Title

Stories from the Other Side:
Outcomes from Narrative Therapy for People who Stutter

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Declaration

I declare that this thesis has not been submitted as an exercise for a degree at this or any other university and it is entirely my own work.

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Name: Fiona C. Ryan
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Acknowledgments

I am grateful to the many clients who have inspired this study, particularly Kate, Mac, RT, Adam, Tracey, Pauline, Maura, Jack, Colm, PJ and Jason, all the participants of *Free to Stutter ...Free to Speak*.

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Summary

Background: Stuttering is a disorder of speech encompassing motor speech, emotional and cognitive factors, impacting on the life and experiences of a person who stutters. It is characterised by overt behaviours such as involuntary blocks in speech; repetitions; prolongations and covert or unobservable behaviours that include a feeling of loss of control central to any definition of the disorder. However, it is the covert aspects, the subtle cognitive and affective layers that lie beneath the surface of stuttering (Manning, 2010) that are often of greater significance to the speaker than the more obvious overt features. The complex multifactorial nature of stuttering with its unpredictable presentation has been reported as resulting in stigma (Boyle, 2013). It has impact socially, emotionally and occupationally on the person who stutters and on their relationships with others (Iverach, Jones, O'Brian, Block, Lincoln, Harrison, & Onslow, 2009; Klompas & Ross, 2004; Koedoot et al., 2011; Kraaimaat, Vanryckeghem & Van Dam-Bergen, 2012; Manning and Beck, 2011). Stuttering is reported as impacting on academic achievement and peer relationships (Klompas & Ross, 2004) (Klompas & Ross, 2004).

Narrative Therapy has its origins in social constructionism that recognises that people construct their lives and identities socially and culturally, through language, discourse and communication (Speedy, 2008; White & Epston, 2009). It has been used to address problem-saturated narratives that may dominate the lives of people, encouraging a sense of agency as individuals rewrite and re-author their story to one that fits with their hopes, values and dreams. Narrative Therapy was identified as a possible means of addressing the impact of stuttering on the person who stutters and was introduced as a core component of the intervention programme *Free to Stutter...Free to Speak* (Leahy, O' Dwyer, & Ryan, 2012; Ryan, O'Dwyer & Leahy, 2015).

Aims: The aim of this research was to explore the nature of outcomes from this Narrative Therapy intervention programme for a group of people who stutter. The analysis of Narrative Therapy sessions conducted with three individuals are presented in conjunction with the statistical analysis of the standardised assessments that were administered over the duration of the *Free to Stutter...Free to Speak* programme for a total of eleven participants.

Methods: Ethical approval was received from Trinity College Dublin and by the HSE South. Data from standardised assessments were collected from 11 adult participants. The results of the standardised assessments were analysed statistically using SPSS. For each participant, pre and post intensive programme data, data from one year later and a final review at a two/three years later was included. Further data from three of these participants was selected for detailed Interpretative Phenomenological Analysis. This data included the recorded Narrative Therapy sessions and Narrative Therapy documents (letters, maps and emails) over a 3-year period. As part of a composite analysis the Narrative Therapy sessions were analysed using Interpretative Phenomenological Analysis.

Conclusions: All 11 participants demonstrated significantly higher scores across three standardised assessments. Five superordinate themes emerged from the Interpretative Phenomenological Analysis: Impact of Stuttering, Identity, Hope as a transformative force, Unique Outcomes and Will. Outcomes for the three participants highlighted the importance of addressing the impact of stuttering whilst encouraging participation and engagement in activities of daily life.

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L1 Response from participants to triangulation email

Introduction

Imagine that you are entering a bank to undertake a simple transaction, one that requires you to wait in line, approach a teller through a glass partition and offer personal details to confirm your identity and then give a series of numbers that are required. While you wait, tension builds in your shoulders, neck and jaw. You become hypersensitive to the people in the queue behind you. You start to shift anxiously from one foot to the other. Finally, it is your turn. As you open your mouth to speak, something sticks. You struggle to get the first words out and manage, acutely aware of the teller’s sympathetic face and response. When it gets to the account number, you block. Nothing comes out of your mouth. The more you try, the greater the physical struggle. With a red face, you abandon the queue and flee the bank.

