
Stammering and the Social Model of Disability: Challenge and Opportunity

Katy Bailey\textsuperscript{a}, St John Harris\textsuperscript{a}, Sam Simpson\textsuperscript{b}* 

\textsuperscript{a} Free Speech, United Kingdom (www.free-speech.org.uk) 
\textsuperscript{b} intandem, United Kingdom (www.intandem.co.uk) 

Abstract

The authors introduce, explain and recommend engagement with the social model of disability; a theory developed by disabled people through reflection on their own lived experience. Separating the impairment from the process of disability, the relevance of this model in relation to stammering and speech and language therapy is explored, along with current relevant writing in the disability field. The authors reflect on their personal journeys in relation to the social model, and identify approaches to stammering therapy that are consistent with this perspective. To conclude, the authors emphasize the importance and potential value for therapists of engaging with the current discourse among people who stammer in the wider stammering world, and leave the reader with some challenging questions for personal reflection.

Keywords: barriers; disability; disablism; dysfluency; impairment; medical model; internalised oppression; social model; stigma; stuttering

1. Introduction

This paper examines how the social model of disability can inform and extend our understanding of stammering and therapy, and raises some key questions to stimulate further discussion. Katy Bailey initially traces the
development of the social model of disability and explores its relevance to the experience of stammering. Sam Simpson continues by considering the ways in which a social model perspective challenges traditional notions of therapy and the role of the therapist. St John Harris then demonstrates how the social model can offer us new ways of conceptualizing stammering and, how a variety of approaches consistent with a social model view of stammering can support people who stammer, both individually and collectively, to overcome the stigma and self-oppression, which so often characterises the condition.

The three presenters bring diverse perspectives from our personal experiences of stammering, therapy and research; but what unites us is a shared conviction of the significance of the social model of disability. To maintain the personal voice chosen for the presentation, sections of this document are written in the first person. To orientate the reader to the particular speaker where this is the case, names are provided to delineate each section presented.

2. Defining Disability (Katy Bailey)

I am disabled, sometimes a lot, sometimes not very much at all. People who are disabled have impairments; these are from conditions, differences or illnesses, such as multiple sclerosis, a spinal injury, a facial disfigurement or dysfluent speech. Disability describes the disadvantage and reduced opportunities experienced by people who have impairments, compared to the general population. As individuals, families, communities and societies the things we choose to do to reduce disability depends on what we think causes it.

2.1 Individual models of disability

Individual models of disability, such as the medical model, remain dominant, stating that the impairment obviously explains, and causes, the disability. In a traditional medical model view the person with an impairment simply has a body that cannot do certain things normally and, therefore, the person is disabled. They consequently experience decreased opportunity to engage in work and wider society, resulting in decreased living standards and social prospects. To decrease disability in this model the obvious need is for expertise in the various impairments, so that they can either be prevented, cured, ameliorated with therapy or the person can be cared for, leading to spending on creating expertise, providing medical treatments, therapists and carers.

2.2 Social model of disability

In contrast, the social model of disability states that the impairment and the disability are different and separate, and that disability does not follow automatically from impairment. The social model of disability was developed in the context of the disabled people's movement. The defining of the social model by Mike Oliver in 1990 was a late stage in its development. The earlier theorising, beginning with Paul Hunt (1966), largely took place within a group of disabled people, mostly living in segregated accommodation, in the Union of the Physically Impaired Against Segregation (UPIAS) (Campbell & Oliver, 1996). UPIAS developed what was then called the ‘social oppression theory of disability’, through reflection on their own lives, and recognition of their shared experience of disability; theorising to produce knowledge which retains a link to lived experience (Finkelstein 2002).

