

**INTERPERSONAL PSYCHOTHERAPY
WITH A PERSON WHO STUTTERS**

by

JACQUES LORRAINE LABUSCHAGNE

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STUDY LEADER: PROF. D. BEYERS
CO-STUDY LEADER: MS. U. L. ZSILAVECZ

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Summary

Stuttering is a problem that touches the lives of many people. The goal of this research is to come to a better understanding of a complex process of psychotherapy with a person who stutters. This is a qualitative study: sixteen sessions of interpersonal psychotherapy were conducted over a period of six months with a twenty-year-old male who was diagnosed with a severe stutter. Process notes were analysed based on the principle of self-reflexivity, which entails personally and systematically examining the reciprocal influences in a process.

This study provides traditional conceptualisations of stuttering and comes to the conclusion that stuttering is a multifaceted phenomenon that may require a complexity of interventions. It is suggested that stuttering can be approached from an interpersonal perspective. This means that stuttering is a less effective means of dealing with other probable interpersonal problems. It is also a problem that is maintained by less effective attempts at alleviating it and by a limited scope of interactional manoeuvres.

Stuttering can be addressed through interpersonal psychotherapy. The study suggests that the therapeutic approach should consider warmth, empathy, congruence, patience, therapeutic decision-making and timing. It is important to note that each client should be treated uniquely and valued as a person.

Self-reflexivity is proposed as an effective way of facilitating the psychotherapeutic process, the scientific basis of this process and the development of the therapist.

Key words: creative intervention; interactional; interpersonal; process notes; psychotherapy; self-reflexivity; speech pathology; strategic; stutter; systemic.

Opsomming

Hakkel is 'n probleem wat die lewens van baie mense raak. Die doel van hierdie navorsing is om 'n beter begrip van 'n komplekse proses van psigoterapie met 'n persoon wat hakkel te bekom. Dit is 'n kwalitatiewe studie: sestien sessies van interpersoonlike psigoterapie is oor 'n tydperk van ses maande uitgevoer met 'n twintig-jarige man wat gediagnoseer is met 'n ernstige hakkelprobleem. Prosesnota's is geanaliseer aan die hand van self-refleksiwiteit, wat die persoonlike en sistematiese ondersoek van die wederkerige invloede in 'n proses behels.

Hierdie studie beskryf tradisionele konseptualiserings van hakkel en kom tot die slotsom dat hakkel bestaan uit verskeie fasette wat aangespreek kan word deur veelvuldige intervensies. Die voorstel word gemaak dat hakkel vanuit 'n interpersoonlike perspektief benader kan word. Hakkel blyk 'n minder effektiewe oplossing te wees vir ander waarskynlike interpersoonlike probleme. Dit is ook 'n probleem wat in stand gehou word deur minder effektiewe pogings om dit te verander en deur 'n beperkte repertoire van interaksionele maneuvres.

Hakkel kan aangespreek word deur interpersoonlike psigoterapie. Die studie stel voor dat die terapeutiese benadering warmte, empatie, kongruensie, geduld, terapeutiese besluitneming en tydsberekening moet oorweeg. Dit is belangrik om daarop te let dat die uniekheid van elke kliënt voorop gestel word. Dit beteken dat die kliënt as 'n persoon geag word.

Self-refleksiwiteit word voorgehou as 'n effektiewe manier om die psigoterapeutiese proses, die wetenskaplike grondslag daarvan en die ontwikkeling van die terapeut te bevorder.

Sleutelwoorde: hakkel; interaksioneel; interpersoonlik; kreatiewe intervensie; prosesnota's; psigoterapie; self-refleksiwiteit; sistemies; spraakpatologie; strategies.

Chapter 1 Introduction

1.1 Introduction

It is generally accepted that human beings are social creatures. Therefore, the ability to communicate can be seen as central to the human experience, as it facilitates participation in this social milieu. Limitations in this ability can consequently be seen as obstructing successful participation in the human world.

Stuttering is presented as one such obstruction by virtue of its membership to the category of communication problems. It has been suggested that up to five percent of members of the general population stutters at any given point in time (Van Riper & Emerick, 1994). Stuttering becomes a relevant matter through the assertion that stuttering can affect the lives of a large sector of the human race. In addition, as will become clear in the study, the person who stutters seemingly carries this behaviour into the majority of areas of his life. Therefore all life spheres are in one way or another potentially affected by stuttering. Furthermore, it is suggested in the literature review that people in general are much less tolerant of difficulties in speech and language behaviour than in any other behaviour. These difficulties include stuttering. The significant impact of stuttering is considered the *raison d'être* of the study in its examination of alleviating stuttering.

The assertions regarding the impact of stuttering relate directly to the researcher's experience in a specific case of psychotherapy. This case is the focal point of the study: a twenty-year-old male diagnosed with a severe stutter was referred for psychotherapy by a practice specialising in speech therapy. This referral related to the client stuttering more severely within a specific relationship and as a consequence placed the stuttering within an interpersonal context. The ensuing sixteen sessions of interpersonal psychotherapy are examined.

During the process of psychotherapy, the therapist created process notes on each session. The method used in the study comprises an in-depth analysis of each individual set of process notes through the identification of themes and through self-reflexivity. The main goal of the study is, on a meta-level, to come to a better understanding of this complex therapeutic framework. Thus it is hoped that, through the use of reflection and self-reflexivity, a conclusion that is the theoretical rationale for the handling of speech problems will be achieved.

In as much as it linked to form part of a more encompassing therapeutic process, the study acknowledges the work of the relevant speech therapy practice in the outcome of the case. Herein, the practice focused on modifying the client's stuttering moments and on enhancing his fluency. These endeavours will be discussed as part of the methodology of the study. However, the focus of the study remains the psychotherapeutic relationship between the client and the psychotherapist.

1.2 A chapter-by-chapter overview

The subject under investigation is briefly introduced in Chapter 1. In working towards the achievement of the goals of the study, the underlying epistemological assumptions of the study will be examined in Chapter 2. An overview of self-reflexivity, as the personal and systematic investigation of reciprocal inputs in a process, is provided. In accordance with this principle, the theories considered salient to the case study are presented. This takes the form of a discussion on interpersonal therapy, which is considered to consist of strategic and interactional/systemic therapy for the purposes of the study.

In Chapter 3 the focus is a theoretical discussion of the phenomenon of stuttering. Stuttering is defined as a multifaceted phenomenon. Preference for the term "person who stutters" is explained and different manifestations of stuttering are described. The psychological, interpersonal and positive facets of stuttering are examined before attempts at alleviating this phenomenon are

considered. In Chapter 4 the method and procedure of the research, based on self-reflexivity, is explained.

Chapter 5 is a presentation of the results of the study. These results are based on the pre-planning, contents, themes, self-reflection and continued post-planning related to each session. In Chapter 6 these results are discussed and associations with relevant theory are pointed out. Conclusions, i.e., implications of the results for the theoretical and practical conceptualisations of stuttering and stuttering-related therapy, are considered. Finally, critique and recommendations for future research are provided.

1.3 The preference for specific terms

The use of certain terms and groups of terms in the study warrant justification. It has been stated that the focus of the study is on a psychotherapeutic process. Accordingly, the terms *therapy* and *therapist* are used to refer to *psychotherapy* and *psychotherapist*, unless stated otherwise.

Masculine pronouns (e.g., he, him and his) are used predominantly in the study, as both the client and the therapist were male. Concurrently, as the speech client's speech therapist at the time was female, female pronouns (e.g., she and her) are used to refer to speech therapists. The intention is to facilitate readability and this practice should not be taken as an indication of gender bias.

First-person personal pronouns (e.g., I, me, and my) are used to give emphasis to instances of self-reflexivity. To further emphasise this process, the relevant self-reflections will be printed in Italics, except in Chapter 5. This exception is made to facilitate readability, as the chapter as a whole is self-reflexive. In addition, in Chapter 6 these procedures are suspended completely in favour of a more scientific style of writing.

1.4 Conclusion

In this chapter, the study has been presented as a self-reflexive examination of a specific process of therapy involving a person who stutters. It has been suggested that the study aspires to an increased understanding of this process in order to promote the theoretical and practical conceptualisation of stuttering and stuttering-related therapy. The use of certain terms and groups of terms has been explained. A chapter-by-chapter review of the study has also been provided. In accordance with this discussion, the next chapter focuses on contextualising the study within an epistemological framework.

Chapter 2 Epistemology

2.1 Introduction

Keeney (1983), in his discussion on the development of process, points the reader to the importance of both the observer and the observed in the creation of what is being observed. He emphasises the effect of the observer's descriptions on what is being observed. The essence of this discussion appears to be that the distinctions the observer makes (i.e., what aspects he focuses on and what aspects he ignores) influence what he is observing and, therefore, is drawing distinctions about. Keeney states that it is important to be aware of the effects of drawing distinctions on one's experiences. However, he also claims that it is impossible for an observer not to draw distinctions, as distinctions are the basis for observation. Thus, while it is impossible for an observer not to make distinctions, it seems that the observer should be aware of the distinctions that are drawn and the effects that they have.

In the current study I set out with one basic distinction: that the study is a self-reflexive work. The reason for this is that I am examining a process of which I am a part. My conceptualisation of the current discussion on the epistemology of the study (and I suppose of the study in its entirety), then also revolves around the distinctions I have drawn as observer and observed. This having been said, the focus now turns to self-reflexivity as epistemology. The discussion then considers relevant therapeutic models.

2.2 Self-reflexivity

Self-reflexivity has traditionally been defined as the process of referring back to the subject (The Concise Oxford Dictionary Of Current English, 1995, p. 1154). Literature on psychotherapy suggests that self-reflexivity can be conceptualised as the systematic examination of the subject's influence. Stated differently, self-reflexivity is a process of self-scrutiny into how someone's inputs affect a

situation. An example of such a conceptualisation can be found in the work of Cecchin, Lane and Ray (1993). These authors emphasise the development of what they call irreverence in therapy. This term refers to an attitude of expedience (as in “use it only as long as it is useful”) relating to any beliefs, theory, thought or action, which is proposed to be an antidote to rigidity and over-reliance on specific assumptions (Cecchin, Lane & Ray, 1994). The central principle informing this attitude is that a reciprocal influence seems to exist between a therapist and a client, and that the therapist needs to be aware of what is brought into therapy as a (potential) influence on the client. It is put forward that the effects on the client cannot be completely predicted and that they are not solely related to the intentions of the therapist. Indeed, these authors propose that the specific effect a therapist has on a client is very often unrelated to the intended influence. The actual effects of what is brought into therapy therefore seem to be of more significance than the therapist’s intent. It is proposed that realising and examining the influences that a therapist has on a client may lead to an understanding thereof. In turn, this may allow the therapist to adapt these influences to be more in line with his intentions and to be more effective.

The instruments of influence between a therapist and a client seem to be anything with communicative value and could include prejudices, beliefs, actions and words (Checcin, Lane & Ray, 1993). McNab and Kavner (2001), in their examination of their own therapeutic work with mothers, point out the potentially harmful influence of a therapist’s prejudices. By being self-reflexive, they attempt to eradicate in their own work the harm inflicted by blaming practices. This process, though not thought of as a magical fix for possible negative influences, seems to provide McNab and Kavner with a better understanding of the therapeutic process and relationship. At the same time it appears as if this awareness allows these authors the possibility of adapting their influence in order to be beneficial. As they relate these ideas directly to their work as therapists,

self-reflexivity is seen as an important tool and attitude for the effective therapist. In their view, Cecchin, Lane and Ray (1994, p. 20) feel that:

“[W]e can imagine an ideal therapist as someone who, through years of experience, has developed a strong personal style with clear beliefs (prejudices) about what works, and what does not work. Simultaneously, this ideal therapist is willing to examine the effects that his or her strong beliefs have on clients. That is, he or she is willing to examine what kind of system is created when the strong prejudices of the therapist meet the strong prejudices of the client.”

Steinfeld (1994) concurs with these ideas and feels they echo many other ideas on being detached from any position, theory, practice or model, and the importance and superior position of cognitive flexibility. This too is the conjecture of Reimers (2000), who puts forth a very passionate argument in favour of increased self-awareness in second-order (or cybernetic or more systemic) views and practices. This increased self-awareness, he feels, should be coupled with a larger flexibility in epistemology and practice. He suggests that, if this approach does not become more self-reflexive, it may collapse under its own rigidity.

The concept of being self-reflexive in therapeutic work has entered the area of therapy with stuttering as well. This can be seen in Gregory's (1984) contention that therapists in this field should each cultivate a more comprehensive and realistic self-understanding. What seems to be proposed in Gregory's ideas, is that the therapist should actively and continuously work at not only becoming aware of the impact of certain behaviours on himself, but also of what he brings into therapy. For him, a more realistic understanding of the therapist himself should help the therapist to have a more realistic understanding of the client and to provide more effective help.

Beyers (1981) approaches these ideas from another vantage point. It is his contention that each therapist needs to be ambivalent towards his own work. The ambivalence pertains to an oscillation between the role of being a practicing therapist and the role of being a scientific researcher. Although the role of therapist is for all practical purposes the main focus of the therapist's work, as

scientist (researcher) the therapist needs to be aware that he operates from a set of hypotheses and that these need to be scrutinised continuously. The important point to be emphasised here is that a therapist as scientist needs to adapt his hypotheses when the need arises for a better fit with what is happening.

These ideas seem to echo the importance of self-reflexivity. Therapists as scientists should be constantly aware of their own hypotheses and assumptions, should be flexible in their adherence to and use of these ideas and their associated practices, and should be aware of the effects of all of these factors upon themselves and their work. Taken with the work of Cecchin, Ray and Lane (1994) it seems plausible that the reciprocal effects that all the members of the therapeutic relationship have on each other warrant scrutiny.

2.2.1 Self-reflexivity as a tool for research

Pratto (2002) examines the assumptions of qualitative and quantitative research. He concurs with the foregoing presupposition that self-reflexivity is a valuable tool. The conclusion is made that self-reflexivity in research is possible and desirable, especially when applied to how our own political and historical context influences our work. Punch (1994) feels that “where you stand will doubtless help to determine not only what you will research but how you will research it” (p. 94). If this argument is followed to its logical conclusion, then the researcher’s position will undoubtedly influence the outcome of the research. Keeney (1983), as cited at the beginning of this chapter, points to the reciprocal nature of all relationships. Taken together with the assertions of Pratto and Punch (as stated above), it would seem plausible to view the relationship between the researcher and his research as reciprocal. Thus we can say that the researcher and the research influence and shape each other mutually.

What transpires from this discussion relates to the overlap between the use of self-reflexivity as a tool for research and the use thereof for therapy. In relation to this overlap Rowling (1999), who is a researcher in the field of death and

bereavement, makes the following assertion. As research in this field is, by its very nature, also seen to be an intervention this author contends that it is vital that the beliefs, experiences and skills that the researcher inevitably carries into the research/intervention are made explicit. This set of explicit inputs is viewed as a resource in the gathering and interpreting of data. Reflexivity is put forward as a means to achieve this understanding.

In accordance with the foregoing discussion, the study is an attempt to push the practice of self-reflexivity in therapy and in research through to a more advanced stage. This will be elaborated on in the chapter on methodology. As the reflexive nature of the study has been established, attention is directed towards the therapist's main theoretical influences at the time of undertaking the study.

2.3 Strategic therapy

During my training as a Clinical Psychologist, one of the approaches to psychotherapy to which I was introduced was strategic therapy. It attracted my attention because of the short-term nature thereof, which I felt suited the relative brevity of therapeutic contact allowed within the practical component of the course. This aspect of the strategic approach has, in part, been ascribed to its interpersonal nature that seems to preclude the traditionally long-term work associated with more intrapsychic models (Haley, 1963; Nardone & Watzlawick, 1993; Quick, 1996; Segal, 1991). Therefore most of the psychotherapeutic work that I undertook during this period I deliberately fashioned on my understanding of the strategic approach to psychotherapy. As the therapeutic process with which the case study for the research project is concerned was undertaken during this period, an overview of strategic therapy is provided.

2.3.1 The origins of strategic therapy

Segal (1991), in an overview of the strategic approach to psychotherapy, points to the interpersonal nature thereof. Subsequently the author states that this model has its roots in the work of Gregory Bateson, who is seen to have

introduced the ideas of communication theory and the concepts of systems theory into the arena of psychotherapy. Watzlawick (1990), one of the main theorists behind strategic therapy, points to the important association of Don D. Jackson with Bateson's research group. This partnership resulted in the establishment of the Mental Research Institute (MRI) as a department of the Palo Alto Medical Research Foundation, which eventually became an independent entity. Guttman (1991) emphasises the work of the MRI as well as that of several other role players, including Fisch, Nardone, Watzlawick and Weakland, as of major importance in the development of the school of strategic therapy. The MRI also acknowledges the importance of the work of Milton Erickson in the establishment of this model (Watzlawick, 1990).

2.3.2 Basic assumptions of strategic therapy

The current study does not intend to provide an all-inclusive examination of the work done within the field of strategic therapy. Instead, the intention is the delineation of major principles underlying the strategic approach.

2.3.2.1 A constructivist epistemology

Segal (1991) points out that strategic therapy assumes a constructivist position on reality. For Quick (1996) this means that there are multiple views of reality. This is in opposition to the opinion that there exists an ultimate view of reality. Constructivism posits that reality can in fact not be known. Instead, it is suggested that only perceptions of reality can be known. It is even possible that these perceptions are the only things that exist. What seems to be important for the constructivist, is that there should be a fit between the more objective facts (or that which is more certain) and the subjective view of reality (Guttman, 1991). To illustrate this idea, Guttman provides the analogy of different views of reality as different keys that fit the lock of more objective facts. Thus, certain views of reality will not fit the lock. Also, other keys may fit the facts more effectively than their counterparts. It is at this level that strategic therapy operates: the fit

between (what is seen to be) the facts and the views of the reality of which these facts are a part, is pertinent.

2.3.2.2 An interactional, interpersonal and systemic approach

When looking at how a problem is maintained, the strategic approach to therapy seems to give preference to social reinforcement, even when biological factors exist (Quick, 1996). Therefore this approach is most basically an interactional and interpersonal approach. The strategic model is in disagreement with the more traditional assumption that a problem is the result of a pathology that is seated within a person (Nardone & Watzlawick, 1993), as it views problems as existing between individuals (Watzlawick, 1990). Quick (1996) puts forward that strategic therapy focuses on current interactions. It is also possible to state this differently: strategic therapy views individuals and their problems as existing within a context (Segal, 1991). Accordingly strategic therapy accentuates current interactions in both its conceptualisation of and solving of problems. As such, this approach focuses on the interrelatedness of the individual parts of an interaction and sees this relationship to lead to more than just the sum of the separate parts. Therefore, because these assumptions are the basic tenets of systems theory (Tubbs & Moss, 1994), the systemic nature of the strategic model is evident.

Segal (1991) points out that the strategic approach to therapy assumes that certain aspects of a person's environment help to maintain the problem. Within this model, precedence is given to how a problem is maintained rather than to how it has come about (Nardone & Watzlawick, 1993). For Watzlawick (1990) this translates into asking *how* rather than to asking *why*, as in "how is the problem present" and not "why is the problem present". In contrast to the traditional assumption that insight into aetiology (i.e., the reasons for a problem coming about) will lead to a solution, this approach believes that understanding how a problem is maintained allows one to change this (Watzlawick, Weakland and Fisch, 1974). To elucidate this assumption: changing that which holds the

problem in place is seen to allow the problem to change. As this change is the goal of therapy, no additional information or understanding is deemed necessary.

As an interactional, interpersonal and systemic approach to problem-solving, strategic therapy assumes that an entire system can be changed through change in any member of the system (Quick, 1996). Readiness to change and influence over the system are both factors that need to be taken into account when deciding on a system member as the focal point of intervention. Before deciding on where to begin the therapeutic process it is important to understand how this model views the area that requires intervention. More succinctly: how does the strategic therapist think about problems?

