects of unhelpful previous therapy identified earlier in the survey. Of the responses, 51% related to therapy and therapist issues and 45.6% to service delivery issues. Five responses we uncodeable and so were discarded. The themes which emerged are shown in Table 8.

Table 8 about here please

Therapy and therapist

Participants' ideal SLT service facilitates successful management of stammering which is characterised by '*a variety of ways to control a stammer*', '*controlling emotions*' and '*addressing underlying issues*' and support to '*build-up confidence and self-esteem*', as previously reported (Stewart & Richardson, 2004). Criticism has previously been levelled at the false environment of the clinic room (Yaruss et al., 2002b) and participants here reinforced the need for functional therapy that takes account of '*real-life scenarios'* and '*pushes out comfort zones*'.

Although participants reported early in the survey that they had experienced long-term gains from SLT in managing their stammering, follow-up support was a dominant feature of an ideal SLT service, as previously identified (Hayhow et al., 2002; Stewart & Richardson, 2004). Participants suggested this support could be achieved through telephone lists, e-mail

contact and refresher courses. It is not known if the focus on follow-up support suggests some respondents have experienced premature or inappropriate discharge from services (Davidson Thompson, McAllister, Adams & Horton, 2009), but clinicians should perhaps be placing heavier emphasis on maintenance of skills from an early stage in treatment.

It is disappointing that some respondents are still requesting more '*tailor made help*' given that unsuitable therapy for the individual was a complaint over a decade ago (Hayhow et al., 2002) and professional guidelines state clearly that therapy planning should be collaborative (Taylor-Goh, 2005). Clinicians '*listening to my needs, and taking on board my opinions rather than doggedly persuing (sic) teaching me a technique I will never use*' would be following Government priorities of person-centred care (NHS Commissioning Board, 2012; NHS Wales, 2010; The Scottish Government, 2010) and would likely be more effective and efficient in achieving success, thereby facilitating positive client perceptions of therapeutic quality (DiLollo, 2010).

Although not the most frequently occurring theme, a positive therapeutic relationship remains important for AWS. Being '*friendly*', '*knowledgeable*', '*non-patronising*' and a '*specialist*' serve as a reminder that clinician characteristics can be a crucial influence on client perceptions of stammering therapy outcomes (Plexico et al., 2010).

Service delivery issues

The most pressing aspect of service delivery related to its timing. Appointments outside of usual working hours, extended sessions of 90 minutes and more frequent therapy contact would facilitate perceptions of improved accessibility. Increased flexibility was also favoured

in relation to the therapy approach followed, the option to attend either individual or group therapy, and the choice of available therapists. One participant wanted '*more money so my therapist can offer more groups and appointments*' and this desire for greater financial investment in services is likely to resonate with clinicians working under budget restrictions and cuts. The interest in '*meeting / learning from other stammerers*' (Crichton-Smith, 2002; Stewart & Richardson, 2004; Yaruss et al., 2002a) continues to be evident suggesting this is still not a routine aspect of SLT services. This may reflect challenges in achieving sufficient numbers of clients in anywhere other than well populated areas to run group therapy (Hayhow et al., 2002).

Setting, Time and Electronic Delivery

Of 56 respondents, the most popular therapy setting was a support group (71.4%), followed by health centre (48.2%), SLT clinic in a hospital (46.4%), real life setting (e.g. restaurant, shop) (44.6%), local community centre (33.9%), and least favoured was at home (19.6%).

The preference for therapy within support groups may be reflective of at least part of the participant sample being accessed via the British Stammering Association's website, with a high possibility of participant involvement in self-help and support groups. Attendance at support groups and self-help conferences offer opportunities for AWS to socialise, develop a sense of identity within a specific community and develop or strengthen a new individual identity (Boyle, 2013; Trichon & Tetnowksi, 2011). Group therapy also has the potential to offer such opportunities and it is unclear from our data how participants have differentiated between group therapy and support groups. University or private therapy was most

preferable for Yaruss et al.'s (2002a) participants, but differences in healthcare systems on either side of the Atlantic leave it difficult to compare the preferred options.

Four timetable / programme options for individual and group therapy were presented and respondents were asked to choose which one would be most preferable. Of these 8.9% (individual) and 13.5% (group) opted for 'short intensive' programmes (multiple sessions per week over a short period); 12.5% (individual) and 11.5% (group) opted for 'short non-intensive' programmes (one session per week over a short period); 25% (individual) and 32.7% (group) opted for 'extended non-intensive' programmes (one session per week over a longer duration). The strongest preference was for a combination of the previous options (53.6% individual, 48.1% group). This particular finding is consistent with Yaruss et al.'s (2002a) survey of members of the National Stuttering Association. Again, presumably, respondents believed that a combination of intensive and extended programmes would offer the optimal therapeutic outcome. The extended format acknowledges the long-term nature of behavioural change but conflicts with health service pressures to neatly define episodes of care, which has limited the amount of treatment provided for some AWS (Davidson Thompson et al., 2009; Hayhow et al., 2002).