The social model states that disability is a process. The disability that a person with an impairment experiences is due to the physical, structural and cultural barriers they face, and is separate to the impairment. Some impairments, including arthritis and multiple sclerosis, involve pain and unpleasant symptoms that the person experiences alongside the disability. There are other conditions, such as a stable amputation, a facial deformity or an increased level of dysfluency, that may not in themselves be unpleasant or painful and people with these conditions experience only disability in relation to their impairments. There are also people with impairments who are sometimes not disabled, if and when they truly encounter no barriers. Unlike the medical model, the social model can theorise a possible future with greatly reduced disability or without disability.

Some physical barriers are obvious and easily identified, however others are more subtle, such as the negative attitudes present in society about impairments. Disability includes the effect of these attitudes when they are internalised by the person with the impairment, in a process called internalised oppression. To decrease disability the obvious need is for expertise in these barriers, so that they can be removed or reduced, requiring spending on
identifying and removing or reducing barriers. So who are the experts in barriers? I would say the people who experience them first hand.

I wish to emphasise again the context of the development of the social model by disabled people discussing their own experience of barriers. It is not just another interesting piece of theory; it is inextricably linked to the on-going demands of the disabled people's movement for the removal of barriers (Bailey 2004).

2.3 The social model and stammering

So how does the social model explain the situation for people who stammer? Stammering is used as an illustrative example in early writings about the social model (Oliver 1990). The impairment is the underlying dysfluency. With a social model understanding, the difficulties that a dysfluent person experiences in life are due to a process of disability separate to the impairment: the disability is due to the particular barriers the person faces rather than due to their dysfluent speech per se. What do these barriers look like for dysfluent people? There are some physical barriers to our different sounding speech e.g. not being able to be understood by computers in automated calls. However, the powerful barriers are about attitudes, both the external barriers fuelled by negative social attitudes to dysfluency and the self limitation of internalised oppression due to the person absorbing negative attitudes dominant in our society. There are many examples of discrimination due to negative attitudes about stammering. I have been turned down by universities and an employer in the past. However, the effects of our own internalised attitudes about dysfluency are often more significant; people who stammer themselves can be among those with the most negative attitudes towards dysfluency. Part of the internalised oppression is an increased sensitivity to our own impairment, to our dysfluency, that interrupts the 'perfect' version of speech we hold in our imagination. We can be the first to judge our speech harshly, often before a word or sound is formed. How do these barriers show themselves? Wendell Johnson said, “stuttering is what you do trying not to stutter again” (cited in Fraser, 1978; pg19). I can push, pull, and do all sorts of things when I speak to try to get a word out the way I think is should sound, with the 'correct' rhythm, timbre and power. Struggle behaviour is a response to the disabling environment, experienced through the lens of internalised oppression. It is about desperately wanting to talk and be the 'correct' way. So struggle behaviour, and avoidance are an integral part of the disability process.

Understanding of stammering has been held back, and individuals who stammer have long been troubled by the inconsistency of stammering. Stammering is typically described as a variable impairment, but I dispute this. Because the variability is in the things the person who stammers does, the traditionally logical step is to look within the person to see what the difference is, leading to a focus on the psychology of the individual. Consequently, the responsibility is often put on the individual to conquer not only our blocks, but also our psychological issues, to monitor and control our stress and anxiety within different situations, and to 'work through our hierarchies'. However, just because something is experienced through thoughts and feelings it does not make it an individual psychological issue. Stammering speech is socially located. From an understanding informed by the social model I assert that the underlying impairment in stammering is relatively constant; that the level of basic dysfluency varies little. However, what does vary hugely is the amount of struggle and avoidance behaviour that occurs in the interaction between the person and the disabling barriers they face, the actual external barriers and the actual internalised oppression. So the struggle and avoidance behaviours are better theorised as part of the disability process, and yes this is hugely variable.

2.4 A personal reflection

I return to my earlier statement, ‘I am disabled, sometimes a lot and sometimes a little’. I have had, and continue to meet, negative responses to my stammering regularly; laughing, copying and comments. However, I have also absorbed a lot of attitudes about stammering, especially as a child. For some children the disapproval is obvious – 'stop doing that', ‘talk properly’ etc. - but for others the disquiet around dysfluency is very subtle. A quick look at the Internet illustrated the diverse messages communicated, some more subtle than others, but the main thrust is clear – ‘Stop it!’