This is the story Jack told when he came for Speech and Language Therapy for the first time in 25 years. A lifetime of shame, embarrassment and avoidance was too much for him to carry on his own any longer.

This research process owes much to Jack and the other participants who willingly shared their stories, their hopes and dreams. For many people who do not stutter, it is difficult to imagine the complexity of a disorder that is only apparent when you open your mouth, and even then, not consistently so. The thoughts, feelings and behaviours that are an integral part of stuttering can become crippling even in the most mundane of social interactions. It is no wonder then, that treatment for stuttering is sought by so many yet the outcomes like the treatment on offer are subject to as many opinions as there are people who stutter. This research arose from these stories: stories of communication breakdown, constant striving for change, successful and unsuccessful intervention and a desire for individual outcomes and questions about how to measure these outcomes.

Roadmap for this Dissertation

This dissertation is concerned with the outcomes from a Narrative Therapy programme for people who stutter *Free to Stutter….Free to Speak*. The primary question is what the outcomes are for people who stutter from this Narrative Therapy programme. To measure outcomes for stuttering entailed the exploration of the nature of stuttering itself. In order to measure changes to behaviours, I had to explore the nature of these behaviours. In doing so, I began to question whether what we measure when we assess stuttering is what really counts for the person who stutters. The constant striving of researchers to uncover the neurological and physiological underpinning of stuttering is matched only by the constant striving of the people who stutter to communicate effectively and meaningfully. Challenges emerge when our understanding of causation and causative factors do not synchronise with what stuttering becomes for the person who stutters. Attempting to track outcomes from a programme is fraught when uncertainty exists about the very nature of stuttering itself. These are the concerns that preoccupied me and that gave rise to this study.

Chapter 1 describes the dilemmas that face the Speech and Language Therapist in attempting to provide intervention for the person who stutters, the dilemmas that provided the impetus for this study. Controversies exist relating to our understanding of the nature of stuttering, measuring stuttering and the treatments on offer for a person who stutters. There is an Irish proverb that states ‘Ni lia duine ná tuaraim’: there are as many opinions as there are people, and this is particularly evident in discussing stuttering assessment and treatment. However there is an increasing acknowledgment with the development of the International Classification of Functioning, Disability and Health (ICF) (2001) that addressing function and participation is an essential component in interventions to support people who stutter whilst exploring the biomedical condition. The ICF has led to the exploration of alternative approaches that acknowledge the person-centred nature of stuttering. One such approach suggested in the literature as having possible applications for the treatment of stuttering is Narrative Therapy (Manning, 2010).

Narrative Therapy is the focus of Chapter 2. The development by White and Epston (1990) from a Family Therapy background of a process fortified with the knowledge of how to work with the stories of illness and the everyday troubles of peoples’ lives is described in detail. The potential for this therapy to “trouble the edges” (Speedy, 2008) of stuttering is discussed. The *Free to Stutter...Free to Speak* programme is introduced and the Narrative Therapy processes within that programme are described with relevant examples. The dearth of published literature detailing outcomes from Narrative Therapy is highlighted setting the scene for this current dissertation.

Chapter 3 concerns itself with the methodological issues that arise when outcomes are explored. Particular attention is given to epistemological issues. Qualitative and quantitative approaches are outlined and the challenges in combining both discussed. Phenomenology is addressed in detail with its attention to the particular, and the everyday experiences of people and how they live and interpret the living of their lives. The development of Interpretative Phenomenological Analysis (IPA) is expounded upon and examples are given of previous research studies exploring the experience of stuttering with the application of IPA.