2.3.2.3 Distinguishing between difficulties and problems

Watzlawick, Weakland and Fisch (1974) emphasise the strategic approach's distinction between difficulties and problems. Difficulties include accidents, death and conflict. As normal occurrences in the developmental course of all systems and individuals that necessitate changes in relationships and roles, difficulties are not of themselves problematic. Yet, they can become problematic. The suggested mechanism here rests on perspectives. In essence, when an individual or a system mistakenly sees an ordinary difficulty as "problematic", unwarranted corrective measures are attempted. The result is that a problem is created by an attempted solution. It is also suggested that a problem can be brought about by the denial of the existence of a difficulty. It seems that ineffective attempted solutions turn ordinary difficulties into maintained problems. This is because it is possible to say that a problem arises when unwarranted corrections are made or when necessary adjustments are not undertaken, and because a denial of a difficulty can also be conceptualised as an attempted solution. Strategic therapy focuses on allowing people to move past a developmental difficulty which has been defined as a problem so that they can face the next difficulty (Quick, 1996). The mechanism by which an attempted solution becomes a problem is the focus of the next section of this discussion.

2.3.2.4 The solution becomes the problem

Watzlawick, Weakland and Fisch (1974) agree that problems are mostly maintained by attempted solutions, because within a fixed system of attempted solutions, the possibility of other more effective solutions is excluded. Thus when a difficulty is perceived to be a problem, attempts are made to resolve it. Sometimes these attempts are successful and at other times they are not. When an ineffective (or less effective) solution is adhered to (a situation known as doing more of the same), new solutions that are more appropriate are not possible (Quick, 1996). In effect, indiscriminate use of only certain solutions is seen as problem maintaining.

The foregoing argument is one of the foundations of the strategic model's assertion: interrupting the cycle of attempted solutions (also known as the "problem-maintaining feedback loop") should decrease the problem behaviour (Quick, 1996). It is suggested that this can be done through what is initially a small change, as this should lead to a systematic decrease in the problem behaviour. Consequently this decrease in problem behaviour should reduce the use of the attempted (unsuccessful) solutions and in turn again decrease the problem behaviour. In this way a cycle is created that changes and solves the problem.

2.3.2.5 First- and second-order change

Another principle of strategic therapy is drawn from the following tenet of systems theory: changing the rules governing a system is a change that is more radical and enduring than a change involving the individual members of a system only. Keeney (1983), though not directly associated with strategic therapy, sheds some light on the ideas that Bateson and, later, the MRI, built upon. From a systems perspective, first-order change is seen as a change within or between members of a system while the system itself remains unchanged. This is a less permanent change, because members of a system push toward stability. Thus the members of a system adjust themselves in order to curtail changes within

other members and thus within the system. When looking at problems and problem perpetuating behaviour, a first-order change does not affect the behaviour that is keeping the problem in place.

Changing a system at a second-order level entails changing the rules of the system, and thus the way in which the members of the system are in relationship to each other. This seems to lead to more permanent and radical change in the system. In strategic therapy, according to Watzlawick, Weakland and Fisch (1974), the therapist intervenes at the appropriate level, i.e., first- or second-order. The authors propose that not intervening at the appropriate level will create, maintain or exacerbate a problem. However, the authors point out that, by the time a client comes for therapy, a second-order change is probably required. As has been discussed earlier, strategic therapy sees the indiscriminate use of any attempt at solving a problem as potentially inducing or maintaining the problem. Thus, if this approach's own logic is used, caution is still necessary as indiscriminate use of second-order change tactics will probably also lead to certain problems being maintained or created. Consequently, when considering problems, changing that which is keeping the problem in place (i.e., the attempted solution), is a second-order change.

The difference between first-order and second-order change can be elucidated through the use of an analogy. With reference to the preceding discussion, it is possible to compare the normal difficulties that individuals and systems experience to a physical wound: Sometimes just applying a first-order change is sufficient. In this case various first-order changes are possible, for example to dress the wound. If this change is brought about, but the wound is not just superficial and is in need of a different intervention, the continuously dressing the wound is not going to solve the problem. Instead of providing a resolution for the difficulty, the current solution constrains the finding of a more appropriate solution. A problem has now been created. More appropriate solutions in this case could take many forms, for example visiting a doctor or cleaning the wound.

The current solution is, however, adhered to for some reason or another. The model assumes that the reason for adhering to a less effective solution is usually social in nature (Quick, 1996). In the current example, it is possible that the person with the wound is getting previously unattainable attention from another person in the system. Changing the way in which the problem is addressed may as a consequence threaten this new-found attention. This scenario necessitates a second-order change that fits the situation and therefore will allow the maintenance of the relationship whilst also allowing a more appropriate resolution of the original difficulty. Accordingly, changing the current attempted solution at this point would necessitate a second-order change.

A significant corollary of this line of reasoning is that sometimes first-order change is necessary and sufficient. However, if we were to find that the problem is maintained or exacerbated, a change in tactic is called for. A difficulty arises when a change in tactic is prohibited by it serving some sort of function. In other words, if there are strong enough advantages to an attempted solution, a second-order change is required. Again caution is required. This is because, if the attempted solution is the intermittent changing of attempted solutions regardless of the efficiency of these solutions (whether or not they have had a chance to affect a real change) this becomes a first-order solution in need of a higher-order change.

2.3.2.6 The problem as focus of intervention

For the strategic therapist the focal point of therapy relates directly to the presenting complaint of the client (Segal, 1991). Strictly speaking, the MRI sees the problem that is to be addressed in therapy and that which the patient brings as the problem as one and the same thing. As the presenting complaint is directly linked to problem-maintaining behaviour aimed at resolving natural occurrences, like accidents, death and conflict, it is possible to view this behaviour as an inevitable and integral part of strategic therapy.

Within the premises of strategic therapy, the therapist is responsible for setting the goals of therapy. These goals relate to solving the problem and flow from whatever the therapist deems helpful within the specific situation (Segal, 1991). The therapist's endeavours to untangle the attempted solutions of the client will in all probability require a creative and even seemingly illogical solution. A link can be made here with Quick's (1996) assertion that common-sense solutions (in therapy as in other systems) often fail or even aggravate the problem. This observation is directly related to the foregoing discussion on attempted solutions becoming the problem, as it is assumed that it is often these common-sense responses to difficulties that create, exacerbate and maintain problems (Nardone & Watzlawick, 1993). The creative and illogical appearance of the therapist's interventions flows from the probable second-order nature of these interventions. This nature requires the therapist to step outside the first-order logic of already-attempted solutions. Stated differently: the intervention of the therapist will probably seem unorthodox from within the frame of the problem and solutions in which the client is stuck. Watzlawick (1990) refers to this frame from which the client seems incapable of escaping, as a vicious circle.

2.3.2.7 The therapist as active agent of change

From the preceding discussion, the central role that the strategic model ascribes to the therapist should be apparent. For Quick (1996) the therapist is seen to be an active agent of change. In the therapist's attempts at initiating change, it is essential that he understands exactly what the problem is and how it is maintained. This clarification of the problem is seen to be the first step in strategic therapy. Thereafter the therapist can consider what could interrupt the cycle maintaining the problem, and subsequently how best to put the change into operation.

The therapist's attempts at changing the problem-maintaining cycle are known as strategies; hence the term *strategic therapy* (Segal, 1991). One of the central guidelines of strategic therapy is the idea that strategic techniques should always

be utilised within a frame of flexibility, clinical decision-making and tailoring of therapy for the individual client (Quick, 1996). It is proposed that the most effective and relevant interventions are those that are constructed in a flexible manner for individual situations. Quick (p. xv) sees the work of the strategic therapist as follows:

“...[The strategic therapist] operates at two levels simultaneously. Working with the client, the therapist attempts to clarify the problem and to facilitate the client’s doing what works and changing what does not. At the same time, the therapist selects techniques tailored to each situation, shifting to something different in response to problems or obstacles as they arise. *Clarifying problems, doing what works, and changing what does not*: that is the recurring theme...” (italics in original text).

2.3.2.8 Working from the client’s position

Watzlawick, Weakland and Fisch (1974) speak of the client’s position to indicate that the strategic therapist works from certain aspects that are more significant in the client’s eyes as a means to gain maximum therapeutic efficiency. Therefore, these more salient aspects also need to be identified (Quick, 1996). They are seen to include the guiding principles in the client’s life and the specific way in which the client uses language. Here, again, the constructivist emphasis on a fit between solutions and more salient aspects can be seen. In a way, these “objective facts” (the client’s position) are conceptualised as the lock to which the therapist’s interventions need to provide a new, more effective key. This idea can be illustrated by referring to the analogy of the wound in the foregoing discussion: the new attention that the wound is providing for the person is part of this person’s position. The new solution needs to acknowledge and needs to fit this position.

2.3.3 Tools of strategic therapy

In the progression of the study, the necessity of considering certain tools (or techniques) of strategic therapy became evident. Explicitly put: as they relate to the case study, a few of these tools are considered briefly.

2.3.3.1 The reframe

According to Segal (1991) reframing involves giving the patient a new perspective from which to view his problem - we do not change the client's perception of reality but rather the meaning it has for him. In essence, to reframe means to change the value ascribed to something by putting the 'fact' into a different context of meaning - thus, by looking at it from a different angle. Reframing operates on the level of materiality - it involves changing the emphasis from one class membership of an object to another equally valid class (Watzlawick, Weakland & Fisch, 1974). This links with the constructivist worldview posited for strategic therapy, in that a reframe presents a different key to the same lock. As such Watzlawick, Weakland and Fisch (p. 95) state that:

“To reframe, means to change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the 'facts' of the same concrete situation equally well or better, and thereby changes its entire meaning.”

2.3.3.2 The “as if” principle

Nardone and Watzlawick (1993) define the “as if” principle as creating a situation in which the client behaves as *if* change has already been brought about. The assumption is that change will ensue. Watzlawick (1990) suggests that the source for this change is the changed behaviour leading to a change in experience and, in turn, to changes in perceptions and cognition.

2.3.3.3 “Go slowly”

According to Segal (1991) the “go slowly” technique can be used to slow down or speed up the client's progress, since the client's impatience may not allow time for interventions to take effect. The suggestion is that, if slowed down, the client is less inclined to be thrown by the ups and downs of changed behaviour. Essentially, the aim of the “go slowly” intervention is to prescribe stability to the client, or to discourage the client from changing in the desired direction. The basis for the intervention's efficacy seems to be its inherent implication that the therapist does not feel an urgent need to change the client. An example of the

“go slowly” intervention is pre-empting the rejection of an intervention to inhibit this rejection.

2.3.3.4 Metaphors

Nardone and Watzlawick (1993) suggest that the strategic therapist can make use of the evocative power in the poetic function of a metaphor. That is to say, they purport that the use of metaphors that fit in well with the client’s problematic situation can lead to a change in behaviour. In turn, it is suggested that such a change will affect a change in the client’s perceptions and cognition.

2.4 Interactional/systemic therapy: towards completing the incomplete

The assertion that Keeney (1983) makes of a constant interaction between the observer and the observed has already been discussed. In essence, Keeney states that there appears to be a mutual influence that changes both parties involved in any interaction. It could be said that there is a co-creation, or a mutual construction, of that which is taking place and of what is consequently being observed. *This idea also seems to hold true for the relationship between the current study and myself.*

In the feedback-loop that exists between the creation and observation of this chapter as an attempt to come to a comprehensive epistemological basis for the study and for the therapeutic work that forms the basis thereof, my observations (and thus I myself) have changed. In re-reading this chapter, I was struck by the incompleteness thereof when comparing it to my recollections of the applicable therapeutic process. Did I really work from a strategic perspective? If so, was this the sole theoretical foundation informing my therapeutic work at the time? Obviously, based on the eclectic nature of my training as a psychotherapist, the answer has to be no. Still, I intentionally moulded my work and thoughts on this school of thought. Perplexed, I spoke to my former supervisor. He pointed me to the role that the interactional/systemic approach to therapy played in my training and, seemingly, on the relevant therapy. In concurrence with this shift in thinking,

and in an attempt to achieve the goals of this chapter, I now turn to salient characteristics of the interactional/systemic school of thought.

2.4.1 Background to the approach: human interaction

It seems from the work of Swart and Wiehahn (1979) that Jay Haley's conceptualisation of human interactions had a significant impact on the development of the interactional/systemic model of psychotherapy. Haley (1963), who acknowledges the formative influence of the work of Milton Erikson on his conceptualisations, contends that, in human interactions, there is always a qualification of a message and an indication of what behaviour is permissible in the specific relationship. The supposition is that there is a constant process in interactions of working out how the relationship is to be defined and, consequently, (as the person who gets to decide this) who is in control of the relationship. There is thus, in any and in all interactions, an attempt at creating, changing or maintaining the manner in which the relationship is defined in terms of what is permissible in the relationship and what is not, and who the individual is who is to define it as such. This is done through messages. Haley suggests that two levels of messages are always present in any interaction- one relates to the specific message that is relayed; the other to how that message is qualified or disqualified. Because messages are always qualified or disqualified through context, body language, verbal messages, or patterns of voice and language, a person's attempts at defining a relationship can contradict each other and therefore deny the original message. Such a message is said to be incongruent with its predecessor, which is in opposition to a congruent, affirming message. For Haley, these ideas point to the intricacies of human interactions and to a process concerned with who is in control of the relationship.

Control in a relationship relates to the mutual acceptance of how one participant in an interaction is defining the relationship (i.e., "this is the kind of relationship that exists between us") (Haley, 1963). This manoeuvre can then either be rejected through an attempt at a different definition, or be accepted. Acceptance

is possible either by going along with the definition (and so conceding control to the first party) or by qualifying the acceptance with the message that the reacting party is allowing the original manoeuvre. In the latter instance, the person allowing a manoeuvre for control is in fact himself manoeuvring for control of the relationship. Even in attempting to hand control over to the other party in the interaction, there is an attempt at defining the relationship, and therefore an attempt at controlling the relationship. In this case, the attempted definition of the relationship is of one that is not defined by the person himself. This is a paradox (or incongruent message), because the message is in effect: "I want you to define our relationship and am therefore defining this relationship as one defined by you".

Haley (1963) classifies relationships in terms of being either symmetrical (wherein the parties involved exchange the same type of, or symmetrical, behaviour) or complementary (wherein the participants respond to each other with behaviour that fits together or that is complementary). Behaviour attempting to change the type of relationship that exists between individuals is called a manoeuvre. "Manoeuvres to define a relationship consist essentially of (a) requests, commands, or suggestions that another person do, say, think, or feel something and (b) comments on the other person's communicative behaviour" (p. 12). Manoeuvres are constantly being exchanged to keep the current definition of a relationship or to change it (Swart & Wiehahn, 1979).

The implications of the preceding discussion on Jay Haley's views on human interactions for the interactional/systemic school of thought should become clearer as the focus is turned more directly to this model. The discussion now moves to more specific underpinnings of the interactional/systemic approach to psychotherapy.

2.4.2 Effective and ineffective interactions

Similar to strategic therapy, interactional/systemic therapy ascribes to a view that emphasises individuals in relationships and behaviour existing within these relationships. In fact, the term “interactional” seemingly refers to how persons are in relation to each other (Labuschagne, 1998). The focus here is, however, on the interpersonal strategies of the therapist, or the therapist’s manoeuvres in his interactions with the client that then change the client’s relationships (Swart & Wiehahn, 1979), and not on how a problem is perpetuated by current attempts at solving it. The assumption of this approach is that this change in the client’s relationships will change the attitudes, emotions and/or behaviour of the client (Haley, 1963). This is in contrast to the strategic approach’s assumption that by solely changing problem-solving behaviour sufficient change will result.

Another shared assumption of these two models is that human behaviour is not ascribable to innate, intrapsychic tendencies (Swart & Wiehahn, 1979). For the interactional/systemic model different behaviours are seen as being facets of relationships. The “interactional model asks how one experiences another, and furthermore, how he allows others to respond to him...” (p. 14). The focus is on the purpose of behaviour within relationship, as in “what is the behaviour intended to accomplish?” There is thus again a focus on broader behaviour than just specific problem-solving attempts. However, the interactional/systemic school sees all behaviour as being directed towards attaining some sort of goal (Haley, 1963). This can be taken to mean that the model sees all behaviour as attempts at solving some problem or another. The real difference between these two models on this point then seems to rest upon how narrowly the problem is defined.

In concurrence with the foregoing, Swart and Wiehahn (1979) point to the interactional/systemic model’s assumption that each person’s behaviour is elicited and maintained through interaction with others. Furthermore, the model seems to assume that messages are constantly exchanged between individuals

and that individuals get reactions from those around them. As a theory focusing on individuals in relationship, the interactional/systemic model stresses the quality of interpersonal interactions between individuals. This is elucidated to mean that the ideal situation, that which is to be pursued, is one in which the members of an interaction are open to the communication or messages being exchanged. Additionally, such a situation entails that the persons involved are able to express themselves freely and directly. The effects of being in such an interaction include constant relationship development, constant self-discovery and experience. It seems that a prerequisite for such a situation is exists in the presentation of a shared flexibility in interactional roles. If this scenario is taken as the blueprint for ideal interactions, then it can be argued that psychologically manifested problems arise due to:

- rigid interactional roles;
- deficient openness; or
- difficulties with free and direct expression.

The model assumes that difficulties in interaction, as described above, originate in earlier interactions, as they become the foundation of the individual's habits for future interactions. Haley (1963) argues that even psychiatric symptoms, as entities that have interactional meanings, can become a part of a person's ineffective pattern of interactions. For Swart and Wiehahn (1979) many interpersonal tactics used by clients presenting for psychotherapy are aimed at creating distance, denying feelings and/or denying relationships, with a view to emotional self-protection. As the client is constantly interacting within a limited scope of behaviours (which is seen to be the problem), the relationships he finds himself in are assumed to be continuous recapitulations of the problematic earlier ones.

As the problem then seemingly lies in inefficient interactional habits, it is taken to be the task of the psychotherapist to use his relationship with the client as the basis for teaching a new way of interacting. This emanates from the supposition

that behaviour, emotions and attitudes can change if opportunities for new interactions occur (Luft, 1969). There is therefore an emphasis on a broad spectrum (or repertoire) of possible behaviour as an underlying assumption to interactional/systemic therapy. This, it is believed, can be acquired in relationships and it reflects the reasoning behind the approach's emphasis on the therapeutic relationship.

2.4.3 The therapeutic relationship

The interactional/systemic school of psychotherapy posits that there are certain prerequisites for therapeutic change (as the overarching goal of psychotherapy) (Swart & Wiehahn, 1979). In this manner, Truax and Carkhuff (1967) point out that the relationship between the therapist and the client is of crucial importance for effective therapeutic change to occur. In a similar manner in which Carl Rogers (1951) emphasised empathy, warmth and congruence, Truax and Carkhuff describe them as the three most basic and most essential elements in a therapeutic relationship. The supposition is that, at any and all times during therapy, at least two of these factors need to be high. These relational facets form the platform from which therapeutic strategies can be executed. That is to say, once the relationship has been established as one in which the therapist is mostly empathic, warm and congruent, the therapist can manoeuvre for change. These aspects are thus seen to relate to the relationship itself. Reciprocity, or the "tendency on the part of individuals to respond in kind to the behaviour they receive from others", is another example of a relational factor that can hinder or promote therapeutic change (Swart & Wiehahn, 1979, p. 12).

Resultantly, it seems that this school of thought presupposes that the manner in which the therapist presents himself to the client influences their relationship and therefore the client's behaviour (Swart & Wiehahn, 1979). From a different perspective, if the therapist can change his own manner of behaving towards the client, the client can start changing how he (re)acts to the therapist and eventually to others. The model postulates that a chain of results will then ensue

starting with a change in the reactions of the people with whom the client interacts. Change in the client's relationships with these people is assumed to arise, followed by the creation of new possibilities for being in relationship. Thus, the interactional/systemic school of thought views therapy as the process of changing the client's relationship with others, starting with the relationship between the client and the therapist. As the therapist is seen to be the initiator of this change from this point of view (Haley, 1963), the role of the therapist within this relationship merits further scrutiny.