I desperately wanted to ‘stop it’ for years and years. These days I honestly do not want to stop stammering. I am
getting much better at identifying, and challenging or negotiating, the barriers I face. For example, today (during this presentation) I could have been very disabled; entering the equivalent of a small town full of speech therapists! I have some difficult memories of frankly oppressive speech therapy in my past, with lovely people who really wanted me to be fluent. I have been having scary dreams in the run up to being here today. I know at this moment, from my past experience, that you are probably above averagely lovely and caring. I also know that most of you have the ability and option, instead of listening to the content of what I am saying, of assessing me as I speak, for the type, frequency and intensity of my blocks, prolongations and repetitions, let alone for psychological overlay and additional pathology. This could have made me want to be really fluent, and increased my struggle behaviour and caused me all sorts of problems. But now I recognise the barrier, I can relax, I can even ask you, simply and assertively, to listen to what I am saying. In this way I can carve out a place to be dysfluent and less disabled.

Even after I decided on an intellectual level that I wanted to accept my stammering, my body continued to fight the experience of dysfluency. I was lucky enough to get some help from some frankly liberating speech therapy, with lovely people who really wanted me to be me. I realised how much of my stammering was about struggle. It was a life changing time for me. Acceptance did not need to be about accepting the unacceptable - nobody wants, or needs, to accept feeling like you are choking to death to get a word out. Real acceptance means accepting the impairment, my underlying natural dysfluency, which I reckon is acceptable. I am working on ‘acceptance from within’ by reducing my struggle; and I am seeking, demanding and campaigning for ‘acceptance from outside’.

The good news is that there are growing communities of people who stammer who are rejecting negative attitudes. There are some great campaigning groups and the Internet is an exciting place to be part of the disabled people’s movement, in the stammering and stammering world. The big issue at the moment is acceptance; that our talking in different ways needs to be acceptable and accepted. The forums are buzzing, and just like the disabled people's movement since the 1960s, disabled people who stammer are now talking about their lives, recognising shared experience, and theorising. We are demanding that this growing knowledge is engaged with.

3. The social model of disability and its relevance to speech and language therapy: a personal starting point
(Sam Simpson)

My interest in the social model of disability originates from my first reading of ‘Mustn’t Grumble’ (Keith, 1994), a collection of short stories and poems exploring the many varied facets of disabled women’s experience. At the time of this book’s first publication, I was in my final year of training to become a speech and language therapist and it challenged everything I was learning to the core.

The principles of respect and value for each individual are deeply important to me and feeling disrespected or seeing others be disrespectful has repeatedly made me angry since I was a young child. As I read more of the literature, I discovered a deep connection with the radical ideas underpinning the social model of disability. Clearly articulated and angry stories of oppression and exclusion led to the painful realisation of what it means for me to be ‘able bodied’ and the automatic social, political and cultural privileges that accompany this identity (Kearney, 1996). Additionally, I was shocked to discover the pervasive, stereotypical images of disability I had been exposed to in fairy tales, films, popular culture, the media, classical and contemporary literature since early childhood, which had subtly and overtly influenced my attitudes, beliefs and openness towards difference as an adult and therapist in training (Barnes, 1994; Shakespeare, 1999). I was left feeling deeply troubled, inspired and captivated.