Chapter 4 describes in detail the method for both the qualitative and quantitative analysis. It commences with selection of participants from the *Free to Stutter...Free to Speak* programme, approached through a gatekeeper and provides information about these participants. Chapter 5 provides a detailed description of the IPA process for each of the participants and the audit trail involved. The standardized assessments taken as part of the *Free to Stutter...Free to Speak* programme for each of the research participants are included in the research and the process by which they were analysed is outlined.

Chapter 5 introduces the results from the quantitative analysis. The decision to present the statistical results initially sets the scene for the individual outcomes reported in subsequent chapters. Each of the standardised assessments taken over the three years of the programme was analysed using the SPSS programme (IBM SPSS 22). Significant results were obtained with the Friedman Test and post hoc testing was completed with the Wilcoxon Signed Ranks. Effect sizes were calculated and reported.

The five Superordinate themes that emerged from the IPA process and their subthemes are the focus of Chapters 6 and 7. Chapter 6 highlights the themes relevant to the onset of therapy: Impact of Stuttering and Identity. Chapter 7 is concerned with Identity in transformation, Hope and Will. Each theme is mapped and supported with quotes from the transcriptions of the Narrative Therapy sessions, letters and emails from the participants.

The results of both the quantitative analysis and the qualitative analysis are discussed in Chapter 8. The implications for people who stutter and the Speech and Language Therapists who provide services for them are described. Implications from this study and the process are described, highlighting the importance of Hope and the practices of Hope for both the person who stutters and the therapist. The quantitative results are explored in the context of the IPA themes linking the outcomes reported by the participants with the results from these standardised assessments. People who stutter are at the epicentre of this research and it is fitting that their own words provide evidence of their hopes, dreams and desired outcomes. The dissertation concludes in chapter 9 with a discussion relating to the implications of the findings of the research highlighting some possible signposts for future research and therapy.

Chapter 1

Defining Stuttering

This research focuses on what the outcomes from a Narrative Therapy intervention programme for people who stutter are. In this chapter the background to the research and current issues in intervention for people who stutter are outlined. Stuttering, its aetiology, diagnosis and treatment are discussed, as to understand the outcomes that emerge from therapy for people who stutter it is important to have information about how stuttering develops, and current research data regarding its aetiology. The definition of stuttering has implications for how stuttering is measured, and this in turn impacts on the evaluation of therapy outcomes. Both the measurement of stuttering and the evaluation of outcomes have been influenced by the development of the International Classification of Functioning & Health (ICF; WHO, 2001). The nature of intervention for stuttering provided by Speech and Language Therapists[1] is dependent on their own understanding and definition of stuttering and its impact on the people who stutter. The challenge to Speech and Language Therapists is that individual variability of stuttering means that no one programme meets the needs of every person who stutters (Baxter et al., 2015).

Figure 1.1 provides an overview of the main thrust of this chapter. At the center of our understanding are the clients who stutter and their understanding of the disorder and their chosen goals and desired outcomes. Crucial to the intervention process is an understanding of the onset and development of the disorder and this influences (and is influenced by) our definitions of stuttering and the intervention that is offered. How outcomes are measured is determined by the stated purpose of the intervention. Supporting and impacting on the above are the beliefs of the Speech and Language Therapist, the theories of stuttering's onset and development, the desired outcome of the client and the impact of the development of the ICF (WHO, 2001).

Figure 1.1 Stuttering: an Overview

Outside labels refer to the wider influences of each of the factors involved.