2.4.4 The role of the therapist

With the therapeutic relationship as the foundation for therapeutic change, Swart and Wiehahn (1979) suggest that the therapist needs to discern the specific aspects of the relationship to be changed in order to change the client's behaviour. Once this has been done, the therapist needs to decide on the most effective manner in which the change can be brought about. By presenting a specific message, response and relationship, the therapist attempts to render the symptomatic (or ineffective) behaviour purposeless. In effect, the therapist attempts to short-circuit the habitual, ineffective interactional patterns of the client. However, since this behaviour forms part of interactions within the person's other relationships as, it is assumed, a reaction to a specific situation, this situation also needs to change. As such, the client's ineffective behaviour is used as a doorway into his problematic and ineffective relationships. Included then in the therapist's conceptualisation of the problem is not only a description of the client's problematic behaviour, but also of the situation to which the person is responding through this behaviour. Again, here there is an overlap with the ideas of strategic therapy, in that this suggestion echoes the suggestion that the strategic therapist should work from the client's position. In addition, the therapist uses strategies to bring about change and is therefore, also from the interactional/systemic perspective, an active agent of change. It is deemed important for the interactional/systemic therapist to have an influence on the

client, as not having an influence on the client is seen to point to ineffective therapy.

What is apparent from this discussion, is that the therapist working from the interactional/systemic paradigm needs to have a clear understanding of the client's problem behaviour and the definition of the relationship. Haley's (1963) formulations of message qualification and disqualification, control and manoeuvres can be taken as facets of such an understanding. The question then seems to be how is the client manoeuvring and what is he manoeuvring for. An analytical endeavour, which is aimed at reaching such an understanding of the client's behaviour, is described next.

2.4.5 The interactional analysis

As with Watzlawick's (1990) contention that the strategic therapist needs to understand the presenting problem, Swart and Wiehahn (1979) argue that the interactional/systemic therapist needs to ask how the problem is manifested in order to understand it. This is then used as the basis for formulating the goals of therapy, and also, together with these goals, it determines the strategies that the therapist will use to affect change. There is thus an emphasis on how the client acts in the here-and-now, i.e., how the client is relating in the present moment towards the therapist and to what effect. This here-and-now interaction is seen to indicate what the client is manoeuvring for (Haley, 1963). It is assumed that the goal of the manoeuvres is inextricably related to the client's problem situation.

To facilitate such an understanding, Swart and Wiehahn (1979) suggest asking the following questions as part of a so-called descriptive interactional analysis:

- how does the client speak to the therapist?
(This question pertains to aspects of the client's speech such as logic, emotional overtones, tone of voice, non-verbal behaviour and discrepancies or consistencies between verbal and non-verbal communication);
- how does the client speak about the problem?

(A description of how the client relates to the problem can include observations of blaming, insight, denial, intellectualising and vagueness);

- what is the nature of the client's relationships with others?

(This section concerns the manner in which the client speaks about his interpersonal relationships and how these relationships are maintaining the problem. Apart from the client's previous relationships, this examination includes the client-therapist relationship to ascertain the client's interactional style);

- what is achieved by the behaviour?

(Another way of phrasing this question is: what are the effects of the behaviour? Or: what are the reasons for the client's adherence to the behaviour? The feelings and reactions of the therapist to the behaviour is pivotal in answering these questions. The importance of the latter is its use in informing therapeutic interventions); and

- what is the context of the therapeutic relationship?

(This section involves taking the client's situation and its influence (for example, on the client's decision in undertaking therapy) into consideration in order to facilitate the therapist's adaptation to the client).

Labuschagne (1998), based on a personal communication from Beyers (1995) and as an attempt to use that which is working effectively already as the foundation for therapeutic change, adds an additional question:

- what are the strengths of the client?

(This question relates to the interactional factors that could contribute to an effective therapeutic outcome, as they are proposed to form the basis for affecting change).

Swart and Wiehahn (1979) stress the importance of an open presentation of the therapist at the outset of the therapeutic process, in order to gain an interactional analysis that is as precise as possible. Stated otherwise, the therapist is meant to place himself in a direct, open relationship with the patient, in which he is

empathic, warm and accepting. It is reasoned that, because the approach deals with people in interaction reacting to one another, this direct and open approach should provide the therapist with an interactional analysis that is minimally contaminated by the client's reactions to the therapist. Ideally the real problematic behaviour of the client is then most apparent and will (as much as possible) not be confused with the effects of the therapist on the client.

2.4.6 The process of therapy

It seems, from the work of Swart and Wiehahn (1979) that there are specific steps in the therapeutic process from an interactional/systemic point of view.

These are as follows:

- the identification of the problem;
- the exploration of the problem;
- the analysis of the problem; and
- the setting of therapeutic goals and planning of the treatment.

Beyers (personal communication, 2002) feels an additional step is necessary:

- the constant evaluation of the process.

Beyers prefers to define this process as an attempt to remain scientifically orientated to facilitate the therapist maintaining focus.

From the foregoing discussion it should be clear that the strategies used by the interactional/systemic therapist are designed to break the pattern of the client's interactions once these patterns have been identified. Swart and Wiehahn (1979) suggest that the therapist is often required to react to the client's behaviour in ways that do not conform to social expectations (or which are asocial). They also call attention to the importance of the therapist (and the client) working in the here-and-now of the therapeutic relationship. The therapist should therefore respond to the patient as the patient is in the here-and-now, and manoeuvre for the patient to (re)act in the here-and-now.

In providing an overview of interactional/systemic therapy, the prominent role of the therapist cannot be overstated, it seems. The onus for change seems to rest almost exclusively with him. For Swart and Wiehahn (1979, p. 47) the effective therapist (and thus the interactional/systemic therapist) is "...a highly active, powerful therapist...who uses the relationship to the fullest extent in order to change behaviour."

2.5 Conclusion

In this chapter, self-reflexivity (as the process of personally and systematically reviewing the influence(s) between the therapist and the client) has been presented as a therapeutic tool and as a tool for research. In addition, strategic and interactional/systemic therapies have been presented as the schools of thought and methods of therapy understood to be most significant in relation to the study. This presentation relates directly to the practice of self-reflexivity as a tool for therapy and for research. At this point it is important to note that Swart and Wiehahn (1979, p. 40), in their discussion of interactional/systemic therapy, also advocate a "thorough self-knowledge" on behalf of the therapist as "an essential requirement for effective psychotherapy". To these authors, this translates into an awareness of each message that is transmitted and the effects thereof, i.e., the questions to be asked pertain to the effects of the client on the therapist and what are the effects of the therapist on the client.

In concluding the discussion on strategic and interactional/systemic therapy I find it important to emphasise the following points. The major difference between the strategic model (as used by the MRI in Palo Alto) and the interactional/systemic model of therapy centres on defining the problem. The latter expands the MRI's notion of working with the "presenting problem" by conceiving interrelated parts of a wider interactional and interpersonal system as constituting the problem. One could argue that this is more "psychologically minded". Despite this obvious difference in focus between these two models, I have attempted in my discussion to explicate some of the many areas of agreement between them. To me the

most important of these junctions is the fact that both models view interpersonal relationships as central to the existence of and solving of problems. As such, these approaches can be described as interpersonal approaches to psychotherapy. For this reason the term “interpersonal psychotherapy” is used in the study to refer to the systemic and the interactional/systemic models of psychotherapy together. Thus, the overarching epistemology of the therapeutic process in the study can be described as interpersonal psychotherapy. This said, the next chapter provides a theoretical overview of stuttering.

Chapter 3

Literature Study

3.1 Introduction

Stuttering can be understood as a complex way of behaving that has effects on the person who stutters and on those with whom this person tries to communicate. For the moment it is sufficient to say that stuttering seems to be associated with great interpersonal distress in many people's lives. As Louw (1996) puts it:

"Stuttering is an age-old problem, yet many people are unaware of the serious handicap facing children and adults who stutter. This is a neglected speech and social problem causing a great deal of fear, frustration, shame, and misery, yet is still shrouded in ignorance and secrecy" (p. 175).

3.2 Defining stuttering

It seems fair to say that arriving at a completely acceptable definition of stuttering is a difficult task. Theorists and practitioners alike seem to disagree amongst each other as to what the best definition of stuttering is (Curlee, 1999). The importance of this definition is obvious when one considers that for the researcher, for the practitioner and (most importantly) for the client a definition provides the boundaries of what is to be worked with. This may also be true for all people who come in contact with stuttering. It could be stated that this vested interest of all of the parties that are involved makes the attainment of an encompassing and acceptable definition an elusive venture.

One of the major areas of disagreement here is whether or not psychological factors should be seen as part and parcel of stuttering. Cooper and de Nill (1999), Klompas (2002) and Manning (1999) feel that phenomena like attitudes, feelings and avoidance behaviour should all be included in the definition. In fact for Manning it is the reaction of the person who stutters to the stuttering that is the most salient aspect of the phenomenon. To the same effect Klompas, in

looking at the phenomenology of stuttering, infers that the person who stutters ascribes meaning to his stuttering behaviour. Conversely, Kander and Naidoo (2002) put forward that stuttering is first and foremost related to speech. The World Health Organisation (1977, p. 202) defines stuttering solely upon the basis of speech and motor aspects when the organisation calls it "...a disorder in the rhythm of speech, wherein the individual knows exactly what he wants to say, but is simultaneously not able to say it because of involuntary, repetitive prolongation or cessation of sound." Despite this, in a later publication (1999), reference is made to its psychological effects when stuttering is classified as an impairment on the basis of an associated reduced participation in many arenas of life.

Another suggested basis for defining stuttering is the probability of certain behaviour to be seen as stuttering. For Conture (2001) such an observer-focused definition of stuttering is most suitable. He includes the repetition of syllables or sounds, the stretching (or "prolongation") of sounds, the repetition of single syllable words and pauses within words in the list of behaviours that observers would probably see as stuttering. Because of this, Conture proceeds from this point to state that it is up to the speech pathologist to assess and diagnose these specific speech behaviours in terms of the probability that they are experienced (or observed) as stuttering. However, there is a contradiction inherent in this assertion: if stuttering is (in colloquial terms) "in the eye of the beholder", would it not be safe to say that stuttering as a phenomenon, and not a clinical diagnosis, belongs to all of those who "behold" it?

Seeing the concept of stuttering as dependent on the reactions of an audience (which may or may not include the person who stutters) presupposes the presence of a feedback system that exists between communicator and audience. This obviously also puts the person who stutters within a system of people with whom interaction takes place. As succinctly put by Conture (2001): stuttering cannot be observed if there is no-one to observe it. Conture also points to self-reports by people who stutter that they do so less when not communicating with

others. Van Riper (1982) speaks of a hierarchy of stuttering in which stuttering increases in likelihood and in severity as the power differential between the person who stutters and his audience grows in favour of the latter. The suggestions of O'Keefe (1996) and Starkweather and Givens-Ackerman (1997) that the audience of a person who stutters seems to focus primarily upon the form in which the message is delivered (as opposed to the content thereof) are taken to be an example of the communicative value of stuttering. The implication of this discussion is that there is an essential interpersonal aspect to stuttering.

What should be forthcoming from the discussion on defining stuttering is that stuttering is a complex phenomenon. However, the most definitions of stuttering seem to emphasise speech behaviour. Shapiro (1999) points to overly frequent attempts at coming to overly simplistic understandings and solutions for such a multifaceted problem as stuttering. Therefore, a definition of stuttering cannot be too simplistic. On the other hand, for its practical application, it should not be overly inclusive. When constructing an overview of what has been written so far, certain elements of stuttering appear evident. It is argued that these should form the basis of a working definition of stuttering. As such, the main features of stuttering seem to include:

- a speech component;
- a reaction to this speech component by an audience (an interactional aspect);
and
- a reaction by the person who stutters to the stuttering and to the audience reactions (psychological and behavioural features); this includes the ascribing of meaning to the stuttering.

It is therefore suggested that stuttering is a complex process that involves sufficiently disjointed speech within a relationship (i.e., within the context of an interaction), as well as behavioural and psychological effects on the parties involved.

3.2.1 The person who stutters

Before we move on from our definition of stuttering to a brief look at types of stuttering, it is important to note some of the implications of the use of such a definition as a diagnosis. For Keeney (1983) the effects of diagnosing someone on the grounds of the observable (i.e., on behaviour) leads to a situation in which this person is doomed to perpetuate this diagnosis. What this means is that diagnosing someone as a stutterer on the grounds of their behaviour leaves this person unable to disprove the diagnosis. Whether the person continues to stutter or not, they will remain a stutterer. In fact, Keeney states that such a diagnosis should make the behaviour on which it is based more probable.

Despite not doing so in our formal definition, a clear distinction between the person who stutters and the stuttering, albeit implausible at least at some level, may be beneficial. Cooper (1984) accentuates the view of someone who stutters as being a person first and foremost (rather than a diagnosis). Within this context the therapist is warned of the dangers of labelling clients, as it detracts from their personhood and makes it harder for the clinician to reach a real understanding of each individual client. To this end, preference is given to the term “person who stutters” over the term “stutterer” within the study. This decision is also influenced by the suggestion by Klompas (2002) in her qualitative study on the experiences of people diagnosed with stuttering that people who stutter prefer this description. Even more importantly Starkweather and Givens-Ackerman (1997) assert that people who stutter seem to take exception to being called stutterers.

3.3 Manifestations of stuttering

As is the case with the definition, there seems to be disagreement on how to classify different manifestations of stuttering. Among the various suggestions there is one approach that concentrates on maintenance and another focusing on severity. These will be discussed in brief.

Oudshoorn (1977) makes a distinction between primary and secondary stuttering on the basis of maintenance. Primary stuttering is seen to cease spontaneously. Also, in this case, the person who stutters seems oblivious to the stuttering behaviour exhibited. For Oudshoorn secondary stuttering is more long-term. What is seen concurrently, is an apparent preoccupation with the stuttering behaviour. Oudshoorn feels that there is a causal relationship between these two factors. He feels that making the person who stutters aware of this behaviour and focusing attention there-upon, leads to such a preoccupation. This preoccupation then keeps the stuttering in place, through mechanisms such as stress. Accordingly, Guitar (1998) suggests that the first occurrence of stuttering behaviour may in fact be related to stress involving the individual's family, the reactions of the listener and the task of acquiring speech and language. The assumption is that psychological phenomena, like stress, can be directly related to the cause of stuttering or, at the very least, play an important role in the presentation and maintenance thereof.

Despite the agreement that stress is an important aspect in the presentation of stuttering, Guitar (1998) provides us with a typology based not on maintenance, but rather on severity. Within this framework there is a general assumption that if stuttering does not dissipate as a person grows older it will increase in severity. Curlee (1999) holds a similar point of view when admonishing that adults who stutter are much less likely to improve than their younger counterparts. For Manning (1999) the increasing severity with time can be ascribed to the stuttering becoming a way of life to the adult who stutters. Three types of stuttering are delineated by Guitar, namely (from least to most severe and usually from most recent to most long-standing): beginning stuttering, intermediate stuttering and advanced stuttering.

Despite the differences, it is possible to look past the specifics of which typology is the most effective. Instead this discussion can be used to see that the attempts at classifying different manifestations of stuttering may be an indication that

stuttering can differ in its presentation. Indeed, according to Curlee (1999) this is the rule rather than the exception. If this is so then support is given to the idea that each client presenting for therapy is indeed a unique individual and should be treated correspondingly. This is in line with the foregoing discussion on how to refer to the client presenting with stuttering. Concurrently it seems plausible to assume that, in the same way that stuttering differs in manifestation, the factors influencing and being influenced by stuttering may differ across individuals. As mentioned before, these factors include both psychological and interpersonal aspects. Each of these is discussed below.

3.4 Psychological factors

Stress has already been mentioned as a psychological phenomenon closely associated with stuttering. Guitar (1998) states that an increase in stress probably leads to an increase in stuttering. Similarly, Bloodstein (1995) showed that factors that increased stress for a person who stutters (e.g., larger audience size, speaking in front of an authority figure, time pressure) seems to lead to increased stuttering.

Louw (1996) includes fear of speaking, feelings of guilt, frustration, shyness, aggression, self-hatred, a low self-esteem and depression in a list of probable psychological effects of stuttering upon the person who stutters. Blood, Blood, Tellis and Babel (2001) add increased insecurity, general anxiety, and fear of speaking with more fluent communicators, as well as decreased assertiveness as part of the psychological aspects of this phenomenon. Guitar (1998) suggests that being a person who stutters becomes part of how these individuals think of themselves. In other words, people who stutter view themselves as just that – people who stutter. He argues that these individuals are usually aware of and are probably embarrassed by their stuttering behaviour. In addition, they seem often to use excessive mental and physical energy to produce speech. This can be taken as an indication that persons who stutter place a great emphasis on speech and stuttering. One could say that a person who stutters may display a

preoccupation with (or over-emphasis on) stuttering behaviour and with speech in general. It appears that the person who stutters often harbours very strong negative feelings towards his stuttering (Klompas, 2002). From the foregoing discussion it seems plausible to state that negative attitudes and feelings are commonly associated with stuttering. As an example of this association, Perkins (1992) describes a common phenomenon in which persons who stutter begin to see their stuttering as an insurmountable problem, as their only problem and/or as the root of all their problems. For Van Riper (1982) the phenomenon of persons who stutter blaming all their problems on their stuttering, relates to another relevant psychological factor. Stuttering, as their singular problem, is then seen as the only thing standing between persons who stutter and tremendous success. Van Riper likens this to the idea of a giant in chains, where the person who stutters is a giant who is chained by only his inability to speak fluently.

Earlier it was stated that stuttering presents in different ways across individuals (as its causes and its effects probably do too). In fact, it can be said that each person who stutters develops his own repertoire of stuttering behaviour (Curlee, 1999). By the same token a wide potential repertoire of stuttering escaping and avoidance behaviour has been described. Van Riper (1982) notes that avoidance and postponement of certain activities are common facets of a stuttering repertoire. Manning (1999) includes various subtle ways of hiding the stuttering and of avoiding self-disclosure. Thus, the person who stutters can incorporate into his life various ways of stepping back from and/or avoiding certain situations. Examples of this include the avoidance of interpersonal contact, public speaking and applying for a new job. Guitar (1998) includes physical distracters, such as excessive blinking of the eyes, as possible additional manifestations of such behaviour. These may be conceptualised as attempts to regain control of stuttering behaviour. Manning (1999) feels that avoidance behaviour is the most devastating aspect of stuttering, because it often keeps persons who stutter from reaching their full potential.

What this discussion illustrates is that there can be little doubt as to the existence of psychological aspects associated with stuttering. As part of the presentation of stuttering, they seem to have many detrimental effects on the lives of persons who stutter. As will be discussed below, this also appears to be the case when it comes to the interpersonal spheres of these persons. While Conture (2001) contends that stuttering finds itself within the context of the interpersonal, Manning (1999) sees it mainly within the psychological. A distinction between the psychological and the interpersonal may be arbitrary, as these areas of life for the person who stutters may in reality overlap and intersect. Nevertheless, this distinction could possibly help to illustrate the extensiveness of stuttering, its causes and its effects. In the next section, the interpersonal factors associated with stuttering will be discussed in depth, as these aspects overlap with the psychological factors from this discussion.

3.5 Interpersonal factors

The effects of stuttering within an interpersonal setting are evident in the reactions of the receiver of the stuttering communication and in the counter-reactions of the person who stutters. In this regard Kander and Naidoo (2002) state that the receiver (where the person who stutters is seen to be the sender) may develop negative views about the sender as communicator. Klompas (2002), in reporting the responses in her study on the experiences of people who stutter, notes a participant (and therefore a person who stutters) as saying that he also frowns on people who stutter in his presence. Thus if persons who stutter expect such negative reactions from their audiences, chances are that they will begin to fear pre-emptively this reaction (Manning, 1999). This pre-emptive fear may then lead to an increase in stress, which will, following from the above discussion, probably increase the frequency and severity of the stuttering. Thus, here is a definite link between the interpersonal and psychological aspects of stuttering. In the same manner it is possible for the person who stutters to learn to view his stuttering as negative (Oudshoorn, 1977). Therefore it is possible to view negative feelings towards a person who stutters' own stuttering as, at least

partially, resulting from audience reactions. As this feeling is psychological in nature, we can see that these two arenas (as has been stated earlier) intersect.