3.1 Implications of the social model of disability

As Katy has outlined above, writings from the disability movement since the 1960s and the principles of the social model have resulted in a re-definition of disability, locating its primary source within the social environment as opposed to the individual. According to the social model, people are not disabled because they have an impaired body, mind or means of communication, but because contemporary society neglects their needs and rights, thereby placing barriers in their way. Disability is, thus, viewed as a human rights issue rather than a medical or therapeutic one (Barton, 1996). This paradigm shift represents a direct challenge to the influential medical model and institutions within which speech and language therapists have been trained and generally work. It also calls into question the very principles upon which speech and language therapy is based, the roles and relationships therapists
establish with clients, the language used (e.g. ‘Specialist in Fluency’), the range of therapies offered and the accessibility and flexibility of service provision (Finkelstein, 1993; Oliver, 1996).

3.2 The tradition of therapy

The social model opened my eyes to speech and language therapy’s historical focus on ‘deficit’, ‘loss’ and the ‘need for therapeutic intervention’ by ‘trained, expert practitioners’. Additionally, as therapeutic practice has traditionally focused on ‘normalisation’ and the ‘reduction’ or ‘eradication’ of difference, I discovered the intrinsic paradox this brings about; the narrow focus of restoration therapy can only serve to reinforce and reaffirm social norms and stigma rather than acting as a vehicle through which these prevailing norms can be challenged and renegotiated (Oliver, 1996). Indeed, St Pierre (2012; pg2-3) writes powerfully about this limitation in the context of stammering:

‘What is both interesting and telling about the existing literature is that stuttering is consistently framed as an individual, biological defect to be coped with, managed or cured. Little attention has been given to what can be learned from resisting the urge to “fix” stuttering and instead reflecting upon what it can reveal about the ways we are accustomed to understanding speech, communication and disability.’

I felt perturbed and exhilarated in equal measure the more I immersed myself in the literature. Drawing on Sheehan’s iceberg analogy, it was disconcerting for me to realise how superficial and surface-level my understanding of speech and language therapy had been until that point. Suddenly, a much bigger picture emerged as the sizeable, murky and somewhat questionable depths of my profession’s history came into focus far below the water level. However, whilst deeply unsettling, there was something raw, alive and compelling about these disability discourses and their open invitation to engage in a dialogue about difference that extended beyond the focus of loss and adjustment.

Reading about the evolution of speech and language therapy led me to recognise the historical paucity of involving people with communication impairments in defining not only their lived experience, but also in determining what therapy, if any, is personally meaningful, timely and effective. It was disturbing to discover how much of the theory, literature and evidence base that I was exposed to as a student and qualified speech and language therapist had been written by non-disabled professionals; that is by people ‘outside’ of the lived experience of communication disability. More recent trends in the social sciences and disability studies have highlighted the paramount importance of exploring insider accounts of chronic conditions when carrying out evidence-based research as ‘the definitions people hold of health and illness, as well as the explanatory models they use, affect both their experience and what they do about it’ (Conrad, 1990, pg1261). Consequently, it is ‘no longer good enough for researchers to look within their own narrow understandings in their attempt to predict the outcome of others. Before we can even begin to predict what people do, we need to gain a better understanding of why people do what they do, based upon their understandings of their actions.’ (Stainton Rogers, 1991, pg233)

Similarly, closer collaboration with people who stammer in evaluating therapy outcomes has been being strongly advocated:

‘Still it appears to us that the answer will be forthcoming if we as a field are serious about engaging in a partnership between researchers and the population of people who stammer, for people who stammer can provide the most meaningful metric for determining whether a treatment is viable.’ (Yaruss & Quesal, 2004, pg11)

3.3 Alternative narratives of speech and language therapy

An increasing interest in the meaning people attribute to their experience of difference as well as therapy has resulted in a number of alternative approaches emerging and offering a welcome break from the traditional
therapeutic model over the past two decades. Speech and language therapy has been positioned as an ‘ethical responsibility’ (Taylor Sarno, 2004), resulting in a drive to enrich and enhance professional accounts by including clients as co-authors of therapy knowledge. Furthermore, as people with communication impairments have increasingly been given a voice and a role in the definition of their lived experience and the evaluation of therapy services, there has been a call for the focus of therapy to broaden and address the role that self-identity, society and social stigma play in making the processes of living with a communication impairment more challenging (Felson, Duchan & Byng, 2004). An indication of what such therapy could look like is given in St John Harris’ client perspective of a ground-breaking self-advocacy course I co-facilitated at the City Lit, London (Harris, 2013). In short, the social model demands a radical re-thinking and re-conceptualization of the scope and focus of speech and language therapy.