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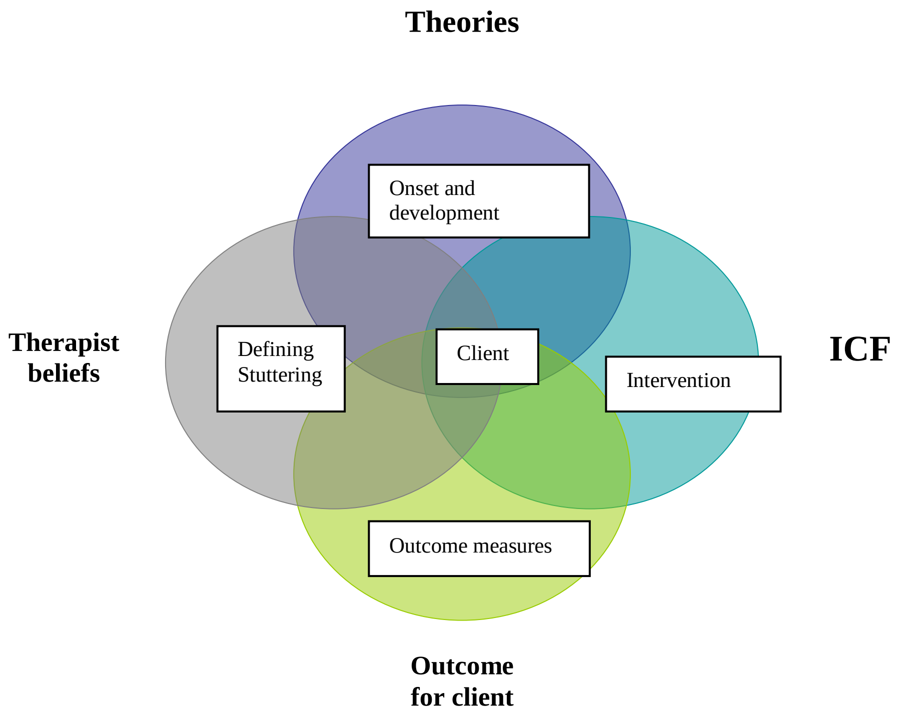
[1] In the literature Speech and Language Therapist, Clinician and Speech Language Pathologist are used interchangeably. For consistency and to acknowledge the Irish context of this research the role will be described as Speech and Language Therapist in this study.



1.1 Definitions of stuttering

Stuttering is a disorder of speech encompassing motor speech, emotional and cognitive factors, impacting on all aspects of the life and experiences of a person who stutters. It is characterised by overt behaviours such as involuntary blocks in speech (stoppage of the air flow that may be silent, or may be represented by a glottal stop); repetitions (of sounds, syllables, words and phrases); prolongations (elongated sounds or syllables) and covert or unobservable behaviours that include a feeling of loss of control that is central to any definition of the disorder. This loss of control is a core constituent of stuttering described by many people who stutter. A key word in the definition of stuttering is the word *involuntary* (Van Riper, 1973; Manning, 2010; Bloodstein and Bernstein Ratner, 2008). There is a feeling of loss of control experienced in the moment of stuttering when the person who stutters cannot voluntarily continue the utterance. Perkins (1990; p375) considers this loss of control, resulting in reactions of apprehension, struggle and avoidance as “the essence of stuttering”. It is this reaction of the person who stutters before, during and after the moment of stuttering that defines the behaviour as stuttering rather than a mere disruption of fluency.

The position that the therapist takes in defining stuttering has implications for therapy, theory and research. As Perkins (1990) observes, defining stuttering defines the therapist’s understanding of the basic nature of stuttering. In acknowledging the overt observable stuttering behaviours, however, Van Riper (1973) recognised that there was another side to stuttering and describes covert or hidden features that impact on the person also.