Another overlap between the psychological and interactional aspects of stuttering is clear when the importance of language and speech in both these areas are considered. Letourneau (1993) argues that language and speech allow a person to convey his intelligence, to influence his environment and to validate his being in the world. There is a definite interpersonal and interactional slant to Letourneau's statement, as all of the aspects he addresses relate to the individual in relationship. However, Letourneau expands the argument to include the psychological in stating that the above-mentioned functions of language and speech play an integral part in the individual's identity in a feedback manner. Likewise, Hayhow and Levy (1989) suggest that stuttering can create a barrier between people. These authors propose that the person who stutters resultantly loses many opportunities for intimacy and runs a higher risk of being hurt in relationships. In addition, Conture (2001) believes that people in general are much less tolerant of difficulties in speech and language behaviour, including those relating to fluency of speech, than of any other behaviour. In overviewing the assertions of Letourneau and of Hayhow and Levy (1989) it can be said that a person who stutters struggles to use language and speech to convey his intelligence, to influence his environment and/or to validate his existence. This then also seems to have a negative effect on his relationships and on his identity. A link exists here with ideas relating to the person who stutters' self-perception of being a person who stutters and other psychological aspects of stuttering which were elaborated on earlier. This paragraph seems to relate to the self-feedback of the person who stutters. However, because communication always receives feedback from the receiver (Haley, 1963), the focus of the next paragraph shifts to this aspect.

Speech therapists and those who research this area seem to agree that often the general, common sense (error-activated) responses to stuttering worsen this

behaviour (Bloodstein, 1995; Gregory, 1992; Guitar, 1998; Klompas, 2002, McKinnon, Hess & Landry, 1986; Nelson, 1992; Turnbridge, 1994; Williams, 1992). These problem-perpetuating behaviours may include behaviours of the observer. Examples may include:

- attempts at completing the sentences of the person who stutters on his behalf (Starkweather & Givens-Ackerman, 1997);
- reacting with visible horror and unease (Starkweather & Givens-Ackerman, 1997; Turnbridge, 1994);
- giving advice (ideas planted such as “Calm down and take your time in speaking”) (Starkweather & Givens-Ackerman, 1997);
- being visibly uncomfortable (Turnbridge, 1994);
- laughing at and making fun of the person who stutters (Turnbridge, 1994);
- pretending that nothing happened (Turnbridge, 1994); and
- giving special attention to the stuttering (Gregory, 1992).

From this list of possible stutter-exacerbating behaviours (or reactions), it would seem reasonable to assume that the reactions of a therapist may also increase or maintain the stuttering behaviour. What is more, Gregory (1984) warns that the therapist should be aware of the behaviours and attitudes that are exhibited in the interactions with the client to avoid such a scenario.

From the above discussion, it may appear to the reader that stuttering can be blamed on audience reactions. However, it is important to note that the reactions of the person who stutters to the stuttering and/or his reactions to the reactions of the audience also potentially keep the stuttering intact. Examples of this include working hard at controlling the stuttering (Turnbridge, 1994), and attempting to avoid situations where stuttering is probable (McKinnon, Hess & Landry, 1986). In line with these ideas, Guitar (1998) takes a circular stance when viewing the relationship between feelings and stuttering. For him the stuttering behaviour and the feelings of antagonism (toward the audience), shame, frustration, and

anticipatory anxiety associated with this behaviour feed off each other. These factors lead to what can be termed a vicious circle.

Taking the above into account, it seems that the relationship between stuttering and reactions to the person who stutters becomes complicated. Moreover, what can be deduced is that there is a great possibility that an interrelationship is present between stuttering and the reactions it elicits. When also taking the psychological factors into account, it seems plausible that the psychological aspects, the interpersonal factors and the speech component of stuttering are all intricately interrelated. This affirms that all of these aspects should form a part of how stuttering is understood. This can additionally be taken as a reason for vigilance on the part of the practitioner wishing to work with this phenomenon. With this in mind, the discussion will soon turn to therapeutic work with stuttering. Prior to this, it is perhaps important to consider possible positive effects of stuttering.

3.6 Positive effects

Insofar as this dissertation focuses on therapeutic work with a client who wanted to be relieved of his stuttering, there has so far been an emphasis on the negative effects of stuttering. This may in actual fact lead to the creation of a distorted view of the phenomenon, for some people who stutter seem not to think of their stuttering as a negative part of their lives. Klompas (2002) provides personal accounts of individuals who actually see their stuttering as playing a positive role in their lives. One respondent experienced stuttering as an opportunity to get to know people better. The respondent explains this on the grounds of the stuttering leading to an increase in listening and a decrease in talking. Another asserted that stuttering has been a positive influence as it fostered personal independence. Guitar (1998) also indirectly cautions in favour of a more balanced view of stuttering, when he cites examples of persons who stutter who are not isolated and who enjoy support and protection in friendships. Moreover, the latter is experienced as relating to the stuttering behaviour itself.

From the current literature review, it seems conceivable that stuttering is a problem if it is defined as such. Consequently, a therapist working with stuttering needs to also take into account whether the presenting stuttering is seen as problematic or not. This presents an ethical dilemma: should a therapist intervene or not when a person who stutters does not view his stuttering as problematic (or sees it as positive). For Klompas (2002) and Neilson (1999) it is vital that therapist convince the client that stuttering is a problem. In opposition to this idea, Sugarman (1980) states that people can be taught to see stuttering as something positive. For Starkweather and Givens-Ackerman (1997), even just an acceptance of stuttering and the person who stutters within a relational context seems to decrease the intensity of stuttering. This could hold true for the therapist working with the person who stutters as well. As differences around this idea are evident and are difficult to resolve, it may be suggested that the decision either to undertake therapeutic interventions or not, rests with each individual therapist. Cooper (1984) suggests a solution here that revolves around providing the client with choices rather than forcing change. In this manner the client can eventually choose between fluency and stuttering. If we take this contention as resolving the dilemma regarding relieving stuttering or not doing so, the discussion now moves to approaches aimed at relieving stuttering.

3.7 Approaches aimed at the alleviation of stuttering

Stuttering seems to be a phenomenon that occurs in both genders and across cultural borders (Guitar, 1998). In fact, the earliest historical evidence of stuttering dates back forty centuries. It is probably fair to assume that for at least as long as stuttering has been considered a problem, there have been attempts at relieving it. (As this relates directly to the ethical questions raised above, cognisance of this matter should again be taken). Klompas (2002) feels that many of these attempts that were used (and some of which are still being used in certain cultures) are in fact cruel and crude in comparison with current western approaches. One of the examples cited is of stones being placed under the tongues of persons who stutter.

Working towards the alleviation of stuttering from a more western frame of reference currently seems to fall within the scope of the speech therapist. A generally accepted approach to this end does not seem to exist within the field of speech pathology and therapy, however (Van Riper & Emerick, 1994). Guitar (1998) broadly classifies the therapeutic interventions incorporated within this arena as being either aimed at modifying stuttering or at enhancing fluency. When working towards the modification of stuttering, the therapist attempts to teach the client to change the moments of stuttering in ways that reduce their severity. In contrast, a therapist attempting to enhance fluency uses skills to increase the fluency of speech. A third treatment possibility seems to exist in various combinations between these two major modalities (Lilian, 2002).

Another way of distinguishing between therapeutic approaches to stuttering seems to rest upon whether to include psychological factors in the therapeutic process or not. It seems that work focused on enhancing fluency tends to negate these aspects knowingly. Guitar (1998) explains the rationale for this as being a belief that once the stuttering behaviour changes, change in the other areas of the person's life will follow. For Manning (1999), however, change in feelings, attitudes and other psychological phenomena are necessary to sustain these changes in behaviour. Also consciously incorporating the psychological, one movement within the field of speech pathology seems to have originated from the premises of the cognitive-behavioural school of psychology. Neilson (1999) describes such an approach as attempting to incorporate the affect, behaviour and cognition of the client. Many people within the field of therapeutic work with persons who stutter seem to emphasise these aspects as all-important. Sheehan (1975) sees stuttering behaviour as the tip of the stuttering iceberg, with psychological and interpersonal aspects making up the bulk of the problem to be addressed. Bloom and Cooperman (1999) broaden these ideas to include the cognitive, affective, linguistic, motor and social aspects of the phenomenon as needing therapeutic intervention.

One of the criticisms of certain attempts at therapy with persons who stutter is that they are only successful in reducing the stuttering temporarily (Conture, 2001). This leads to a focus on effective carry-over of therapeutic success from the context of therapy itself to other contexts (Klompas, 2002). As such, many techniques that have shown to be effective in relieving stuttering for a limited time-period have fallen out of favour and out of use amongst speech therapists. These include the use of rhythmic speaking (which may make use of a metronome or the rhythmic swinging of arms), singing, the wearing of certain devices around the neck so as to shift focus from the stuttering, memorised speeches and acting. Currently the most popular assumption relevant to this aspect is that successful carry-over can only be the result if changes in attitudes, thoughts and feelings accompany changes in fluency (Conture, 2001; Guitar, 1998; Manning, 1999; Neilson, 1999). Cooper (1984) suggests that this goal can be reached by also undertaking a process of psychotherapy.

Despite the obvious plethora of ideas and techniques associated with therapy regarding stuttering within the field of speech therapy, therapy with persons, and more specifically, adults who stutter, seems to be difficult and often results in unsatisfactory termination (Curlee, 1999). Conture (2001, p. 283) attributes this to the observation that “[h]abitual inappropriate behaviour may feel more normal than novel, appropriate behaviour.” For Van Riper (1982) the frequency of unsuccessful therapy with adults who stutter leads to the idea that the use of specific techniques does not guarantee success. For him successful outcomes can be ascribed to the love and concern of the therapist for the client. Therefore, in contrast to the assertion that therapeutic success with a person who stutters depends on the client’s level of motivation (Klompas, 2002), there is a notion that the role of the therapist is actually central in this regard. Manning (1999) echoes these ideas when he warns against an over-reliance on therapeutic techniques to the detriment of the therapeutic relationship. In addition, Manning emphasises the importance of the therapist being in sync with the client and of the correct timing of interventions. For Silverman and Zimmer (1982) the basis for this

relationship is seen to come from the therapist's ability to come across as warm, empathic, open, and willing to listen. Manning (1999) adds therapeutic decision-making and appropriate timing of responses in the mix.

Louw (1996) emphasises the difficulties in the attainment of and the frequent lack of satisfactory therapeutic outcomes in work with stuttering. For Louw this points to the potentially harrowing intricacies of the relationship between the behavioural, psychological and interpersonal aspects observed in stuttering. This line of logic is taken to indicate that stuttering can never totally be ameliorated and that it is essentially a life-long affliction. Whether this is true or not may be less important than the realisation that therapeutic interventions with persons who stutter are problematic, and that there seems to be reason for frustration when working within this field. Also, it seems plausible to assert that a fit between the client and the therapist is necessary for a successful outcome.

3.8 Conclusion

Stuttering has been presented as a complex phenomenon with behavioural, psychological and interpersonal components and implications. The multifaceted nature of stuttering is seen to complicate therapeutic work with persons who stutter, as it creates intrinsic challenges and demands for therapists finding themselves confronted by these individuals. In summary of this section, it is important to emphasise that each case of stuttering in which a therapist is involved should be considered a unique scenario involving work with a unique individual. Thus, it is important for the therapist to consider the unique nature of each individual case, and to base tailor-made interventions on this consideration.

Chapter 4 Methodology

4.1 Introduction

The intention of the discussion in this chapter is to explain the nature of the research as well as the methods applied. The overarching goal of the study is to gain a better understanding of a complex therapeutic process.

To promote scientific presentation of the chapter, references to the therapist and researcher are made in the third person.

4.2 A qualitative research methodology

The study is qualitative in nature. Qualitative research epistemology has at its roots the basic assumption that subjective experience is of great importance. This suited the notion that the study is based upon personal experiences and views regarding the relevant process of therapy. One of the methods of qualitative methodology is the case study method.

4.2.1 The case study method

Neuman (2000) defines case study research as the in-depth examination of features of a few cases, which may be limited to one or two, over a period of time. For him, this approach to research involves detailed, varied and extensive data, which is mostly qualitative in nature. In using the case study as research method one or a few cases are selected to illustrate and analyse one or more issues. As such, the context and the composition of the parts of the case are to be examined. The method is seen to lead to a connecting of the actions of individuals to large-scale social structures and processes. In addition, a case study leads to questions about a case, and more specifically about its boundaries and defining characteristics. It is posited that these questions will help in the generation of new thinking and theory, which are corollaries of the main goal of the study. In fact, Walton (1992) feels that case studies are likely to produce the best theory.

However, looking at the case study from another perspective, the research, although concerning a case, addresses sixteen sessions of psychotherapy, their contents, the therapeutic processes as well as the complex relationships of and between the therapist and the client. The discussion now turns to how these sixteen sessions were approached.

4.2.2 Self-reflexivity as a method of research

Discussions within teams (which may or may not be multidisciplinary), supervision, and the keeping of process or clinical notes all seem to be well-established practices within the health professions. These can all be seen as various ways in which feedback is given on a constantly developing process and on the progress of work with a specific patient. It seems (at least theoretically) plausible to apply the notions inherent to the practice of self-reflexivity within the therapeutic process to this type of feedback. In fact, the procedure of delivering (and keeping) these forms of feedback can be seen, at least in part, as practices of self-reflexivity (Cecchin, Lane & Ray, 1993; Louw & Edwards, 1994).

This proposal links with the earlier discussion on the epistemology of the study wherein the assumptions inherent in the use of self-reflexivity in the study were broached. As was stated then, the study is an attempt to further the practice of self-reflexivity in therapy and in research by taking it to a more advanced stage. The aim is an even better understanding of what transpired during a specific process of therapy. The study hopes to expand the process of self-reflexivity that already seems to be the practice in psychotherapy in an effort to gain a thorough meta-perspective on a specific therapeutic process. Included is not only a report on the process of development during therapy, but also a description of the interactions between the therapist and the client, the reciprocal effects of these interactions, the context as well as the complexity of meaning that the therapist theoretically attached to the whole process.

In the study the meaning that the author ascribes to the process and context of the interactions in turn forms the basis for the study, has intentionally already been introduced to the reader as far back as the beginning of the discussion on epistemology. The reason for the early discussion self-reflexivity relates to the difficulties encountered regarding the nature of the reciprocal relationship between the researcher (as subject or observer with his own distinctions and observations) and the research endeavour. These two interrelated aspects can be considered as being both inputs and outputs. As such, the views of the author and the process of research are continuously shaping each other.

4.3 Aims of the study

The aims of the study are provided below:

- the central aim of the study is to determine, by means of self-reflexivity, the efficacy of therapy with a person who stutters;
- secondly, the study aims to provide an effective analysis of the process notes created during the therapeutic process;
- thirdly, the study aims to analyse the reciprocal relationship between the therapist and the client;
- the fourth aim is to be descriptive;
- the study is also aimed at furthering the theoretical and practical foundations of therapeutic work with persons who stutter; and
- sixthly and lastly, the study endeavours to advance the researcher's own development as a psychotherapist.

4.4 Method

In the current study sixteen psychotherapy sessions previously conducted with a twenty-year-old male client who presented at a practice specialising in speech therapy were scrutinised. The client had received speech therapy intermittently for a number of years. During his final year of school (age eighteen) communication became critical. He presented with a complaint of long-term

stuttering (approximately fourteen years). This was later diagnosed as a severe stutter.

The speech therapists at the practice focused on modifying the client's stuttering moments, gaining control and, thus, increasing fluency. They utilised techniques to increase the speech sound (or motor) control of stuttering moments combined with fluency enhancing techniques.

During this treatment process, the speech therapists found that they could manage partially addressing the client's attitude towards stuttering. Nevertheless, they felt the need to employ a collaborative and team approach to address his emotions. Specifically, it was decided to refer the client to the psychotherapist for therapy due to suspected relational problems. The referral from the practice included the request that psychological problems concomitant with the stutter be determined and perchance attended to in therapy. During the course of the treatment the therapist kept clinical notes on the developing process, which paralleled the keeping of clinical notes by the practice. The psychotherapy took place at the speech therapy practice and was conducted two years ago.

The sessions were roughly an hour in length each, were held not more than once a week, and were distributed over a period of approximately six months. The clinical notes on the sixteen therapy sessions were then used as the basis for reflectively and self-reflexively examining the process of therapy. Consequently, the method used in the study comprises the session-for-session examining of documentation, reflecting, and self-reflexivity in an attempt to gain a better understanding of a complex therapeutic framework.

In their discussion of these processes Cecchin, Lane and Ray (1993; 1994) do not propose a clear method of reflection and self-reflexivity. Therefore, it was decided to facilitate the processes of reflecting and self-reflexivity through the analysis of themes in each session. The researcher identified themes he felt to

be relevant. This approach was adhered to because of the self-reflexive epistemological nature of the study.

The following format was used for the analysis of the process notes for each therapy session:

- pre-planning (this pertains to the therapist's planning of each session prior to these sessions);
- contents and processes (this section provides a review of what occurred in the session itself. It includes a description of the interactions and interpersonal processes between the therapist and the client);
- themes (the identified themes, as discussed in the preceding paragraph, are reported under this heading);
- self-reflection (in writing up the process notes, the therapist reviewed his own experiences and understanding of each session. These attempts at self-examination are provided beneath this caption); and
- continued post-planning (this section relates to the suggestion by Beyers (personal communication, 2002) that there should be a continued evaluation of the process of therapy throughout (as discussed in the section on interactional/systemic therapy in Chapter 2). Therefore this section is intended to provide an understanding of the therapist's evolving view of the process and of how he positions himself in the therapeutic process).

4.4.1 Interactional analysis

At the beginning of the process the therapist made use of the interactional analysis as proposed by Swart and Wiehahn (1979). The interactional analysis and its format were discussed in the chapter on epistemology. The goal of using this analysis is to gain an understanding of the interactions and interpersonal behaviour of the client as well as the results thereof. As explained, the here-and-now interactions of the client, i.e., the manner in which the client is relating towards the therapist, and the effect of this behaviour are an indication of what

the client is manoeuvring for. It is assumed that this behaviour and its effects are inextricably related to the client's problem situation.

4.4.2 Supervision

Part of the therapeutic process was continual supervision with a senior Clinical Psychologist and member of the Masters Clinical Psychology training team. The supervision sessions were on a weekly basis for the most part and consisted of:

- discussing the contents and process of each session;
- commenting on the therapeutic relationships and their implications for the developing process and therapy;
- analysing the process as a whole;
- deciding on goals for each session;
- the planning of interventions or the creation of strategies as means to achieve the goals;
- what-if phase (discussion of the possible unexpected); and
- the supportive function of the supervisor for the trainee/researcher.

4.5 Training as Clinical Psychologist

During the first phases of the therapist's training as a clinical psychologist there was a strong emphasis on conditions for therapeutic change. This aspect of the training drew specifically on the work of Rogers (1951) and Truax and Carkhuff (1967), who propose that the prerequisites for effective therapy are warmth, empathy and congruence. The suggestion relates to the establishment and maintenance of the therapeutic relationship.

4.6 Quality

Krefting (1991) and Sparkes (1998) emphasise the importance of quality in research. These authors suggest that the criteria for quality in qualitative research are:

- credibility (or truth value),
- transferability (or applicability),

- dependability (or consistency), and
- confirmability (or neutrality).

These criteria are intended to enhance the trustworthiness of research. Krefting (1991) suggests means of ensuring adherence to these criteria:

- for credibility member: checking and peer examination,
- for transferability: dense description and nominated sampling,
- for dependability: stepwise replication and code-recode data analysis, and
- for confirmability: triangulation and reflexivity.

The following measures were undertaken in accordance with Krefting's (1991) suggestions to foster quality:

- for increased credibility of the process notes, they were scrutinised by the therapist's supervisor throughout the case;
- transferability was pursued by the method of research being a dense description of the case;
- to increase dependability, the researcher set about code-recode data analysis. This was achieved through separately creating two sets of themes for each session of the process notes a month apart. Thereafter, these sets of themes were compared and only the converging themes were included in the study; and
- triangulation and reflexivity addressed the confirmability of the study. Triangulation was built into the process through the therapist's supervision sessions. The results thereof can be seen in the therapist's attempts to converge his thoughts and those of the supervisor into coherent conceptualisations of the therapy process, the client and his problem. Above all, the study is an attempt at reflexivity. Throughout the study the author, as both therapist and researcher, reflected on his work, the processes and the relationship effects in order to increase its quality.