Personally, I consider stammering therapy a unique branch of speech and language therapy in that many eminent therapists stammer themselves and, therefore, bring both inside and professional perspectives to the field. Consequently, I find it all the more curious that the radical ideas espoused in the social model of disability have had such little impact in the stammering therapy world and remain so underexplored (Cheasman & Simpson, 2000). This contrasts markedly with developments in many other fields within speech and language therapy - aphasia, hearing impairment and learning disability to name just a few. It seems crucial to me that we now locate the stammering therapy discourse within the wider debate about disability. I believe passionately that the social model demands our attention and engagement with and offers us an exciting opportunity to extend the boundaries of our thinking about stammering and stammering therapy (Simpson, 2013).

An excellent example of this is the new and exciting ‘Did I stutter?’ project. Co-founded by Zach Richter and Joshua St. Pierre in 2014, this project was created to provide an alternative way of thinking about speech and communication disabilities. The authors write thoughtfully about stammering, difference and disability, with the aim of challenging assumptions and stereotyping as well as the normalcy often assumed in speech and language therapy. On the home page of their website they radically state:

‘We affirm informed consent at all ages to any form of speech rehabilitation as a basic human right. There is no hope of confidence or empowerment as long as dysfluent speech is shamed. We remain alone and stigmatized as long as we are led to believe that dysfluent speech is a problem. We need to be given the choice of whether or not to receive speech rehabilitation. Dysfluency-positive and dysfluency-negative perspectives should always be offered before choosing long-term speech therapy. We contend that at any age multiple perspectives on dysfluency are an absolute necessity for autonomous choice regarding one's therapeutic options.’ (Richter & St Pierre, 2014)

This foregrounds the project’s emphasis on the importance of creating communities that positively affirm dysfluent speech.

4. The social model of disability and its relevance to stammering: cultural issues (St John Harris)

We live in a performance-driven, perfectionist and time-pressured culture in which image often seems to trump substance, communication comes in neat little packages, and there is little toleration of deviation from narrowly defined norms. The media reflects back to us these ideals by seeking to reduce to a minimum the natural dysfluencies of everyday speech through a polished and edited presentation style. No wonder the appeal of near total fluency exerts such power over people who stammer – this is ‘the perfect version of speech’ to which Katy alluded above. And yet theorists like Gary Rentschler and Charlie Osborne (2012) have argued that it is precisely this exaggerated concern for fluency, and unrealistic notions of what constitutes fluency (and normality), which distinguishes many people who stammer from so-called fluent speakers, who may in fact exhibit more dysfluency than their stammering counterparts.

4.1 Re-defining stammering

As both Katy and Sam have explained, the social model conceptualizes disability in terms of social oppression.
The model has developed over the years from concern with the physical barriers that exclude and marginalise
disabled people, also to encompass the disablism that operates along psychological and emotional pathways.

Carol Thomas has come up with a useful definition (2007, pg 73): ‘Disablism is a form of social oppression
involving the social imposition of restrictions of activity on people with impairments and the socially engendered
undermining of their psycho-emotional wellbeing’. She also writes (2004, pg 10): ‘This form of disability shapes in
profound ways what people can be, as well as affecting what they do as a consequence.’

This disablism affects how we stammer: the avoidance strategies, fillers, pulling away from the stammer etc. But
it also affects us internally, leaving a damaged sense of self, self-belief and self-worth, restrictions on my activity
and my decision-making. This internalised oppression can be tantamount to the invalidation of the stammering self.