It is the covert aspects, the subtle cognitive and affective layers that lie beneath the surface of stuttering (Manning, 2010) that are often of greater significance to the speaker than the more obvious overt features. The overwhelming emotional aspects experienced by the person who stutters are described by Van Riper (1973; p213): “Truly, stuttering is enough, more than enough, the anxiety, the frustration, the fears that dominate the lives of many stutterers are more than sufficient”. The feelings of the person who stutters, can be as much a part of the disorder as the speech behaviours (Guitar, 2006); indeed for many people who stutter, these covert or hidden features have impact beyond the moment of speaking itself. Themes of helplessness, shame, fear and avoidance (Corcoran & Stewart, 1998) have emerged from research as key elements of the suffering experienced by people who stutter. These themes resonate with the findings examining quality of life and stuttering. Moderate to severe stuttering has been found to have an overall negative impact on quality of life affecting speech, emotion, cognition, [2]pain and discomfort, all of which influence activities of daily living and may result in anxiety and depression (Koedoot, Bouwmans, Franken & Stolk, 2011). Klompas and Ross (2004) used content analysis to examine the narratives of 16 adults who stutter (Klompas & Ross, 2004). Stuttering as reported in their study, was perceived as impacting on academic achievement and peer relationships. Participants reported negative experiences of therapy, yet highlighted therapeutic procedures, fluency-

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2. Two possible reasons were offered, firstly people who stutter may report pain in the chest area due to tension or secondly the author reports the link between social and physical pain.

enhancing techniques and the relationship with the therapist as key to their positive experiences of therapy.

Klompas and Ross (2004) reported that stuttering can form a primary part of the identity of people who stutter, and therefore, opportunities for therapy to reduce stuttering may be rejected because it may imply self-rejection. These authors also reported, however, that some participants in their study emphasized that 'stuttering can imbue the person with inner strength, courage, resilience and a sense of accomplishment' (Klompas & Ross, 2004; p300). This finding contrasts with the literature describing how people who stutter face negative stereotyping from members of the general public, educators, employers, and healthcare professionals, among others, who reportedly believe that people who stutter possess negative/undesirable personality characteristics (Boyle, 2013a, 2014, 2016). Boyle (2016) suggested that people who stutter can internalize negative stigmatizing attitudes from the public to the detriment of their self-esteem and quality of life. He further suggested that provision of biological explanations for stuttering is no more effective for reducing stigma than no explanation at all; he described the prognostic pessimism that can result from such biological explanations while recognising that it is important to provide such information to clients in the light of current research findings.

1.2 The onset and development of stuttering

Current models of onset and development of stuttering are multi-factorial describing a complex disorder that links genetics (Buchel, 2004), neurology and physiology (Brown, Ingham, Ingham, Laird & Fox, 2005), environmental factors and individual temperament (Bothe & Andreatta, 2004; Kefalianos, Onslow, Block, Menzies & Reilly, 2012). However, to date no one single theory sufficiently explains the origins of stuttering (Rautakoski, Hannus, Simberg, Sandnabba & Santtila, 2012).

Stuttering develops in early childhood, usually before the age of four years (Bloodstein & Bernstein Ratner, 2008; Manning, 2010; Yairi & Ambrose, 2013, 2005; Blomgren, 2013). The pattern of onset for both genders is similar although more males than females stutter as adults (Bloodstein & Bernstein Ratner, 2008). Rate of onset may be sudden or gradual (Van Riper, 1973; Yairi & Ambrose, 2013). In an attempt to understand how some children persist with stuttering and others recover spontaneously, Yairi and Ambrose’s longitudinal study (2005) confirms the above characteristics and identifies that cognitive abilities for children who stutter are no different to children who do not stutter. Furthermore, in their study expressive language skills were average or above average close to onset of stuttering, although children who persisted in stuttering tended to be slower in phonological development than those who recovered. Watts et al. (2017) report developmentally appropriate spoken language skills in children who stutter during the first twelve months after onset of stuttering. Bernstein Ratner (2010) suggests that a child’s relative level of language development may be a factor in predicting remission and persistence in early stuttering. At least one study has found that children who stutter do not perform as well as children who do not stutter, on non-word repetition tasks (Pelczarski & Yaruss, 2016). Central speech sound discrimination has also been found to be insufficient in children who stutter (Jansson-Verkasalo, Eggers, Järvenpää, Suominen, Van den Bergh, De Nil & Kujala, 2014). There is some evidence that articulation scores are higher for children who eventually recover, with higher non-word repetition abilities associated with stuttering recovery (Spencer & Weber-Fox, 2014). Rates of recovery from stuttering differ across studies though it is generally accepted that approximately 70- 80% of children who begin to stutter will spontaneously recover from symptoms. Some have suggested that recovery occurs between the ages of two and half and four and a half years (Bernstein Ratner, 2010) while others report that spontaneous recovery may occur up to five years post onset (Baxter, 2015; Bernstein Ratner, 2005; Curlee & Yairi, 1997; Blomgren, 2013).