4.7 Ethical considerations

Informed consent was obtained from the client concerning the utilisation of the process notes for the purpose of research. An unsigned copy of the consent form is provided in Appendix A. Anonymity was assured. Any information that might reveal the client's true identity has been altered or omitted. Accordingly, a pseudonym is used, namely the first name John. Also for the purposes of anonymity the original process notes are not included in the study. The above is also a prerequisite of the University of Pretoria for conducting research with human participants.

In further concurrence with the ethical requirements of the university, permission for the use of the process notes was obtained from the relevant speech therapy practice. Attempts have been made to ensure the practice's anonymity upon their request. The ethics committee of the Faculty of Humanities approved the study (see Appendix B).

4.8 Conclusion

Although the original psychotherapy with a person who stutters was performed as part of practical work during the researcher's training as a Clinical Psychologist, it was never conducted without the required supervision by a senior psychologist (as set out by the Professional Board of Psychology). In this case a senior lecturer and Clinical Psychologist from the Department of Psychology conducted it.

In Chapter 5 the results of the study are discussed.

Chapter 5

Results

5.1 Introduction

In this chapter the results of the study are presented as an analysis of the process notes. The following format is used in the exposition and description of the results of the study: the sixteen sessions are individually examined beginning with their pre-planning phase. Thereafter the contents and process of the session is discussed. The themes that relate to the session, the self-reflecting process and the continuous post-planning phase in preparation for the subsequent session(s) ensue.

In an attempt to convey something of how these notes were written, the contents of each session are presented in the present tense. The rest of the analysis primarily focuses on the subsequent reviewing of these sessions, and is therefore presented in the past tense. As mentioned in Chapter 1, the use of italics to convey occurrences of self-reflexivity is deemed redundant in the current chapter due to its self-reflexive nature.

5.2 Session one

5.2.1 Pre-planning

The client was referred for psychotherapy by the speech therapy practice due to an apparent increase in his stuttering when conversing with his father. The reason for referral was primarily to help the client work through a possibly troublesome relationship with his father. Secondly, the referral was to assist him with his speech problem. The client was diagnosed with a severe stutter at the speech therapy practice.

At the time of the first session, I had received only four months of training in Clinical Psychology and psychotherapy. I was clearly a novice in the practice of psychology and felt quite inexperienced.

Despite attempting to not have expectations, I could not ignore the belief that the most effective way of reaching an understanding of the client's problem was to establish a therapeutic relationship. Informed by my training, I understood the latter as meaning that I was required to predominantly reflect emotions and express non-possessive warmth, accurate empathy and congruence (Rogers, 1951; Truax & Carkhuff, 1967). To me, not reacting in a manner that would lead to a "more of the same" situation (or behaviour), i.e., not to give the types of responses that would keep the client in his problematic interactions, was instrumental in trying to create an asocial space. While endeavouring to reach an understanding of the problem and how it was maintained, I did not want to participate in the maintenance of the problem. To attain this I decided that, wherever possible, I would use open-ended questions (e.g., "where would you like to begin?") and primarily focus on reflecting the client's emotions throughout the session.

5.2.2 Contents and process

The session opens with difficulty. The client seems to be pushing for a more social space by providing superficial answers to open-ended questions. I manoeuvre strongly for an asocial one. This leads to the client's confession of a problematic relationship with his father that is contrasted with his relationships with other people. I reflect his feelings of sadness and frustration, on which, to my amazement, he elaborates. While the client expresses sadness, I am also overcome by a feeling of sorrow. Although I notice that John also seems on the verge of tears, it is not shared.

The client stutters vehemently and continuously throughout the session, but I purposefully show no reaction to his speech deficit. Near the end of the session, John admits that I am the first person in whom he has confided regarding these troubles.

5.2.3 Themes

The following themes were identified in the first session:

- the client's interpersonal relationship with his father (this is described as problematic due to his father's impatience, yelling at him and lack of understanding);
- confrontation (specifically between John and his father);
- pressure (related to John's relationship with his father);
- the client's emotions were sadness and frustration (these related to the father-son relationship);
- stuttering (seen in the observations that the client's stuttering was extreme and continuous);
- the client's interpersonal relationships with other family members, specifically with his mother and sister (these were described as less problematic);
- the client's interpersonal relationships with friends (these were described as less problematic);
- inability to communicate;
- the therapeutic interventions were open-ended questions and reflection of emotions;
- the therapist's manoeuvres for an asocial space;
- the client's manoeuvres for a social space;
- directly referring to the therapist (as seen in the client's disclosure that the therapist was the first person in whom he had confided); and
- inability (the therapist's inability to cry, his struggle to create and maintain an asocial space, the shortcomings of the client's father and the client's struggle for fluency).

5.2.4 Self-reflection

I experienced the session as very difficult. I found it hard to establish an asocial atmosphere; the client continually manoeuvred for a social, friendly space. My feeling was that John had suppressed anger and that people rarely listened to him. I also noticed that his stuttering worsened when the conversation was more

emotional. The effects of the client's stuttering on me were immense: I felt as if I was losing control because of its continuous nature. At one point I had the urge to laugh, at another I was very bored and wanted to complete his sentences. I was overcome by sadness and even wanted to cry. I suspected that this feeling was related to my relationship with my father.

After the session I completed an interactional analysis to gain a better conceptualisation of the problem and of the client's position. I could not, however, answer many of the questions as I was feeling too overwhelmed. The analysis at that point in time looked as follows:

- a) how does the client speak to the therapist?
 - he stutters continuously and speaks monotonously. The stuttering is worse when talking about emotions or when the content of the conversation is laden with feelings;
 - when somewhat fluent he speaks very slowly and clearly; and
 - he shows almost no eye contact during the whole of the session.

- b) how does the client speak about the problem?
 - he seems to be saying that the problem has to be fixed; he seems hard on himself, yet seems to expect the solution to come from an external source; and
 - he comes across as frustrated, sad, and possibly even anxious and/or under pressure.

- c) what are the effects of the behaviour on the therapist?
 - at times his communication was boring;
 - I felt that I was not in control;
 - I wanted to complete his verbalisations; I felt anxious and impatient;
 - it was hard to keep on listening to him; and
 - it evoked strong feelings – I was very frustrated and sad afterwards.

- d) what is the nature of the client's relationships with others?
- the relationships seem superficial; it is like nobody listens to him;
 - the relationship with his father seems strained; he seems unable to deal with it; and
 - his relationship with me altered from social manipulation to frustration, sadness and, possibly also, agitation.
- e) what is achieved by the behaviour?
- ambivalence and uncertainty; and
 - frustration and sadness.
- f) what is the context of the therapeutic relationship?
- the relationship forms part of services offered at a speech therapy practice. Therefore, difficulties in speech are assumed to be the focus of interactions here; and
 - the context includes issues relevant to a person in the developmental phase of young adulthood.
- g) what are the strengths of the client?
- he is motivated (though uncertain of the prospects of change).

5.2.5 Continued post-planning

It was evident from the session that John's main concern was his relationship with his father. His biggest problem seemed to be his stuttering. I felt that I lacked a thorough understanding of this problem and of that which was maintaining it. I needed supervision. During the supervision, it was suggested that I tape-record the second session.

5.3 Session two

5.3.1 Pre-planning

I prepared to tape-record the session. I decided to continue focusing on understanding the problem and on establishing the therapeutic relationship.

5.3.2 Contents and process

I request John's consent for using the tape-recorder. Despite agreeing, he appears uncomfortable (strange facial expression and stiffened body language) and I decide to stop recording. I ask open-ended questions, explore what is said and reflect on John's emotions as being sadness and loneliness. John rejects the latter reflection. He asserts that his relationship with his father upsets him since such a relationship should not be problematic. I reframe this: "Your relationship with your father is very important to you." For John this is as it should be.

I reflect John's emotion as feeling pressured, which he rejects. I stay with this idea through a metaphor: while being in the bottom part of an hourglass, he finds himself enveloped by sand. He accepts this image, and replies that he is able to get out (albeit temporarily) to my suggestion that at times he wants to break the hourglass to escape. John comes to the conclusion that it is more precise to compare his experience to being sucked down into the hourglass. He supplants this with another metaphor: he is similar to Atlas; the world seems to reside on his shoulders.

5.3.3 Themes

The themes of the session are:

- the use of metaphors, specifically being in an hourglass and having the world on one's shoulders;
- the client's feelings are sadness, loneliness and of being under pressure;
- attempts at solving problems (as in temporary escape of a situation);
- the client's interpersonal relationship with his father;
- the client's views of how things should be (attitudes;.

- negotiation between the therapist and the client for a fit;
- the client assuming ownership (for an intervention);
- rejection of the therapist's interventions (at least four times);
- half-acceptance of the therapist's interventions;
- the therapist's adherence to interventions;
- the therapist's modification of interventions;
- the therapist's interventions during this session consisted of reflecting emotions, exploration, reframing and using metaphors; and
- working hard (or having to work hard). (As seen in the therapist's post-session self-reflections).

5.3.4 Self-reflection

I felt that my actions (including reframing the client's relationship with his father as important) were predominantly aimed at relieving the client and the father-son relationship of pressure. I could not understand my motives for this.

I wondered whether it was easier for John to speak of his feelings through metaphors and whether doing so was counter-productive. Yet, I felt satisfied since he had taken ownership of the metaphors. I berated myself for the scarcity of here-and-now interactions.

5.3.5 Continued post-planning

I felt that I had gained a better understanding of the client's position, in that I understood more of his emotions and his frame of reference (or attitudes). I felt worried that the therapy was becoming counter-productive. However, to my shame, I could not foresee an alternative approach. Supervision focused on my feelings of ineptitude and the themes of pressure and having to work hard. It was suggested that I was excessively pressuring both the process and myself.

5.4 Session three

5.4.1 Pre-planning

I decided to address the session as it presented itself. That is to say, I wanted to free myself of the pressure to intervene in a miraculous fashion, while still working to establish the therapeutic relationship and to understand the client and his problem.

5.4.2 Contents and process

I start with open-ended questions. (From this point onwards, unless stated differently, this can be taken as the way in which each session begins). John recounts an argument with his father wherein he did not retort. I tell him that I liked him not having to do anything in response. He half-accepts this.

John stutters extensively in acknowledging that the world weighed moderately on his shoulders during the last week. I ask him to comment on the world's position in the here-and-now. It is slightly present and I ask him to remove it. My attempt at facilitating a verbal expression of aggression towards the world is disallowed. I introduce symbolically applying pressure to John's shoulders at the level that the world rests there. This having been done, I say: "I want you to position your body as if the world was not on your shoulders." A fit is negotiated, at which point John exclaims a feeling of relief and reports that "the world is almost absent". He stutters significantly less.

5.4.3 Themes

Themes identified in session three are:

- stuttering (this is seen in the therapist's observations that John's stuttering fluctuated and seemed less than in the previous session);
- the metaphor of the world resting on the client's shoulders;
- the here-and-now (this is indirectly present through the Atlas metaphor);
- the therapist deliberately abandoning an intervention;
- inability (or failure);

- the therapist's adherence to an intervention (despite difficulties);
- direct confrontation (this can be seen in the session, i.e., the therapist confronting the client and the therapist pushing for the client to confront him and the "world on his shoulders", and outside of it, i.e., the client's argument with his father);
- the client's interpersonal relationship with his father;
- the client's behaviour outside of therapy;
- negotiating a fit;
- the therapist's interventions during this session were open-ended questions, reflection, reframing, confrontation (challenging), "go slowly", direct feedback (referring to the therapist as a person), metaphors, the physical acting out of a metaphor and the "as if" principle;
- body language, as part of the therapist's interventions;
- direct reference to the therapist (by the therapist);
- activity levels (the therapist felt, overall, that both he and the client were more active than before); and
- working hard (the levels seem to have fluctuated).

5.4.4 Self-reflection

Overall I felt satisfied that I was more effective in the session. However, I wondered whether I was becoming too adventurous and self-assured. Was the client ready for my interventions? My discomfort with the manoeuvre for direct verbal expression of aggression was apparent.

5.4.5 Continued post-planning

The structuring of power within the client's relationships was discussed in supervision. I felt very worried and unsure of myself after supervision

5.5 Session four

5.5.1 Pre-planning

I felt uncertain of my own value as a therapist and observer. I felt that I should approach the session in the same way as I had approached its predecessor – by focusing on building the therapeutic relationship and on what presented itself.

5.5.2 Contents and process

John jokingly rejects my open question. I continue with the intervention and he lists various reasons why, during the past week, he had not consciously considered his problem. He reacts on the bulk of my interventions by saying: “Interesting”. After one such a comment, John volunteers that he feels ill and that he had considered non-attendance. Exploration ensues, in which he affirms his commitment to therapy. I state that I would have understood his absence and that he may still leave. John rejects the latter suggestion.

I reintroduce the Atlas metaphor into the here-and-now. Negotiation ensues. John eventually states that the world is only partially resting on his shoulders. Upon request, he reflects this in his body language by sitting slightly forward. John reflects that he feels freer than last week, as if he is no longer stuck in a constricting pipe. His stuttering increases. By bending forward completely, I convey my perception of the world’s weight. We negotiate a fit somewhere in between our initial positions. Subsequently, I ask him to adjust his body language as if the world is absent. He complies and states that the world is still partially present. I relay my doubt as to the possibility of completely removing the world. Once more, he responds with an “interesting”.

5.5.3 Themes

The analysis of the process notes resulted in the following themes being identified:

- the client rejecting the therapist’s interventions;
- the client’s manoeuvres for a social space, e.g., jokes;

- the therapist's manoeuvres for an asocial space;
- the client only accepting one therapeutic intervention;
- the client half-accepting a few interventions;
- inability (or failure) (this relates to the therapist's inabilities);
- adhering to interventions (despite difficulties);
- the client's behaviour outside of therapy (e.g., studying, handling a snake and not tending to his problems);
- problem solving (in this case through escape);
- being more venturesome (the therapist speculates about both his and the client's increased risk taking);
- confrontation (this can be seen in client's indirect acts of confronting the therapist);
- non-attendance (this is discussed);
- commitment to therapy;
- the client's perception of how things should be (attitudes) – this relates to commitment to therapy;
- an early end to the session (this is discussed);
- the therapeutic interventions employed were: open-ended questions (open beginning), reflecting of emotions, exploration, direct feedback (referring to the therapist as a person), bringing the discussion into the here-and-now, acting out the Atlas metaphor, challenging the client, the "as if" principle and "go slowly" (questioning the client's abilities);
- the here-and-now (seen in the suggestion that the client may leave and in the Atlas metaphor);
- negotiation between the client and the therapist for a fit;
- the client taking ownership (here of a metaphor and by discussing his own opinions); and
- stuttering (the client's stuttering was much less pronounced during this session).

5.5.4 Self-reflection

The session was very frustrating. I felt hurt by John's joking reactions and his comments of "interesting", because I viewed them as rejections of my interventions. I felt that the client might have become more venturesome due to therapy. This might relate to my own increased risk-taking.

5.5.5 Continued post-planning

Supervision examined the possibility that John was starting to work with me as a person. It was suggested that he was confronting me in preparation of confronting his father. The discussion also focused on my decision to give interventions that are more physical in nature (by relating to his body), as well as others' reactions to the stuttering. This was connected to the strong reactions I had at times. It was suggested that I might be afraid of John, which I disagreed with. After supervision, I doubted the efficacy of the therapy. Apart from questioning my interventions, I began to question my observations and experiences.

5.6 Session five

5.6.1 Pre-planning

I felt apprehensive and had no idea what to expect or how I could effectively behave in the session.

5.6.2 Contents and process

John's speech therapist phoned me a few hours before the session to cancel on his behalf.

5.6.3 Themes

The themes identified in session five are listed below.

- non-attendance;
- the client's behaviour outside of therapy (in asking the speech therapist to contact the therapist); and

- the client's speech therapist.

5.6.4 Self-reflection

I felt there was a definite link between our discussion on non-attendance (session four) and John's cancelling. I felt hurt and rejected.

5.6.5 Continued post-planning

I felt uncertain as to what to do next and suspected that my understanding of the problem had not progressed sufficiently.

5.7 Session six

5.7.1 Pre-planning

I felt apprehensive towards the session. I also felt defiant – I wanted to prove that the suitability of my observations and interventions. I decided to give John my phone number so that he could contact me personally in future.

5.7.2 Contents and process

John is fifteen minutes late, to which I congruently reply that I was about to leave. He explains that he was involved in an accident. Despite his joking responses to my open-ended questions, I persist. He is uncertain where to begin and asks questions about my personal life. I state my appreciation for his interest. We negotiate whether he or I should be the focus of the session. An exploration of his inability to describe where he wants to begin ensues. I reflect his frustration. In exploring this, John explains his struggle in addressing this emotion, which he relays to the wrongfulness of showing it to people. Loneliness is also mentioned.

He discusses his use of and dissatisfaction with the interventions. I manoeuvre very strongly for direct feedback on my ineptitude, which he softens by saying that the results vary. I give a positive connotation to his evaluations, but continue to manoeuvre for stronger feedback. We decide that he will tell me if he disagrees with my suggestions and we will continue with therapy. I reintroduce

the Atlas metaphor and we conclude that the world is only slightly present in the here-and-now.

5.7.3 Themes

The following list constitutes the themes in the session:

- the client's emotions are loneliness and frustration;
- the client's behaviour outside of therapy (having an accident and almost losing a toe);
- being more venturesome (the therapist speculates about both his and the client's increased risk taking);
- the client's manoeuvres for a social space;
- the therapist's manoeuvres for an asocial space;
- the client's view of how things should be (attitudes) (this relates to expressing frustration);
- inability (seen in the therapist's inability to help the client, as well as the client's inability to begin the discussion and to express his feelings);
- the client directly referring to the therapist;
- switching roles;
- direct feedback (more reciprocal than before);
- confrontation (here this theme relates to confrontations between the therapist and the client);
- the client taking ownership;
- problem solving (in this case through direct confrontation);
- the negotiation of a fit;
- the here-and-now;
- the Atlas metaphor; and
- the therapeutic interventions used in this session relate to open-ended questions (open beginning), reflecting emotions, exploring, congruent feedback (referring to the therapist as a person), manoeuvring for direct

feedback, confrontation, bringing the discussion into the here-and-now, and the use of metaphors.

5.7.4 Self-reflection

John's inability to express frustration frightened me, as I feared not being able to handle this. Due to my belief in direct communication, I had put a lot of pressure on him to directly confront me. However, I felt that my fervour in this matter was disproportionate. I suspected that we were becoming impatient for results. I also considered that I had acted on feelings of aggression towards John's tardiness. This aggression seemed connected to the suggestion that John was busy working with me. I considered that John's stuttering might create a separation between his thoughts and his emotions.

5.7.5 Continued post-planning

John's management of frustration (or aggression) was examined in supervision. It seemed necessary to explore this with John. It was suggested that he might struggle to control his impulses. I experienced the supervision session as harsh: it indicated an over-emphasis on myself to the detriment of the therapeutic relationship in these discussions.

The necessity of providing direct feedback about the effects of John's stuttering became clear. This scared me. I thought that doing so might make him more aware of his stuttering and therefore create a more of the same situation. I also felt that the relationship just wasn't strong enough for this kind of feedback. I realised that I wanted to compel John to maintain eye contact while we were communicating.

5.8 Session seven

5.8.1 Pre-planning

I intended to continue building the therapeutic relationship. I wanted to relieve myself of pressure, so I again decided to play the session by ear.

5.8.2 Contents and process

John has concluded that the Atlas metaphor varies in its success. He rejects the attempt to explore the idea of success. I introduce the “role-play” of the Atlas metaphor at its worst. We negotiate a fit and re-play the scene three times. John explained that he feels depressed, frustrated and constricted at these times. The “world” is usually made up of one main and many smaller issues, he says. I suggest that he take the world apart and work through it one problem at a time. He agrees and explains that the bulk of the “world” usually relates to loneliness.