Donna Reeve maintains that psycho-emotional disablism is not just in the mind, but is embodied (Reeve, 2012;
pg 89). For me, as for Katy, it is in the very act of stammering. Reeve (2014) describes the negative psycho-
emotional aspects of concealment, particularly for conditions such as living with pain and fatigue, which are often
invisible. For many of us who stammer, maintaining a fluent façade also weighs heavily in our lives.

‘A disabled person who is struggling to emulate the ableist norm, is manufacturing an identity as non-
disabled; this takes emotional energy, is forever at risk of fracture and exposure and denies access to
alternate ways of being in which disability is associated with diversity, as a site of potential resistance and
possibility.” (Reeve, 2014; pg 95)

We will come on to alternate ways of being shortly through which disability becomes a site of potential
resistance, possibility, growth and self-realisation.

4.2 Stigma

This psycho-emotional disablism, although he does not refer to it as such, chimes very well with recent work on
stigma by the American speech pathologist, Michael Boyle (2013; 2014).

Boyle maintains that often the most debilitating aspect of stammering is not so much the speech aspect per se,
but how it can make us think and feel about ourselves, and what it stops us doing in life. The thinking goes, ‘if I
stammer, they’re going to think less of me. I’m flawed. Their opinion of me will drop in some way.’

Boyle applies the paradigm developed by Patrick Corrigan to people who stammer. He distinguishes between
(i) the public stigma (for which he amasses much evidence) – the prejudice, stereotyping and discrimination, and (ii)
the self-stigma which is directed inward through a three stage process of (1) awareness of negative stereotypes, (2)
agreement with negative stereotypes, and (3) self-concurrence, applying the negative beliefs to oneself. A good
example is the lower opinion of oneself evidenced by the ‘why try? effect’, that is, ‘Why should I even try to apply
for that job?’

In Boyle’s research he finds that twice as many people who stammer demonstrate the third stage – stigma self-
concurrence – as they do the second stage – stereotype agreement. In other words, we tend to be harder on ourselves
than on other people who stammer.

4.3 Beyond fluency – practical steps

Before we look at alternate ways of being, let’s look at some practical measures for people who stammer to
resist the powerful narrative underpinned by the medical model, which equates fluency with success, and to try to
overcome the negativity and prejudices around stammering.

Boyle refers in particular to self-disclosure and assertiveness which can empower people who stammer and
reduce self-stigma; the peer support of self-help groups, web chats and conferences through which experiences and
stories can be shared; and also to the cognitive reframing of mindfulness techniques and cognitive behaviour
therapy, through which people who stammer can look at their thoughts around stammering differently, and foster
more positive and realistic thinking patterns and behaviours.

Interestingly, Donna Reeve echoes the importance of everyday interpersonal interactions for disabled people in
which much psycho-emotional disablism is enacted, but also through which disabled people can educate strangers and retain control of the interaction. However, she emphasises this takes self-confidence, self-worth and energy.

This issue came up recently on the British Stammering Association Facebook page through the question put to members: ‘Do people ever say to you: “Did you forget your name?” when you block? And how do you respond?’ The responses ranged from the passive and ashamed in which the preference is to continue to conceal and perpetuate misunderstanding: ‘Yes, they most certainly do. I just jokingly laugh with them… then cry and have a meltdown afterwards (without them knowing of course)’ to the more assertive ‘I say, “No, I have a stammer.” That usually shuts them up. Honesty is the best policy.’

The moving personal accounts in Stuttering: Inspiring Stories and Professional Wisdom (Reitzes & Reitzes, 2012) testify to the power of self-help groups in assisting people who stammer to see beyond the isolation of the individually framed medical model narrative, to a wider collective response which resists the understanding of stammering in terms of the individual’s problem and deficit. Roisin McManus (2012) describes the potency not just of self-disclosure, but also of voluntary stammering – the profoundly transgressive and liberating act of doing on purpose that which we have always recoiled from: stammering.