Fifty eight respondents also selected the time at which they would prefer to attend for stammering therapy. In order of preference, respondents opted for during the early evening (5-7pm) (82.1%), during the later evening (7-10pm) (46.5%), during the working day (9-5pm) (44.7%), and weekends (Sat-Sun) (29.6%). The preferred time of therapy in the early evenings could mediate the need for time off work and allow clients to avoid open

acknowledgement of stammering which can be challenging. Later evening and weekend sessions may have been considered more disruptive to clients' free time.

Respondents were asked how interested they would be in SLT delivered by electronic means including e-mail, Skype and videoconferencing. Incorporating technology within adult stammering therapy is in its relative infancy but has potential benefits (Allen, 2011; Packman & Meredith, 2011) and early efficacy research suggests remote support via e-mail may well be more efficient than face-to-face support (Carey et al., 2010).

Of 55 individuals responding to this question, 56.4% expressed an interest in using e-mail to communicate with their therapist. The remainder was either not interested or unsure, and 14.5% reported that they were already using e-mail in therapy. A multidimensional chi-square test showed there was no relationship between the geographical location of respondents (urban vs. rural) and their interest in e-mail in therapy, $\chi^2(1,n=43)=0.405,p=.525$. Around half of respondents (49.1%) were interested in videoconferencing. Only 1 respondent was already using videoconferencing. No relationship was found between geographical location and interest in videoconferencing, $\chi^2(1,n=47)=0.016,p=.898$. Finally, around half (47.3%) were interested in the use of Skype. No participants were currently using Skype to communicate with their therapist. Again, no association was revealed between geographical location and interest in the use of Skype in stammering therapy, $\chi^2(1,n=46)=0.063,p=.802$.

Although remotely and electronically delivered healthcare was originally developed with rural service users in mind (Mashima & Doarn, 2008), an interest in this by both urban and

rural respondents suggest that clients do not have to live far from health services for engagement with SLT to be more convenient by remote delivery methods (Allen, 2011).

Adding visual and real-time dimensions to remote communication, videoconferencing and Skype may be more comparable to face-to-face interactions, with the added convenience of reduced travel to the clinic. However, camera positioning means direct eye contact is not possible and if developing eye contact is a key focus of therapy, the effectiveness of Skype and videoconferencing to deliver therapy may be compromised. Broad popularity here of incorporating technology in to stammering therapy is a prompt for clinicians to consider this novel means of service delivery, given the increasing role of technology in modern life (Packman & Meredith, 2011).

Relevance for the wider rehabilitation team

Depending on sample size obtained, nationwide research may vary in its generalisability, but nevertheless has value in framing conversations between local services and their patients. We are hopeful that individual SLT services will utilise our findings to design services with local needs in mind and would encourage our allied health colleagues to consider adopting a similar 'top-down' approach. Although this research has been carried out with a dysfluent participant sample, the desire for flexible services, extended therapy hours, use of technology and the need for functional, personalised therapy may also have relevance for other allied health services.

Limitations

It is acknowledged the modest sample size means that the findings need to be interpreted carefully and cannot be generalised with certainty to the broader community of AWS in the UK. Because the survey was conducted anonymously, it was not possible to determine the response rate as a function of BSA membership or AWS attending therapy. It could be argued that using the BSA website and SLTs to recruit participants influenced the sample size and responses. However, the study intentionally sought AWS who had accessed support, whether through self-help or therapy routes, and who were therefore well suited to addressing the questions presented in the survey. That the majority of respondents had had two or more experiences of SLT further confirms their suitability in this user-involvement study.

A second limitation relates to how the term 'speech and language therapy' was construed. Although it was made clear to respondents that the survey was designed to obtain views about 'speech and language therapy services for adults who stammer', it was evident that a small number of responses actually related to non-SLT stammering therapy experiences. Future studies assessing client views on SLT services specifically, should define more explicitly the term 'speech and language therapy'.

Conclusions

This study presents a generally positive picture of SLT services for AWS in the UK as perceived by service users. SLT support is generally reported to have adopted a comprehensive view of stammering and addressed both the speech and non-speech aspects. For the majority of respondents in this study, previous therapy has facilitated long-term management of stammering as advocated in professional guidelines, although more

consistent follow-up support is clearly still desired. Variable SLT services exist for AWS across the UK and a 'postcode lottery' still seems to exist, particularly regarding the provision of group therapy. Greater flexibility in service provision is favoured; a wider choice of session times, therapists, therapy formats and an increased use of technology to deliver therapy would go some way to furthering person-centred design of SLT services.