I suggest that we role-play me being one of the things he carries on his back. John reprimands me as a person who has wronged him through gossiping. Looking me straight in the eye, he tells me that he has a three-step plan in case the problem persists: the first time he would tell me not to do it again, the second time he would provide a warning and the third time he would inflict physical harm. I commend his eye contact during the role-play. John verbalises surprise. He states having read that maintaining eye contact while stuttering unnerves others, and that doing so embarrasses him. He accepts my offer for direct personal feedback that maintaining eye contact affirms the importance of what he is saying to me. He stutters profusely while saying that this is a new and valuable idea. I suggest repeating this statement while maintaining eye contact, which he does. I acknowledge the exertion in this and my acceptance of what he has said. I then provide a “go slowly” intervention by questioning his ability to keep eye contact outside therapy and suggesting that doing so is perhaps unnecessary. I acknowledge John’s hard work.

5.8.3 Themes

The analysis of session seven yielded the themes provided here.

- inability and ability (or success and failure);
- confrontation;
- direct feedback;
- the Atlas metaphor;

- problem solving (this is seen in the suggestion of addressing one problem at a time and in direct confrontation);
- the client's acceptance of therapeutic interventions;
- not undertaking an intervention (or timing) (this is seen in the therapist's deliberate decision not to link the client's stuttering to the Atlas metaphor);
- the client's feelings of loneliness and embarrassment;
- body language (i.e., eye contact);
- the therapist's interventions in this session consisted of open-ended questions (open beginning), reflecting emotions, the use of metaphors, manoeuvring for here-and-now interactions, role-playing, the "as if" principle (adjusting the client's body language), direct feedback (as in direct reference to the therapist as a person), challenges to the client and "go slowly";
- the client taking ownership (e.g., the client's evaluation of therapeutic interventions);
- negotiating a fit;
- stuttering;
- the client's interpersonal relationships in general;
- other people's reactions to the client's (stuttering) behaviour and his adjustment to these reactions;
- manoeuvres for self-sufficiency (seen in the therapist's acknowledgement of the client's hard work); and
- the here-and-now (seen in the direct feedback on the effects of eye contact).

5.8.4 Self-reflection

I did not link the Atlas metaphor with John's stuttering in this session deliberately, since I suspected that this would create excessive anxiety. Focusing on his eye contact was a corollary of the "as if" principle: if John kept eye contact *as if* he was not stuttering, he might stop stuttering. I felt pleased that maintaining eye contact allowed him to see my reaction to his stuttering. By the end of the session I was close to tears and had felt that a real breakthrough had been made.

It was difficult to remain with him consistently, and I believed that this was hard for him as well. Although I really liked that John was evaluating our work together, I speculated whether his criticisms were germane. Was something more or else called for?

5.8.5 Continued post-planning

During supervision I confronted my supervisor with my feelings of ineptitude from our previous discussion. He explained that he perceived me as not unquestioningly doing as I was told and applauded my work in therapy. After the supervision on session seven I felt it necessary to credit John for his efforts, while confirming my unconditional positive regard for him.

5.9 Session eight

5.9.1 Pre-planning

I was satisfied that the process was on the right track. I decided to continue to see what John brought to the session before choosing an intervention.

5.9.2 Contents and process

The session revolves around an up-coming job interview. John is scared that the interviewers' attitudes towards persons who stutter will be negative and that it will be the only thing that they take into account. He wants to know whether he should pre-emptively inform the interviewers of his stuttering. I explore these thoughts and feelings through an analogy (how would he act in a romantic relationship) and through a role-play (of such an interview) during which we switch roles. I re-emphasise the use of eye contact and challenge him to stutter as much as possible, which he eventually does. I curtail my reactions to the stuttering. To John's obvious amazement I praise him for stuttering so well. He admits to feeling calmer regarding the interview. I end the session early by saying that we should see how the interview goes.

5.9.3 Themes

The themes identified in the notes on this session are:

- work (or job interview);
- other peoples' reactions to the client's (stuttering) behaviour;
- self-disclosure;
- labelling;
- inability (or failure);
- the client's feelings were mainly (pre-emptive or anticipatory) fear and uncertainty, with amazement and increased calmness being outcomes;
- not doing more of the same;
- stuttering. (this is the first session in which the therapist directly addresses the stuttering with the client; the stuttering lessens significantly after the final intervention);
- direct feedback. (Here specifically regarding the stuttering);
- the client's perception of how things should be (attitudes) (this is seen in the value ascribed to pre-emptive self-disclosure);
- the therapist's interventions in this session are open-ended questions (open beginning), reflection of emotions, exploration, use of analogies, changing the client's body language, the "as if" principle, role-playing (including role reversal), prescribing the symptom, direct feedback (i.e., referring to the therapist as a person) positive reinforcement and positive connotation.
- body language;
- the therapist's adherence to interventions despite difficulties (or timing);
- working hard.
- responsibility;
- pressure (as in the presence and the reduction of pressure) (along with responsibility, this is also seen in the self-reflection process); and
- an early end to the session.

5.9.4 Self-reflection

On the whole, I was satisfied with what transpired. Yet, I was threatened by my uncertainty as to the best course of action regarding John's self-disclosure. I believed I needed to be able to provide him with these types of answers. I also felt that I would be responsible if he did not get the job. I was afraid to disclose these feelings to him.

It was difficult to provide direct feedback about John's stuttering for fear of maintaining the problem. Yet, I wondered if the challenges posed to me in the previous session allowed us to speak directly about the stuttering and allowed him to accept my interventions.

5.9.5 Continued post-planning

Since I thought that termination was drawing near, I felt that I needed to start preparing John for this event.

5.10 Session nine

5.10.1 Pre-planning

I intended to start preparing for termination. I wanted to talk about what happened with the job interview and about John's stuttering.

5.10.2 Contents and process

John is excited and playful in his manoeuvres for a social space. I reflect and explore these emotions, which he attributes to a romantic situation. He elaborates on this relationship and on the idea that his love interest does not have a problem with his stuttering. John does not react to me, even when I tell him that he is stuttering much less. I eventually praise his accomplishments in therapy and mention that termination is growing near. The next appointment is rescheduled to be in a fortnight.

5.10.3 Themes

A list of the themes is provided:

- the client's romantic interpersonal relationships;
- other people's reaction to the client's (stuttering) behaviour;
- the client's feelings during this session are mainly excitement and playfulness;
- the client's manoeuvres for a social space;
- the therapist's attempts at creating an asocial space;
- the therapist's struggle to adjust to the client's position;
- stuttering.(this is manifested in the client's low levels of stuttering);
- the here-and-now;
- direct feedback (here this theme relates to the client's stuttering);
- activity levels (the therapist's activity levels (being low) and those of the client (being high) are referred to);
- inability (as in the therapist's inability to adjust to the client and to get the client to respond to him);
- the therapeutic interventions in this session are open-ended questions (an open beginning), reflection of emotions, exploring, direct feedback (as in referring to the therapist as a person), prescribing the symptom and crediting the client with the successes in therapy;
- (preparing or negotiating for) termination; and
- the therapist's manoeuvres for the client's independence. (Credit for success).

5.10.4 Self-reflection

I could not understand why I was disappointment by John's manoeuvres for a social space. I suspected that it might relate to a belief that therapy always needs to be serious and to a feeling that I had worked hard to establish the relationship and an asocial space. I found myself at odds with John and struggled to remain with him, yet felt that I did not want to take away his excitement and happiness.

I noticed how little John had stuttered, so termination still seemed imminent. I was ambivalent: I felt both relieved (as the end of therapy was growing near) and irritated (as my expectations had been foiled).

5.10.5 Continued post-planning

As I believed that termination was within reach, I felt no need to continue planning past preparing myself for this event.

5.11 Session ten

5.11.1 Pre-planning

I meant to terminate; I was to re-emphasise all John's growth to date and to attribute it to his hard work.

5.11.2 Contents and process

John is sad because he was jilted and because of the manner that this was done. He agrees when I reflect on his deep affection for his former girlfriend. His stuttering is extreme (as in the first session). As he admits to loneliness, I remind him that we have discussed this feeling before. He usually feels lonely, he says. Despite his friends' tendency to not focus on his stuttering and his feeling that he can communicate with them (as with his mother and sister), John still feels lonely around them.

He is angry for being betrayed and used, and also for his inactivity. Upon exploring other possible reactions, we fall into a role-play in which, following my prompts for to him to retain eye contact, he congruently confronts the girl. He reports feeling better afterwards, while remaining angry. I relay my admiration for the congruent confrontation. John requests an early end to the session.

5.11.3 Themes

The following themes were identified:

- the client's romantic interpersonal relationships;

- loss;
- the client's interpersonal relationships with friends;
- the client's interpersonal relationships with other family members (mother and sister);
- others people's reactions to the client's (stuttering) behaviour (this relates to the client's friends not focusing on it);
- inability or failure (here this is manifested as the therapist's wrongful assumption that therapy was coming to an end and the failure of the romantic relationship);
- the client's feelings are sadness, a feeling of having been used, feeling betrayed and, most significantly, loneliness and anger;
- the ability to communicate (this is connected to the client's loneliness, as this ability does not alleviate the feeling);
- direct confrontation (as seen in the direct confrontation in the role-play);
- direct feedback (the therapist's approval for the confrontation);
- the here-and-now (related to the feedback);
- the therapeutic interventions in this session were initially reflections and explorations, but later included a role-play, adjusting the client's body language (eye contact), the "as if" principle, pushing for a direct confrontation (or congruent response) and direct feedback (i.e., referring to the therapist as a person);
- not undertaking an intervention (or timing) (this is present through the therapist not giving feedback about the stuttering);
- solving problems (through doing nothing and through direct confrontation);
- an early end to the session (on the client's request);
- the therapist going along with the client's manoeuvres (in allowing the early end to the session);
- working hard (both the therapist and the client had done so); and
- an early end to the session.

5.11.4 Self-reflection

I felt angry, sad and worried about John. I was disappointed, mostly because I had misjudged the end of therapy. I was exhausted and struggled to think back on the session. The romance to me became a plaster that was put over a deep wound, in that it solved John's problem superficially and temporarily.

5.11.5 Continued post-planning

In supervision I received an article by Oudshoorn (1977) dealing with interpersonal approaches to therapy with persons who stutter.

5.12 Session eleven

5.12.1 Pre-planning

I was scared to see John and had not read the Oudshoorn (1977) article.

5.12.2 Contents and process

John postpones the session for a week via a cellular phone text message. Then I telephonically reschedule the session for the next week.

5.12.3.Themes

The only theme in this session is non-attendance. (First the client and then the therapist cancel the session).

5.12.4 Self-reflection

John's reasons for cancelling worried me. I felt very bad when I had to cancel. I was preoccupied with and despondent about the case.

5.12.5 Continued post-planning

In supervision the possible functions of the client's (stuttering) behaviour and the possibility of a reframe for the client's problem were discussed. Oudshoorn (1977), who describes examples of effective strategic interventions on stuttering, suggests framing the stuttering as an act of aggression. I could not see the

intervention fit with the client and felt very possessive over the client and the therapeutic process. I concluded that, if there was indeed a fit between these suggestions and the therapeutic dyad, the timing was not right. I wondered whether I had done enough in session ten and whether John was coping.

5.13 Session twelve

5.13.1 Pre-planning

John's speech therapist told me that he had cancelled the previous session due to work responsibilities. I was relieved. Due to my disappointments earlier, I decided to play the session by ear again.

5.13.2 Contents and process

John explains how he confronted his ex-girlfriend as suggested. This apparently shocked her. We explore his continued anger and satisfaction regarding the situation. I comment on the decreased presence of the world on his shoulders, which he amplifies to it being absent. I congruently convey my admiration for John's initiation of and direct expression during the confrontation. I ascribe milestones in the therapy to his actions and mention that termination is approaching. We explore this, but I struggle to ascertain his reaction.

5.13.3 Themes

Session twelve contains the following themes:

- direct confrontation (or congruent feedback);
- the client's romantic interpersonal relationships;
- not undertaking an intervention (or timing) (i.e., not rectifying the client's perception that the therapist had suggested the confrontation and not talking about the client's stuttering);
- the client's emotion during this session was mainly relief, but he also felt indignation and joy (or enjoyment);
- stuttering (albeit implicit in that the therapist noticed fluctuations – it was at its lowest level during the discussion of the confrontation);

- the Atlas metaphor (this is seen in the discussion of its relative absence);
- negotiating a fit (the client adjusts the presence of the Atlas metaphor);
- the here-and-now (regarding the metaphor);
- the therapist's interventions in this session are open-ended questions (open beginning), exploring, re-introducing a metaphor, positive connotation, crediting the client (with change), and direct feedback (referring to the therapist as a person);
- (preparation or negotiation for) termination (this time termination is directly referred to);
- the therapist's manoeuvring for the client's independence;
- inability. (As in the therapist's inability to read the client's reactions);
- the client taking ownership. (This relates to the client initiating change); and
- an early end to the session.

5.13.4 Self-reflection

I did not rectify the assertion that I had suggested the confrontation, since I felt it less important than the confrontation itself. I felt that I should not comment on John's stuttering either. I was ambivalent about beginning preparations for termination: despite knowing that the year was coming to an end, I was scared that I was repeating my previous premature attempts at concluding therapy. (It was possible that I had moved on to this because I felt the need to do something and believed that therapy was stagnating). Yet, I felt that the preparations for termination were justified in preventing over-reliance on me.

I deeply believed that John deserved the credit he received and felt very satisfied regarding his ownership of and initiation of change. I recognised my efforts here as well. I had reservations and doubts though: why could I not give direct feedback about John's stuttering and why had we not spoken about his dad for the past few sessions? Why did I feel that something dramatic needed to happen in therapy? Did the little advances that were made not add up to something significant?

5.13.5 Continued post-planning

Supervision focused on the proposed reframe. I was still not convinced and decided to discuss the case in peer supervision with a student from another university. He described work that he had done with persons who stutter and also proposed seeing stuttering as an act of aggression. This preoccupied my thinking about the case.

5.14 Session thirteen

5.14.1 Pre-planning

I went into this session aiming to address what happens. I was also contemplating whether there was somehow a fit between the client and the suggestions made in supervision. I felt pressure to intervene in a dramatic manner.

5.14.2 Contents and process

The session begins awkwardly. I work very hard for something to happen and then become silent to alleviate this pressure. John articulates his work fatigue and the increased control he feels since living on his own. He says that he has been considering our work and has started to move the world off his shoulders. I respond that this is clear from his decreased stuttering in the last session. He felt less self-conscious and more relaxed, he says. I tell him that his body language was in line with these feelings. In doing so, I stammer and fall over my own words. I give John credit for the progress he has made, which he attempts to ascribe to my efforts. I reinforce the idea that, without his work, mine means nothing.

5.14.3. Themes

By analysing session thirteen the following themes were identified:

- working hard (and not working hard);
- moving away from home;
- work;

- the client's feelings during this session focus on exhaustion, relief, being in control, being less self-conscious and being more relaxed;
- control;
- switching roles (the two participants appear to have switched roles in that now the therapist was self-conscious and the client was in control);
- the therapeutic interventions in this session consist of open-ended questions (open beginning), sitting back (allowing the client to work), reflection, exploration, silence, direct feedback (directly referring to the therapist as a person), deliberately moving away from the here-and-now and giving credit to the client;
- not undertaking an intervention (this can be seen in not giving direct feedback);
- (preparing for) termination;
- the therapist's manoeuvring for the client's independence;
- the client's behaviour outside of therapy (i.e., his work, moving away from his parents and thinking about therapy);
- direct feedback (or confrontation) (as in the therapist addressing the stuttering);
- stuttering (the therapist's failed attempts at fluency and direct feedback on the client's stuttering);
- the client taking ownership (by reflecting upon therapy, re-introducing the Atlas metaphor and in asking open-ended questions);
- accepting the client's manoeuvres;
- rejecting the client's manoeuvres;
- the client's acceptance of therapeutic interventions;
- body language;
- inability (seen in the therapist's lack of fluency and inability to relate in the here-and-now); and
- an early end to the session.

5.14.4 Self-reflection

I felt that I had once again worked too hard. I speculated that my deliberate moving of the discussion out of the here-and-now was due to fear and the feeling that such feedback was inappropriate then. The session was uncomfortable. It felt like John and I had switched roles so that I became the self-conscious person on whom the focus fell. I feared that I had focused exceedingly upon myself throughout the process and felt that I was beginning to lose control. Why was control so important to me? I enjoyed John's attempt at sharing the credit.

5.14.5 Continued post-planning

Supervision concentrated on the function of John's stuttering and on how to reframe this behaviour. I was frustrated by my inability to comprehend the relational function of the stuttering.

5.15 Session fourteen

5.15.1 Pre-planning

My intentions were to concentrate on not working too hard and to determine whether the reframe of John's stuttering being an act of aggression truly was fitting.

5.15.2 Contents and process

John is excited as he had a very successful speech therapy session wherein he placed an order for coffee telephonically. The speech therapist enters and I accept the cup of coffee she offers. After her departure, I comment that John has a satisfying relationship with her. He adds that this is due to the ease with which they communicate and he juxtaposes it with our relationship in his feeling that, at times, there is too much focus on his stuttering. I comment that I have deliberately not focused on his stuttering, but that it has an effect on me.

I tell him that (although he will probably reject this) I believe that his stuttering is a way of angering people and of showing them that he is angry. "I think it is a

positive thing,” I say. John expresses shock. I explain that it is something additional to what other people can use to this effect. He recounts that he only began viewing his stuttering as something negative based on other people’s reactions. I endeavour to envelop everything he brings up in the frame. I reiterate the positive connotation. His body language (sitting forward and wide-eyed) betrays his excitement. I say that stuttering may not be the most effective way of getting what he wants, but that it is effective. He sits back and seems relieved. I convey how the congruent confrontation with his ex-girlfriend made his stuttering redundant at that time. I pre-empt his rejection of the intervention, but John accepts the reframe as making sense.

5.15.3 Themes

The themes in session fourteen are:

- the client’s relationship with his speech therapist;
- ability and inability (or failure and success) (in the juxtaposition of the two therapeutic relationships);
- the speech therapist’s manoeuvres for a social space;
- the therapist’s manoeuvres for an asocial spaces;
- ability to communicate. (I.e. ease of communication);
- the client’s feelings were excitement and, later, also shock and relief;
- the therapist intervened in the following ways: open-ended questions (open beginning), reflection of emotions, exploration, direct feedback (as in referring to the therapist as a person), “go slowly”, reframing and positive connotation;
- the therapist’s adherence to an intervention;
- timing (this is seen in the therapist’s perception that the right moment for the reframe had arrived);
- stuttering;
- other people’s reaction to the client’s (stuttering) behaviour;
- the client directly commenting on the relationship with the therapist;
- the client taking ownership of therapy (by using therapeutic techniques, e.g., exploration);

- direct feedback (or confrontation) (as in the therapist providing information regarding the effects of the client's stuttering);
- the function of the client's behaviour;
- an early end to the session; and
- working hard.

5.15.4 Self-reflection

I was careful not to see John's excitement as a sign that termination was growing near again. I became aware of the differences between John's speech therapist and myself regarding her social manoeuvres and my asocial manoeuvres. I was jealous of the type of relationship that she had with the client.

When John commented that our relationship did not focus on his stuttering, I felt that the timing was right to directly comment on his stuttering. I had ended the session early to provide time for the intervention to be absorbed and for the creation of links. I believed a breakthrough had been made and that I had done enough to reinforce the intervention.

5.15.5 Continued post-planning

I was satisfied with the session and conveyed this in supervision. I felt that termination was near.

5.16 Session fifteen

5.16.1 Pre-planning

I was convinced that this would be the last session. I needed to be cautious to not let this expectation negatively impact on the session, though.