‘The night of that first group, I came home giddy and overwhelmed. Part of me wanted to run away from the group and its outspoken leader. People there were not just openly stuttering; I suspected that some of them were openly doing it on purpose. They were talking about stuttering with no apologies, as if it was our right to stutter freely. I wasn’t sure I had it in me. But I was invigorated. A strong intuition told me that I had done something important, that these were the people that would show me the way out of hiding.’ (Reitzes & Reitzes, 2012; pg72)

She concludes her chapter by stating that ‘stuttering has shown me something. I have learned that allowing myself to live boldly and authentically isn’t painless, but it is worth it.’ (Reitzes & Reitzes, 2012; pg76)

4.5 Beyond fluency – alternative meanings of stammering and the bigger picture

Aside from practical steps, people who stammer are starting to challenge the ontological invalidation of having an impairment, which according to the traditional view should be mended, and are starting to re-construe its place in their lives.

For me, an interesting phenomenon is the spiritual direction some people who stammer are taking, leading them to re-think their identities and to develop alternate ways of being. Jacqueline McMenamin (2014) writes in Diary of a Stutterer.com:

‘The biggest shift came when I stopped trying to hide it and shared it with others…I see it all as a gift…yes, it is a gift that I now use to inspire others to be who they are and accept themselves just as they are. My spiritual self means that I am living life from a place of authenticity, from a place of love, from a place of compassion, and from a place of acceptance.’

And Brent L. Smith in Stuttering: Inspiring Stories and Professional Wisdom (2012, pg150):

‘It wasn’t too long ago that it dawned on me: a stutter isn’t something to hide or fix, but it’s a catalyst for developing neglected inner strengths and skills. It’s kind of like the universe slapping you in the face and telling you to pay attention…”

Spirituality is increasingly recognised as an important aspect of wellbeing. Achieving a more person-centred focus may well require the speech and language therapist to address spiritual concerns, experiences, beliefs and practices.

Tees, Esk and Wear Valley Mental Health NHS Trust (2012) have developed what they term as a ‘spirituality flower’ as a means of finding a shared understanding and vocabulary of spirituality, and as a tool for exploring people’s spiritual and religious needs. According to the flower, spirituality has six aspects:
1. Being in the present moment
2. Meaning and purpose in the things we value
3. The search for inner freedom, wellbeing and peace of mind
4. An experience of living, flourishing, and finding hope amidst pain and difficulties
5. Loving relationships with self, others and something beyond, giving a sense of belonging

These are all notions that can and do have resonance for people who stammer, and can provide an underpinning to help us overturn, even transcend, the influential medical understanding of our condition as deficit.

I have alluded briefly to mindfulness - an approach underpinned by a basic stance of non-judgemental and friendly curiosity (and self-compassion) towards one’s stammering. Both the eastern and western contemplative traditions from which mindfulness techniques spring, find a common ground in seeking to cultivate a state of being and mind based on receptivity to the present moment, suspension of the hyper-activity of the mind, but also based on acceptance, a sense of wonder, on trust in oneself and in ‘reality’ – letting go and allowing oneself to be vulnerable.

Zen Buddhists have the notion of beginner’s mind or original mind (shoshin) – the practice of meditation that seeks to unpeel the layers of fear, expectation, judgement and self-image, which we impose on our experience. The Buddhist commentator Satya Colombo (2013) writes: ‘shoshin enables a tangible sense of wonder and a deeper connection to my spirit as I go about daily life and work. This state of mind offers a rich foundation for living in alignment with my spirit, and being more effective in helping others have more fulfilment and ease in their own lives and goals.’

In adult stammering therapy, this notion of shoshin reminds me of the image of unpeeling the onion of all the acquired behaviours mainly driven by fear and avoidance, and attempting to identify what is we do when we stammer. What does this original stammer look like? That is, the impairment pure and simple, without the distortions and contortions of disability. Some people who stammer I believe wish to find their original, real stammer and their original, authentic selves at the same time.