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Table 1. Demographic characteristics of the sample (n=74)

Characteristics	**%**
Age	
18-24	9.3
25-35	40
36-50	5.3
51-64	21.3
65+	4
Gender	
Male	72
Female	28
Education Level	
Secondary school	20
College	28
University	48
Vocational training	4
Location of Residence	
Urban (city centre)	40
Suburban (city outskirts)	41.3
Rural (countryside)	18.7

Table 2. Types of therapies received as an adult (n=53)

Type of therapy	**%**
General communication skills e.g. developing eye contact, listening skills	90.2
Slowing speech rate	84
Managing feelings associated with stammer	82
Reducing avoidance of situations, words etc.	80.4
Voluntary stammering	80
Block modification e.g. pre-block, in-block, post-block	76.6
Breathing exercises	76
Relaxation	74.5
Soft contact, easing physical struggle	74
Other	26.4

Table 3. What adults who stammer found helpful about therapy (n=49)

Themes	No. of coded responses	% of total responses
Process		45.8
Meeting other people who stammer	11	
Exploring one's own stammering	7	
Talking about non-speech issues related to stammering	5	
Learning about stammering	5	
Support	3	
Talking to someone about stammering	3	
Being listened to without being judged	2	
Interaction with SLT	2	
Outcome		27.7
A more positive attitude	11	
Acceptance of stammering	7	
Successful management of stammering	5	
Types of therapies and specific techniques		26.5
Avoidance reduction / desensitisation	11	
Block modification	3	
Group therapy	3	
Private stammering therapy course	3	
Breathing exercises	2	
Total number of coded responses	83	

Table 4. What adults who stammer found unhelpful about therapy (n=45)

Themes	No. of coded responses	% of total responses
Process		47.6
Service delivery issues	10	
Negative SLT characteristics	7	
Negative impact of other people who stammer	3	
Outcome		31
Lack of transfer of techniques to outside world	7	
Lack of lasting effect	6	
Types of therapies and specific techniques		21.4
Slow speech	4	
National Health Service (NHS) speech therapy	3	
Relaxation	2	
Total number of coded responses	42	

Table 5. Percentage agreement with RCSLT good service outcome statements (n=47-49)

Statement of outcome	Yes, in the short term	Yes, in the long term	No	Chi-square goodness of fit
It helped me to develop strategies to reduce the amount of stammering	27.1	52.1	20.8	$\chi^2(2,N=48)=7.88$*
It helped me to develop strategies to reduce the severity of my stammer	27.1	47.9	25.0	$\chi^2(2,N=48)=4.63$, n.s.
It helped my friends/family/partner to support my communication more effectively	19.1	25.5	55.3	$\chi^2(2,N=47)=10.51$**
It helped me to understand my stammering behaviour	10.2	77.6	12.2	$\chi^2(2,N=49)=43.14$***
It helped me to make changes to my stammer e.g. reduction in avoidance of words, situation, people	19.1	59.6	21.3	$\chi^2(2,N=47)=14.60$**
It helped me to deal with my negative feelings and attitudes towards speaking	14.3	65.3	20.4	$\chi^2(2,N=49)=22.82$***
It helped me to become more assertive	14.6	54.2	31.3	$\chi^2(2,N=48)=11.38$**
It helped me to maintain the skills I learnt in the clinic	35.4	31.3	33.3	$\chi^2(2,N=48)=0.13$, n.s.
It helped me to develop my attention and listening skills to enhance communication skills	10.4	43.8	45.8	$\chi^2(2,N=48)=11.38$**
It helped me to maximise my potential to communicate more effectively	24.5	53.1	22.4	$\chi^2(2,N=49)=8.61$*
It helped me to develop strategies to reduce the number of dysfluencies experienced	34.7	42.9	22.4	$\chi^2(2,N=49)=3.10$, n.s.

* $p<0.05$, ** $p<0.01$, *** $p<0.001$

Table 6. Importance ratings for content of individual (n=58) and group (n=51) therapy

Therapy content	Individual (%)	Group (%)
Learning how to manage your stammer more effectively	98.3	98.1
Increasing confidence	98.2	98
Group discussions	-	94.2
Meeting other people who stammer	-	92.2
Managing my negative reactions to my stammering	96.5	92.1
Being taught by the therapist	93.1	82.4
Sharing your experiences with another person	89.7	96.1
Practising therapy techniques	89.5	80.4
Increasing assertiveness	85.7	86.3
Working towards specific communication goals	80	68.6
Managing other people's negative reactions to my stammering	72.4	64
Other	12.1	11.8

Table 7. Importance ratings for organisation of individual (n=57) and group (n=52) therapy

Individual therapy structure	**Individual (%)**	**Group (%)**
Joint goal setting between therapist and client	89.5	-
Common goals amongst member	-	73
Weekly practice tasks	71.4	59.6
Set plan for each session	59.6	63.5
Planned by the therapist	53.5	61.6
No set plan for each session	33.3	31.4

Table 8. Aspects of ideal adult stammering service (n=59)

Themes	No. of coded responses	Themes	No. of coded responses
Therapy and therapist		**Service delivery issues**	
Successful management of stammering	21	Timing geared to individual needs	17
Maintenance	16	Group therapy	13
Therapy geared to individual needs	10	Choice/flexibility	12
Clinician characteristics	9	Where therapy is provided	8
Therapy approaches	8	Miscellaneous	8
Knowledge / information	7	Individual therapy	5
Therapy outside the clinic	4	Involvement of family / friends / others	4
Total number of coded responses	75	Total number of coded responses	67