5.16.2 Contents and process

John excitedly relays testing the reframe on his friends. Apparently they do not completely agree, which I "frame" as the doubts that I predicted. I add that his stuttering may be an expression of any of a variety of strong feelings, not just of

anger. John is more comfortable with this idea. I re-emphasise that his stuttering, as an interpersonal manoeuvre, is an advantage but that there are more effective ways of achieving his goals; he can begin experimenting with the latter. In agreement and in connection to fluently testing these ideas with his friends, John states that he has already started. I concur by reminding him of his fluent confrontation with his ex-girlfriend and of his fluent interaction with me in the here-and-now. I relate John's fluency in all of these examples to directly communicating about his emotions. He actively joins in with these ideas.

I attempt to pre-empt his coming doubts, which he rejects on the grounds that, in his words, "all of this really makes sense to me." I explain that other people disagreeing with these ideas do not invalidate them. I relate this phenomenon to the difficulties inherent in adapting to change in others, evident in how I have struggled to remain fluent in response to his increased fluency. John excitedly adds examples of similar experiences and accepts my submission that his stuttering is a gift that he can use at any time. We negotiate a two-week break so that he can have time to see how our conclusions fit into his life. I broach the probability of terminating within the next two sessions.

5.16.3 Themes

Session fifteen contains the following themes:

- negotiations between the client and the therapist for a fit;
- reaching a fit;
- the therapist's adherence to an intervention (here this is also seen across sessions);
- stuttering;
- the ability to communicate;
- the therapist adapting an intervention (as seen in widening the scope of the reframe);
- the client's half-acceptance an intervention;
- the client's acceptance of therapeutic interventions;

- the therapist's acceptance of the client's manoeuvres;
- the client taking ownership (here specifically of the reframe);
- the client's behaviour outside of therapy;
- all of the client's interpersonal relationships that have come up previously, including the relationship with the therapist;
- direct feedback and confrontation;
- other people's reaction to the client's (stuttering) behaviour;
- the function of the client's (stuttering) behaviour;
- problem solving (here seen in using stuttering to relay emotions and of experimenting with new behaviour);
- switching roles;
- the here-and-now;
- the client's main emotion is excitement;
- the therapist's interventions in session fifteen are open-ended questions (open beginning), direct feedback (referring to the therapist as a person), the here-and-now, reframing, positive connotation, enlargement of a previous intervention, a "go slowly" intervention (pre-empting doubt and the contradictory opinions of others) and giving examples;
- activity levels of both participants are high;
- success (this is in opposition to inability or failure); and
- (preparation or negotiation for) termination.

5.16.4 Self-reflection

I stuttered at times, until I expressed this experience to the client. I wondered whether the new frame I had given John was also a fit for me. I felt more relaxed and excited. I ascribed this to John's complete acceptance of my interventions and the achievement of a thorough fit. I felt that a two-week break would be enough time for John to metabolise what had happened, although I considered the possibility that this was enough time for our work to be undone.

5.16.5 Continued post-planning

I firmly believed that the intervention was going to stick. I struggled to allow the possibility of a setback in my planning. I decided to curtail this in favour of appraising the client's position at the beginning of the next session.

5.17 Session sixteen

5.17.1 Pre-planning

While leaving a modest amount of doubt alive, I felt that session sixteen would indeed be the last session in the process. I felt a need to verify whether the reframe had stuck and whether the client had reached a point where I was redundant.

5.17.2 Contents and process

John enthusiastically and fluently speaks of considering and acting in accordance with the interventions. He has begun expressing his feelings and purposefully experimenting with his degree of stuttering. "It all makes sense to me," he says. After approximately fifteen minutes I call attention to his achievements in therapy. In response he recognises my inputs. We come to the agreement that we created the outcome together. I reiterate the pivotal role that John's commitment and hard work has played. We decide that this is the last session, but that, if he so wishes, John can contact me to schedule a follow-up session. John thanks me for my help and I deliberately accept his gratitude.

5.17.3 Themes

The themes of the session are listed below:

- termination;
- stuttering;
- being able to communicate;
- other people's reactions to the client's (stuttering) behaviour;
- the function of the client's (stuttering) behaviour;

- problem solving (as in experimenting with different interpersonal manoeuvres);
- direct feedback (or confrontation);
- switching roles (the difficulties in changing established relationships are relevant here);
- the client taking ownership (of therapy);
- remaining with an intervention;
- negotiating a fit;
- accepting the other person's manoeuvres (i.e., both accept some of the credit for success);
- success (as opposed to inability or failure);
- the client's activity levels are much higher than those of the therapist;
- the therapist's interventions here are sitting back (allowing the client to work), crediting the client with the communal successes, accepting the client's manoeuvres (i.e., accepting credit), creating the possibility of another session despite termination, and moving into a more social space;
- a social space (manoeuvred for by both parties);
- the client's feelings are mainly excitement, relief and gratitude;
- allowing for a follow-up session; and
- an early end to the session.

5.17.4 Self-reflection

I had a strange feeling that I could only describe as “the wound having closed”, meaning that the relationship between the client and I felt foreign or as if we had moved on to a different level. Along with feeling in control, I took this as an indication that the time for termination had arrived. I felt that through terminating I had lost something of value, but that this was appropriate, since continued therapy would have been negative for both of us.

I felt ecstatic regarding the effective outcome: John was more fluent and I felt that I had made it possible for him to remain this way and/or to not be bothered by his stuttering.

5.17.5 Continued post-planning

I created the possibility of another session if John so requested, in order that related problems could be handled in the future and so that John did not feel abandoned. I suggested to the speech therapy practice that all of John's therapy be terminated completely with the understanding that he be allowed to initiate it again. This was done so that the possibility of more of the same happening through continued attention to his stuttering was minimised. I emphasised the importance of recognising John's achievements and of providing the opportunity for self-sufficiency. I believed that the latter included being trusted with knowing when he needed help and with finding it. I also congruently acknowledged the work of the practice in attaining success to prepare them for the loss of termination.

5.18 Follow-up

I spoke to John on four additional occasions, ranging from six to eighteen months after termination. The three initial conversations were telephonic, while the last was a brief personal meeting. In all but the last of the telephonic interactions, John was completely fluent. During the last phone call, John exhibited stuttering behaviour, but nowhere near the extent to which he had stuttered at the outset of therapy. Moreover, during the brief personal meeting, John did not exhibit any stuttering behaviour whatsoever and reported being well adjusted. Along with the satisfaction of the client and the staff at the practice, this is taken to mean that therapy was effective and that effective carry-over was achieved.

Chapter 6

Discussion of results, critique and recommendations

6.1 Introduction

At the outset of the final chapter of the study, the aims of the study (as discussed in Chapter 4) are provided as guidelines. To recap, the central aim of the study is, by means of self-reflexivity, to determine the efficacy of therapy with a person who stutters. The study aims to effectively analyse the process notes created during the therapeutic process. Thirdly, the study aims to examine the reciprocal relationship between the therapist and the client. Being descriptive is the fourth aim. The study is also aimed at furthering the theoretical and practical foundations of therapeutic work with persons who stutter. As a corollary aim, the study endeavours to advance the development of the researcher as a psychotherapist.

In accordance with these goals, the study's results are discussed below. In this chapter the use of first-person personal pronouns and the client's pseudonym are suspended to provide a more scientific quality to the discussion.

6.2 Discussion of results

6.2.1 Stuttering: a multifaceted phenomenon

In reviewing the preceding chapters, it becomes evident that stuttering is indeed a multifaceted and complex phenomenon. The behavioural, psychological and interpersonal components and implications of stuttering, as indicated in Chapter 3, are unmistakably present in the case study. An example that relates to the behavioural component of stuttering was experienced in the fluctuations in the client's stuttering (e.g., from the very extreme and continuous stuttering seen in session one to the pre-intervention fluency in session nine). The client's intense feelings of sadness (most notably in sessions one and two), loneliness (especially in sessions two, six, seven and ten) and frustration (particularly in sessions one and six) as well as the metaphorical world resting on his shoulders

are examples of the psychological dimensions of his stuttering. The client's avoidance behaviour (which will be discussed shortly) is also a manifestation of these psychological features. Furthermore the prominence of the client's problematic interpersonal relationships throughout therapy (especially regarding his father) and the interpersonal nature of the therapeutic process illustrate the interpersonal dimension of stuttering. The therapist seems to have tended to all of these factors.

While all of the proposed facets of stuttering were present throughout the process, a pattern of prominence does emerge. From the study it seems that the therapist initially focused primarily on the psychological elements of the problem (especially emotions). Thereafter, there was a shift towards the behavioural aspects of the client's stuttering (e.g., addressing body language and self-disclosure). (This shift did not necessarily exclude the emotional tones). Finally, prominence was given to the interpersonal aspects of the phenomenon.

6.2.2 Various phases of the therapeutic process

The therapy process can be divided into distinct sections. The first section of the therapy can be seen as a focus on building the therapeutic relationship. This stretched over a long time, as evident in the therapist's hesitance to make major interventions for the largest part of the process.

During the early phases, warmth, empathy and congruence, as the basic building blocks of a therapeutic relationship (Rogers, 1951; Truax & Carkhuff, 1967) were introduced. (Thereafter the therapist attempted to maintain these three elements throughout the process). In retrospect these conditions were crucial for the effective development and outcome of therapy. Their presence in other therapy processes involving stuttering is therefore advocated. Silverman and Zimmer (1982) support this contention (see Chapter 3) by describing the conditions for a therapeutic as warmth, empathy, openness and a willingness to listen. From the interactional/systemic model's point of view, there was an emphasis on an open

attitude (presentation) during therapy in an attempt to facilitate an understanding of the client's position and problem. The study supports, for example, the use of open-ended questions as a means to assist an open presentation (Nardone & Watzlawick, 1993).

Concurrent with the formation of the therapeutic relationship, the therapy shifted to include increasingly "venturesome" endeavours in the following phase. A period of exploring the client's frustrations in his relationship with his father (see session one) was followed by a period focusing on using metaphors as means of dealing with feelings, especially frustration (see sessions two through six). One session concentrating on the client's interactions (see session seven) is followed by a stage of working through short-term situations in the client's life (applying for a job and the failure of a romance) (see sessions eight through ten). The penultimate section of therapy (see sessions twelve to fifteen) concentrated on the client's stuttering along with his interactions with the therapist and other significant people. Finally, termination occurred after the sixteenth session.

Overlapping with all of these phases, is the therapist's attempt to understand the problem, including how the client saw and experienced it. This stage seems to have lasted throughout therapy. In contrast with Swart and Wiehahn's (1979) assumptions (as discussed in Chapter 2) of progressing and hierarchical processes, e.g., problem identification, problem exploration, problem analysis, goal setting and planning, these stages appear to overlap and most often be intertwined in the study. Nevertheless, as can be seen in Chapter 5, all of these phases appear to have been present. Similarly, constant evaluation of the process as proposed by Beyers (personal communication, 2002) and as discussed in Chapter 2 is also of importance. Constant evaluation is paralleled in how the therapist treated his understanding of the problem as "a work in progress" (or as working hypotheses). To summarise, the above appears to represent the interactional/systemic perspective's conceptualisation of a problem and the applicability thereof.

The theme(s) of confrontation and feedback appear frequently in the analysis of the process notes. In concurrence with the interactional/systemic assumption, it is apparent that the therapist's approach to the therapy (and the interpersonal process in supervision) was influenced by an inherent conviction that interactions of these kinds (i.e., confrontation and feedback) are essential for effective communication. Interactions in therapy became congruent over time. This culminated in the therapist conceptualising the client's behaviour in session four as attempts to experiment with confrontation in this relationship. It is possible to view this behaviour as trials in preparation of disagreements and confrontations with other people as well.

Nearing termination, the therapist came to the conclusion that the interpersonal aspects of stuttering were paramount for effective psychotherapy.

The following section addresses the stuttering both as a problem through the application of less effective solutions and as a less effective attempt at solving other problems. Furthermore, this section also addresses proposed implications of these ideas for therapy.

6.2.3 Stuttering: a difficulty that has become a problem

The interactional/systemic approach asserts that all communications have a relational function (Swart & Wiehahn, 1979). Aligning this idea with the discussion on the strategic school of thought (see Chapter 2), it can be said that all communications may be attempted solutions for specific (relational) problems. Following from the strategic model's supposition that ineffective attempted solutions maintain the problem (Nardone & Watzlawick, 1993), it appears that indiscriminate use of any communication in this regard may have a similar result. More importantly, it stands to reason that a person's communication practices may provide the therapist with information about the problem that is being maintained. Thus it seems that stuttering as an interpersonal phenomenon is preserved by other behaviours, and keeps certain other unresolved problems

intact. Combining these views of the strategic and the interactional/systemic models of therapy, this can be partially seen as an interpersonal conceptualisation of stuttering.

The case study, along with the preceding argument, gives support to viewing stuttering and the various behaviours of the client from an interpersonal perspective. Accordingly, the client's interactions (with the therapist and with others) were the foundation of conceptualising the problem. An example is the therapist's reaction to the stuttering: the therapist reacted to the client's stuttering by adapting his interactions with the client. Especially initially, this adapted behaviour included the therapist not reacting directly on his feelings seen in his being less directly confronting. An example of this is seen in how the therapist did not show his feelings of frustration to the client in session one.

The adapted responses to the client's behaviour can be considered the therapist's attempts at not creating a more of the same situation (Watzlawick, Weakland & Fisch, 1974). Creating an asocial space (a common theme in Chapter 5) may be similarly viewed. By his own acknowledgement, it was hard for the therapist to create an asocial space and a therapeutic relationship. It is possible that this relates to difficulties in attaining the trust of a person who stutters, i.e., persons who stutter are so used to being reacted to in a certain way, that it is difficult to convince them that other options are possible. This study seems to suggest that a "safe distance" needs to be maintained in the initial phases of therapy. The use of metaphors, gradually introducing the here-and-now and at focusing directly on stuttering are suggested means of achieving this. An example of this can be seen in how the therapist initially commented on the client's stuttering and the issue of fluency in the "there and then" of previous sessions rather than in the here-and-now (e.g., session thirteen). The gradual introduction of the here-and-now to the client follows an ebb-and-flow progression. This process can be seen in the following: the here-and-now was relatively prominent in session seven, relatively or completely absent in sessions

eight through twelve, minimally present in session thirteen, absent in session fourteen and then fully present in session fifteen.

The therapist's attempts at not creating a more of the same situation are juxtaposed with the negative result of ineffective attempts at solving a problem in the study. The latter can be seen in the client's recollection that, for him, his stuttering only became problematic due to the reactions of others (see session fourteen). This statement is in support of an interpersonal conceptualisation of stuttering behaviour and of the interactional/systemic model's assertion that difficulties in current interactions seem to originate in earlier and other interactions. Therefore, this submission also substantiates Oudshoorn's (1977) concept of secondary stuttering. In the literature study (Chapter 3) this concept was explained as long-term stuttering perpetuated by preoccupation. As suggested here, people in the client's life seem to have focused his attention on his stuttering behaviour. It seems plausible that these reactions fuelled stuttering as a behavioural pattern. Oudshoorn believes that stuttering is maintained through similar mechanisms, which cause stress.

Pressure to succeed (e.g., to be fluent) and pre-emptive fear (e.g., of stuttering) partially maintain. This specifically concerns the literature review in which related phenomena like stress, fear, frustration, aggression, guilt, insecurity and other so-called "negative" (for lack of a more appropriate word) emotions were discussed.

It seems at this point as if the reactions of other people to the person's stuttering play a significant role in maintaining the problem. Ineffective reactions to the stuttering leads the client to fear pre-emptively these reactions and to feel pressured to speak fluently. The reactions of the client's father to his stuttering (i.e., impatience, yelling at him and lack of understanding as seen in session one) and the therapist's sense that people tend not to listen to him (see session one) are examples of this phenomenon. Simultaneously, the suggestion that audience

reactions may maintain (or increase) stuttering may explain the therapist's decision to refrain from acting on his impulse to complete the client's stuttered sentences (see session one) and his initial discomfort with directly commenting on the client's stuttering.

The analysis also points to the importance of gradually communicating directly with the client in the here-and-now about, amongst other things, his impact on the therapist, his stuttering and the preferences of the therapist. On the other hand stuttering should not be the focus of the therapeutic interactions all the time. It is suggested that stuttering enter the discussion lightly during the initial phases of therapy until a trusting therapeutic relationship has been established. Manning's (1999) proposal (as discussed in the literature review) that an emphasis on the therapeutic relationship should override an over-reliance on therapeutic techniques, is relevant here.

Concerning the foregoing discussion, it seems easy to scapegoat an audience for their reactions and behaviours when confronted with a person who stutters. As mentioned in the literature review, a reciprocal process is maintained. The person who stutters and his audience are captured in an inescapable process of interactions and communications. In attempting to assist the client to become more fluent (starting from the first session), the therapist behaved in a manner that would probably not perpetuate the stuttering. It seems plausible that the client kept his own stuttering behaviour in place at least partially. An example of this is found in session eight in which the client seems to view his stuttering as the only obstacle in his up-coming job interview (see the discussion of Van Riper's (1982) "giant in chains" in Chapter 3). Manning's (1999) suggestion that stuttering eventually becomes a way of life is seen to be relevant here, as is Conture's (2001) assertion that the client may feel more comfortable with habitual inappropriate behaviour.

In the analysis of the process notes there seems to be a link with Turnbridge's (1994) suggestion that the person who stutters seems to work relentlessly, trying not to stutter. The reciprocal relationship between feelings and stuttering, suggested by Guitar (1998), is also especially relevant here, as it seems that the client's stuttering behaviour and the associated feelings of antagonism (toward the audience), frustration, and anticipatory anxiety created a vicious circle in which all of these elements were kept in place. This ties with the client's beliefs regarding how relationships should be (e.g., session two) as they pertain to the themes of pressure and inability.

The theme of problem solving was identified frequently in the analysis of the process notes. The client's less effective strategies of solving problems include escaping the situation (see sessions two and four), and doing "nothing" (see session ten). His counter-reaction to how others responded to his stuttering seems to include these two manoeuvres, as well as breaking eye contact (most notably relevant in session seven) and avoiding self-disclosure (see session eight). From the analysis it becomes clear that another of the less effective strategies that the client employed was to conceptualise and tend to his problems as one big problem (most notable in session seven). Seeing all problems as one big problem may relate to pressure and failure.

In the study it is suggested that, in spite of appearing arbitrary, a conglomerate of issues or problems is made more manageable by dividing it into smaller parts and addressing the parts individually. This idea is also set out in the literature study (when the interrelated psychological and relational aspects of stuttering are separately discussed) and in the method of research (where the different aspects of the process are broken up). This also shows how the process in therapy developed, first addressing the lesser aspects of a problem and gradually moving towards addressing the more complex ones. This process seems to have benefited the efficacy of therapy.

In summary the client's problem(s) seem to have related to interpersonal relationships and his style of behaving in these relationships. The results of the study imply that his stuttering and related behaviour can be viewed as being captured in rigid interactional roles. This rigidity at the outset of therapy can primarily be seen in the client's intense stuttering when emotionally salient aspects were addressed. The therapist's attempts at creating a different style of interaction can be viewed as behaviour towards the client as *if* the client was not a person who stutters. Initially, this behaviour did not change the client's stuttering and other behaviour sufficiently. This observation supports the interactional/systemic conceptualisation of psychological problems arising due to problematic interactional patterns, including deficient openness to communication (see Chapter 2). In addition, the client's initial retreat from these "new" types of interactions supports this model's suggestion that problems with free and direct expression are manifested in psychological problems. The therapist's interventions can be construed as attempts at attaining a shared flexibility in interactional roles and, therefore, at reaching a shared openness to the communication being exchanged.

Separate from viewing the maintenance of the client's stuttering as resulting from less effective attempts at alleviating it, it can also be seen as a less effective attempt at solving other relational problems. In the next section, this assertion comes under scrutiny.

6.2.4 Stuttering: a less effective solution

As previously discussed, Quick (1996) calls attention to the strategic model's assumption that a less effective solution is usually adhered to due to a social reason (see Chapter 3). This relates to the implicit assumption of the interactional/systemic theory that it is important to consider the functionality of behaviour. In Chapter 2 on epistemology it was stated that, taken as a whole, problematic interactions are often aimed at protecting the client emotionally.