Speech pathologists, Phil and Uri Schneider in Stuttering: Inspiring Stories and Professional Wisdom (2012; pg232, 233, 235, 238) describe how ‘the physical challenge of stuttering [the struggle] can ultimately rob us of our sense of freedom of speech, the freedom to connect with others without fear… When people who stutter fight their way out of the fear and shame of stuttering, and move towards a sense of freedom of self-expression, they often experience joy and fulfilment… On-going therapy is not simply about learning something new; it is about becoming someone new. It is about becoming “your-self”: the person you believed you could be, but lost along the way… We must focus on helping people transcend their stuttering through wholesome understanding, care, acceptance, and of course, speech strategies.’

The contemplative tradition I believe not only provides the profoundest challenge to the inadequacies of the narrow, utilitarian focus of the medical model, and its attempt to restore normality, but can also lead us to a deeper understanding of what it means truly to accept oneself and the liberating power of self-acceptance which ultimately is self-transcendence.

5. Conclusion

We hope this presentation has inspired you to engage with the social model of disability and the on-going discussions and demands of people who stammer. We, and many others in the stammering community, are passionate about removing barriers, making dysfluent speech accepted and challenging negative attitudes about stammering. Within this wider discourse, what is the on-going role for speech and language therapists?

We believe the future is bright for stammering and stammering therapy; there is a wonderfully rewarding mission, full of potential for liberating therapy and the satisfaction of truly accompanying your clients on journeys of fruitful discovery. We urge you to reflect on your values, motivations and therapy choices – the questions included in appendix A of this paper will facilitate this reflection – and we encourage you to discuss your ideas and responses with other therapists and your clients.
Appendix A

STAMMERING & THE SOCIAL MODEL OF DISABILITY: CHALLENGE & OPPORTUNITY

QUESTIONS FOR CONSIDERATION/POINTS FOR DISCUSSION

Where does the real problem of stammering lie?
- To what extent is dysfluency a natural, ‘normal’ and acceptable part of speech?
- How do you feel when you hear someone stammering?
- How does society communicate its values and norms about fluency and how does this affect people who stammer?
- How does the social model of disability demand a redefinition of stammering?
- How can ‘struggle’ in stammering be theorised?
- In what different ways can reflecting on the experience of stammering become a source of personal or spiritual growth instead of an embarrassing or limiting factor?

Stammering therapy
- Would you welcome a cure for dysfluency and how attractive to you is the vision of a ‘world without stammering’?
- How does the social model alter your understanding of ‘successful’ stammering therapy and the goal of fluency?
- How can the socially created nature of stigma and internalised oppression inform your understanding of the difficulty experienced by people who stammer across different situations (hierarchies)?
- How does the SLT tread the delicate path between helping their client manage their stammering more effectively (and increase ease of communication) without reinforcing negative ideas about fluency/stammering?
- How does speech and language therapy work best with self-help? What are their distinctive roles and how can they support each other to challenge social stereotypes of stammering?

What is the role of the therapist from a social model perspective?
- What could be the future role for speech and language therapy in reducing the problem of stammering from a social model perspective?
- What ethical responsibility/role do stammering therapists and researchers have in addressing the social and cultural dimensions of stammering and effecting change at this level?
- Is there a role for SLTs to enable people who stammer to reflect on the social context of their experience and to develop the skills necessary to negotiate the barriers they face, including countering popular misconceptions of stammering?
- In what ways can SLTs encourage and support personal/spiritual growth or facilitate this kind of reflection by their clients?

Personal reflection
- To what extent have you examined your views and values around stammering and how these influence the way you work? For example, do you want your clients to be fluent?
- To what extent does the social model support or challenge your understanding of stammering and your model of/approach to stammering therapy?
- To what extent do you embrace/celebrate difference in your stammering therapy and facilitate access to alternative theories of stammering?

References


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