The client's stuttering and stuttering-related behaviour seem to fit with these assumptions, although it took the therapist a long time to come to this conclusion (see the discussion of sessions fourteen and fifteen in Chapter 5). In additional retrospective self-reflecting (regarding session two amongst others) the therapist's motivations appear to be a desire to facilitate congruent emotional expression. The therapist came to view the function of the stuttering as follows: the client substituted the direct expression of feelings with stuttering. This appears to have served as protection from the consequences of such expressions, since it is not possible for the receivers in these interactions to hold someone responsible for feelings that are never expressed. Instead of emotions, it seems that the client's stuttering became the focus of interactions.

Nevertheless, stuttering as an interpersonal "strategy" does not appear to be effective. The client is left with constant feelings of sadness, loneliness and frustration. These seem to be the difficulties that the client attempted to address. In Chapter 3, Hayhow and Levy (1989) mention that stuttering can create a barrier between people. Letourneau's (1993) (in the same chapter) emphasises the importance of being able to express oneself verbally. The latter ties with O'Keefe (1996) and Starkweather and Ackerman's (1997) contention that the audience of stuttering mostly focus on the form of the message (the stuttering) and not on the content thereof. A prevalent theme in Chapter 5 is being able to communicate (see sessions one, ten, fourteen, fifteen and sixteen) and how individuals like his father react with anger and impatience towards stuttering (see session one). Therefore, since his interactions with other people still include negative feelings, stuttering, as a full-time interpersonal tactic, does not fit the client's situation completely. In conclusion, it seems that his stuttering facilitates interpersonal distance and the denial of feelings in order to protect him emotionally, while also being an attempt at alleviating feelings such as frustration and loneliness. It is also possible that the therapist's focus on warmth, empathy and congruence helped the client to realise that feelings per se are not problematic.

Despite the assertion that the client's stuttering is a less effective interpersonal manoeuvre and with reference to Quick (1996) (see Chapter 2), there are obvious advantages to this behaviour. The next section represents an attempt to clarify how these advantages can be taken into account.

6.2.5 Stuttering as a gift: a consideration of the advantages of stuttering

It is suggested that one of the reasons for the constructive shift in the process of psychotherapy was, through assistance in supervision, taking into account the possible advantages (or gains) for a person who stutters. This process considered stuttering as a manoeuvre that may disallow the person who stutters to engage in intimate relationships; it can be considered an escape mechanism and safeguard against emotional issues (e.g., conflict and confrontation). Although the effect of his stuttering related in feelings of frustration, anger and loneliness, the client benefited by not having to take full responsibility when relationships failed, or when he found himself in conflict situations.

It was decided to creatively use the intervention of reframing. The reasoning was as follows: because of its long duration, attempted solutions and "more of the same" nature, the client's stuttering could only be solved if approached from a second-order change perspective. The intervention had to meet the requirements for an intervention on a second-order change level, as a consequence. Watzlawick, Weakland and Fisch (1974) state that what appears to be the solution from a first-order change perspective, from a second-order change perspective "reveals itself as the keystone of the problem whose solution is attempted" (p. 82). Secondly, these authors state that first-order change always appears to be based on common sense. Second-order change usually appears "weird, unexpected, and uncommonsensical"; there is a "puzzling, paradoxical element in the process of change" (p. 81). The attempted solution (or first-order solution) should be dealt with in the here-and-now and should be placed in a different frame.

After discussions, considerations and deliberations in supervision, it was decided to reframe the client's stuttering as "a gift" – a second-order change strategy. As this idea was also a personal reflection, it is presented as such in the following paragraph:

I now understand that reframing the client's stuttering as a gift was in fact a manifestation of the "as if" principle: by stating that and behaving as if his stuttering was constructive, my view of his stuttering came in line with this notion. The change in me then allowed us to reach a point where the client could substitute his stuttering with other behaviours, while not disallowing his old stuttering behaviour altogether. The reframed manoeuvre removed the pressure to be fluent "from his shoulders".

From the strategic school of therapy's point of view (see Chapter 2), the intervention shifted to a second-order change level. This means that the relationships between the client, his feelings, his stuttering and the people he interacts with, were changed from one in which stuttering was negative and unaccepted to one in which it served a positive function. The relative peculiarity of the intervention due to its second-order nature should also be noted (Watzlawick, Weakland & Fisch, 1974). Haley's (1963) conceptualisation of control in a relationship is also relevant, in that that the therapist's acceptance of the client's stuttering behaviour as an interpersonal manoeuvre seems to have put the therapist in control of defining the relationship. This seems to have allowed the therapist to affect change.

Forthcoming from this discussion it seems that to work with persons who stutter change in the client appears to be inspired by change in the therapist's behaviour. This suggestion seems to explain why interpersonal therapy emphasises the role of the therapist in bringing about change. In essence, changing the behaviour of the therapist so as to change the behaviour of the client is what the strategic approach to therapy calls a strategy. The (re)actions of

the therapist can thus be viewed as the “tools” for bringing about change, and an asocial context is created (as proposed by the interactional/systemic school of thought). Another example of asocial context can be seen in session thirteen, when the therapist “sat back” instead of working hard for something to happen. This seems to have created an opportunity for the client to do something. In addition, this affirms the assertions of the interpersonal models, as well as those of Van Riper (1982), that a therapist is central in attaining change. In this regard, it is appropriate to reiterate the therapist’s suggestion to the client: fluency (or not stuttering) is not the overarching goal of therapy. This statement can be reframed: the goal of therapy with people who stutter is to provide possibilities for a wider repertoire of behaviour. The positive outcome of the reframe is that the client can experiment with different ways of relating (as seen in the last three sessions).

The focus of the discussion now turns directly to the implications of the study for psychotherapy.

6.2.6 Additional implications for therapy

Taken with the manner in which the themes of pressure and of inability (failure) and success seem to intertwine with the client’s stuttering behaviour, it is proposed that patience is a significant tool for the therapist working with persons who stutter.

In reviewing the results of the study, it appears that timing was an important factor in the process of therapy. As such, timing relates to the many times the therapist did not undertake an intervention or felt that an intervention did not fit at that point in time, as well as to the moments when he chose to intervene. This also relates to adjusting to the client’s position, since the client’s actions in session nine can be viewed as an attempt to decelerate the pace of the therapy. In comparison to subsequent therapy processes, the pace of the whole process seemed slow to the therapist. The ebb-and-flow introduction of the here-and-now

(as previously discussed), the length of each session (i.e., a short or a full session) and creating the possibility for a follow-up session (see session sixteen) appear to be instances of adjusting to the client's position.

Persons who stutter may in fact require more patience and the therapist should be aware of timing as a strategy. The proposed patience is a key element in therapy concerned with stuttering and presents only half of the more comprehensive picture, in which the therapist needs to adapt the pace of therapy. This would mean that, as in session fourteen and fifteen, there are moments when timing requires the therapist to quicken the pace dramatically.

Patience and timing seem directly connected to the various moments when the therapist chose to remain with, adapt or abandon an intervention. Associated with this idea is the assumption inherent in interpersonal therapy that, by consistently behaving in a manner that is not conducive to the status quo, the therapist will induce change. However, it also relates to the theme of negotiating a fit with the client. It seems necessary for the therapist to discern when to adapt or abandon an intervention that does not fit the client. Judging by the therapist's self-reflexive ruminations, this seems a difficult task. That is to say, consistency and adaptability both seem essential for change to occur. Also, this seems to suggest that self-reflexivity is an important tool to abet this process.

In its totality, timing can therefore be brought in line with Manning's (1999) view that the therapist working with stuttering should concentrate on being in sync with his client, on appropriate timing and on therapeutic decision-making. It is also possible that a part of the therapeutic process involves balancing the therapist's planning with the position taken by the client. To explicate: despite the need for continued planning, it seems necessary that the therapist not be blinded to the position of the client (in the here-and-now) by his expectations of the therapy. An example of this can be seen in the therapist's planned tape recording of session two, and the reversal of this decision due to the client's reaction. Another

example is the therapist's struggle to adjust to the client's position due to his expectations (e.g., session nine). This discussion points to the complexities of the psychotherapeutic process.

The pervasiveness of the therapist and the client's negotiations point to the importance of allowing the client to influence the therapist's manoeuvres and conceptualisations. There is a link with the aspect of continued evaluation of the process – allowing or disallowing the client to directly influence the course of the therapeutic process requires continued evaluation.

The study emphasises the importance of allowing the client to test the therapist (e.g., the discussion of the acceptability of not coming to therapy in session four and the client's subsequent cancellation of session five). It is only in retrospect that the parallels between the therapist's relationships with the client and with his supervisor become evident (see, for example, session seven). The complexity of the therapeutic process can also be seen in the suggestion that therapy is a process that involves more role players than just the client and the therapist, e.g., the client's significant others and the therapist's supervisor. This is exemplified in the anxiety created in the therapist's relationship with his supervisor that was consequently brought into the therapeutic dyad. It is thus evident in the results chapter that these extra-therapy relationships have a strong bearing on what transpires in the process. The therapist should take these complexities into consideration.

Another complexity in therapy is the difficulties in creating and maintaining change. The former can be seen in how the therapist found it hard to be fluent in reaction to the client's increased fluency. As the therapist suggested then, it seems that once a relationship has been established as consisting of a person who is fluent and one who is not, this definition is difficult to change. This also appears evident in the reactions of other people to the client's increased fluency as discussed in the same session, and the theme of switching roles in the

analysis of sessions six, eight, thirteen, fifteen and sixteen. The theme of the therapist manoeuvring for the client's independence points to the importance of mechanisms for maintaining change. The therapist's attempts to this effect in Chapter 5 suggest that if the client believes that he is responsible for the new behaviour, it is easier for him to replicate this behaviour on his own. This idea is also seen in the frequent use of "go slowly" interventions in the study.

In the literature study, Curlee's (1999) notion was discussed: each client should be appreciated as and treated as a unique individual. It is clear in the chapter on the results that the therapist wanted to come to his own understanding of the client and his problems; this is exemplified in the rejection of his supervisor's suggested interventions from session ten despite this being an agreement. There seems to have been an initial ill fit between the client and the therapist based on the therapist's lack of knowledge and experience regarding stuttering. This ignorance probably allowed the therapist to approach the client as a unique individual, and can be deemed positive.

The results of the study confirm the ideas and suggestions of many authors as discussed in Chapters 2 and 3, e.g. to see the person who stutters as a unique individual with unique problems. Approaching each client as unique does not invalidate the applicability of the findings of the study to other cases, though. It does, however, serve as an admonition against over-generalising the process and subsequent suggestions: there are certain deductions that can be made from the study with relative certainty. However, certain aspects of this case are set as idiosyncratic. Thus, whereas the statement that stuttering possesses an interactional function may be applicable in general, not all stuttering is necessarily an expression of emotion. Similarly, the view that stuttering is maintained by people's reactions to it is probably more universal than the suggestion that all therapists who work with stuttering should make use of interpersonal therapy. This suggests that a therapist needs to be in tune with himself and his own client and to take cognisance of other assessments (or

perceptions) of the process and to consider other similar processes. The study is thus relevant for other therapists working with stuttering.

By emphasising the individuality of each client, the study also purports trusting the client and not assuming responsibility for him. This is evident in the positive results attained by allowing the client to experiment with new behaviour on his own, by allowing the client to take the consequences of his actions and by fostering independence from the therapist. The latter was mostly accomplished by crediting the client with successes (essentially in the last few sessions). In as much as these suggestions can be made applicable, it seems beneficial for the therapist to be responsible to the client, without taking responsibility for the client.

In all, the study seems to support the use of self-reflexivity as a tool for the therapist as researcher and the researcher as therapist alike as this relates to Beyers' (1981) suggestion that these roles should oscillate (see Chapter 2). The use of the process of self-reflexivity (or personally and systematically reflecting on reciprocal influences on a process) seems to have not only served the purposes of the study, but also the purposes of the therapeutic process recounted in the study. That is to say, this process has illuminated the process of therapy with a person who stutters through the study and has proved a valuable input into the actions of the therapist and the development of said therapeutic process. In this manner, the process notes, the supervision discussions and the study can all be seen as part of a larger self-reflexive process.

It is possible to view the process of therapy from the perspective of Keeney (1983) in that the observer and the observed reciprocally influence each other (which was discussed as part of the study's epistemology). It may therefore be appropriate to view the outcome of this process as a co-creation between the client and the therapist. This can be directly linked to the recurrent theme of the client taking ownership (especially from session six onwards). In this, the eventual fit negotiated between these two role-players for sharing recognition for

the achievements in therapy seems sensible. Yet this co-creative process has also been made applicable to the process between the researcher and the research. The above points to the relativity of all observations. Viewing this from a constructivist position, as upheld by the strategic school of therapy (see Chapter 2) the research is proposing one key that, in the specific case involving himself (as therapist), the client and the client's stuttering, seems to fit the facts. Therefore, it is proposed that different keys (i.e., views) may in fact fit the same lock (i.e., more objective facts or certainties) equally effectively or even more so. This fit relates to the client and to stuttering, as well as to other clients who stutter. In saying this, deliberate reference is made to the suggestion that all clients are unique individuals and that their problems are also unique. Relating this discussion to the research as a whole, the co-creative process between the researcher and the reader of this research also becomes evident: the reader needs to ascertain whether and in what manner the key(s) provided in the study fit the lock(s) of the reader's "reality".

The self-reflective process seems to lend support to the suggestions in the literature review, e.g., by Curlee (1999), that the process of therapy with a person who stutters is a difficult process. However, these reflections also seem to suggest that it is potentially very rewarding. Before a final conclusion is presented, it is important to consider the limitations of the current study and suggestions for future studies.

6.2.7 Conclusion

The current study supports the view that stuttering is a multifaceted phenomenon and suggests that therapy aimed at alleviating stuttering is a complex endeavour. Accordingly, the study seems to substantiate the work of Manning (1999). As discussed in the literature review, Manning suggests that a change in stuttering behaviour needs to be sustained through relevant changes in feelings, attitudes and other psychological aspects. As such, support for the previously discussed proposal by Neilson (1999) that such an approach should incorporate the affect,

behaviour and cognition of the client is also evident. If we consider the work of the speech therapy practice as part of the process described in the study, we see the significance of Bloom and Cooperman's (1999) contention (discussed in the same chapter). To recap, these authors state that therapy concerning stuttering should include the cognitive, affective, linguistic, motor and social aspects of the phenomenon.

Thus, stuttering is seen to be a multifaceted phenomenon requiring a multifaceted intervention. It is suggested that the interpersonal approach to psychotherapy, in combining the assumptions and techniques of the strategic and interactional/systemic models, is an effective way of tending to the multiple facets of stuttering. The study suggests that warmth, empathy, congruence, patience, therapeutic decision-making and timing are crucial to this psychotherapeutic process. In addition, the study proposes that self-reflexivity is an effective way of facilitating this process.

6.3 Critique and suggestions

From a positivistic paradigm (or point of view) various objections and criticisms can be brought against a study of this nature. However, one of the aims of the study was to be descriptive in the examination of an interpersonal therapeutic process. Only a qualitative study of this nature can attempt to:

- analyse a process in its development over time;
- transcend content and to concentrate on circular and reciprocal processes; and
- move to a "higher level" of analysis;

In relation to the latter, this means to:

- rethink the development, over a period of six months or sixteen sessions, of a psychotherapeutic process; and
- leave the reader with creative ideas on the efficacy of therapy with a person with a speech problem, such as stuttering, by means of a reflexive process.

Nevertheless, my own criticism is that, because I was in the beginning phase of my training to become a psychotherapist/Clinical Psychologist:

- I realise in retrospect that my process notes can be described as sparse, and that they could have contained more meta-comments on the process;
- secondly, the interactional analysis was also very limited and there was a paucity in the descriptive nature of its contents; and
- thirdly, the discussions and deliberations in supervision were not recorded and only the slightest of these interactions, as I could recollect, could be taken into account for the execution of the study.

Although the intention of the study was to focus on the psychotherapeutic process, inclusion of the remedial work of the speech therapy practice could have added to a more comprehensive picture and “healing” process of the client. This could also, for future purposes, have enhanced the multidisciplinary complex process with speech problems and how it could be approached. Despite this, the scope of a thesis of this nature is limited, as the research is only one part of a coursework Masters degree in Clinical Psychology.

6.4 Conclusion

A secondary aim of the experience gained in undertaking the study (and the therapeutic process) was facilitating my own development as Clinical Psychologist and, more so, as psychotherapist (as stated in Chapter 4). It is apparent that I have learned the value of being a practitioner as well as a scientist. With this I mean that practice, as in psychotherapy, requires not only a philosophical or theoretical foundation. In order to be clinically responsible, practice should also be grounded scientifically. The notion of working from “the gut” may be applicable to the practice of psychotherapy, but I believe that, if the effects of working “on a gut level” cannot be explained conceptually, questioned and/or analysed, psychotherapy (in the words of Truax and Carkhuff, 1967) may be “for the worse”.

The learning experience of this case brought me to an understanding of the complexities of human behaviour and of people's lives as well as their problems. It also brought me to the position where I believe that all people should be respected and valued. It does not matter how intensely you struggle to understand, or are impatient with or even frustrated by a client, the person is a person of value and of quality. Acknowledging, not necessarily sharing, your own feelings during psychotherapy allows for higher levels of congruence (Truax & Carkhuff, 1967). Therefore, I have also learned that congruence is important in general, but especially in all psychological endeavours with patients. In its simplest form congruence means to be yourself. Accordingly, strategies as your own behavioural manoeuvres in relation to a client should fit with your own style and behaviours, or should be acquired over time in order to assure that these behaviours are expanded and flexible to suit the therapeutic context congruently.

To conclude, it is not only the client (or patient) that benefits from psychotherapy. Through thorough self-reflexivity the psychotherapist gains knowledge, experience and wisdom.

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Appendix A
Letter of consent (unsigned)

Department of Psychology
Faculty of Humanities
University of Pretoria
0002

Jacques L Labuschagne (Researcher)
P.O. Box 70143
The Willows
0041

LETTER OF CONSENT

I, the undersigned, consent to participate in the research study to be conducted by Mr Jacques L. Labuschagne, a Masters degree candidate at the University of Pretoria. I recognise that the goal of the study concerned here is to facilitate a better understanding of the process of stuttering and that it is preliminarily titled Psychotherapy with a person who stutters from an interpersonal perspective.

I thus consent to the use of all documents and reports that accrued during the period of my treatment at the Communication Pathology Clinic for the purpose of research. The specific sessions of psychotherapy and the notes thereof were from my participation in treatment during the year 2002 in the Department of Communication Pathology, University of Pretoria. The researcher may make reference to communications between us and may access my patient files at the Department of Communication Pathology. It is my understanding that my personal information will be treated with the strictest possible form of confidentiality and anonymity. I take this to mean that, in writing up the study, the researcher will take care to not make my personal identity or situation(s) known. It is my perception that this will be put into action by the omission of or changing of specific facts as far as possible. The researcher, the researcher's supervisor and both the Departments of Psychology and Speech Pathology will be the only parties with access to my personal information. I therefor also acknowledge that I

consent to these practices. The foregoing taken into account, I give the researcher my permission to use the information as part of his dissertation and in any possible subsequent publications provided that confidentiality is guaranteed.

I am older than 21 years of age and am therefore legally signing this document on my own behalf. I also state that I sign this document and agree to its implications completely of my own free will. I see this as meaning that the researcher did not force me to take part in this study and that the special relationship that exists between psychotherapist and client was not abused in obtaining my co-operation. I also acknowledge being given the choice not to participate. I am aware that I will receive no compensation for my participation. It has been made clear to me and I recognise that I may withdraw my permission from this study at any time if I so choose and that there will be no negative repercussions to myself if I decide to do so.

I am aware that I am able to contact the researcher at any time at the above address or through the Department of Psychology.

Participant

Date

Place

I have taken care to explain, to the best of my current knowledge, the implications of the proposed study to the participant. I have made it clear to him that his participation is totally voluntary and that he may refuse participation or withdraw from it at any time if he wishes to do so. In addition I feel that I have made it clear that I will do my best to protect his rights as a participant in this study and also as a former client of mine. These include his rights to confidentiality, anonymity and to dignity.

Jacques L Labuschagne
Researcher

Date

Place

Appendix B
Letter of ethical clearance