Awareness of stuttering in others has been observed in 56.7% of young children (i.e., at 2 years of age), increasing to 89.7% of children at age 7 years (Boey, 2009). In the latter study, negative evaluation of dysfluent speech by peers was evident from the age of 4 years. McAllister (2016), reports that children who stutter may begin to show impaired behavioural, emotional and social development as early as three years of age. In a meta-analysis of attitudes to communication (Guttormsen, Kefalianos & Naess, 2015) it was identified that communication attitudes of children who stutter become more negative as children get older resulting in increased covert behaviours.

By adolescence, teenagers with persistent stuttering cite lack of information about stuttering, limited awareness of the impact of stuttering and insufficient openness in society leading to a sense of isolation, as highlighted by a study into stuttering treatment for adolescents: “I thought I was the only person in the world who had it” (Hearne, Packman, Onslow & Quine, 2008; p87). Research has also indicated that self esteem is impacted by stuttering severity (Adriaensens, Beyer & Struyf, 2015). In this way, by adulthood the overt stuttering features may be enmeshed in a complicated web of covert features affecting self esteem and attitudes to communication that may result in self stigma.

1.3 Etiology of Stuttering

1.3.1 Historical Perspectives on etiology

Current views on etiology and intervention for stuttering have evolved from the experience and understanding of past researchers and therapists. Historical models of stuttering can be divided into the physiological, psychological, learning and multifactorial models. Some of these theories focused on the etiology of stuttering while others were concerned with explaining the nature of the stuttering event itself. Many focused on the overt observable symptoms; others were concerned with the covert aspect of stuttering, linking these covert features with deep-seated and repressed conflicts, and describing the overt symptoms as expressions of these conflicts. Elements of many of these theories are still influential in treatment and in the explanations given to people who stutter as to the cause of their stuttering.

The physiological theories identified that fluent speech was disrupted by a form of stress or malfunction in the individual’s system. A classic example of such a theory was the Orton Travis theory of cerebral dominance that emerged in the 1920s and 1930s (Travis & Knott, 1936). This theory suggested that the nervous system of people who stutter was not sufficiently mature, resulting in a failure of left hemisphere dominance over speech. Orton considered stuttering as an expression of confusion of cerebral dominance (Travis & Knott, 1936; Fleming, 1928). Many of those who provided intervention for stuttering at that time were physicians (Bloodstein & Bernstein Ratner, 2008; Guitar, 2006; Manning, 2010) and for some, the focus of intervention was on the overt symptoms of stuttering. Others at this time took a psychoanalytic perspective on stuttering, with psychological theories suggesting that stuttering emerged as a result of repressed emotional conflict or trauma. The stuttering behaviour was viewed as a symptom of this conflict. Treatment involved psychotherapy in many instances (Bloodstein & Ratner, 2008; Manning, 2010; Van Riper, 1973).

A view of stuttering as a learned behaviour or rather as a learned anticipatory struggle obtained popularity in the mid-20th century as many researchers had a background in psychology. The Diagnosogenic theory by Johnson (Bloodstein & Bernstein Ratner, 2008; Johnson, 1949) was one such theory that arose from the University of Iowa and became part of what was known as the Iowa Development (Manning, 2010). In this theory, stuttering is described as arising when normal fluency breaks in a child's speech are labelled as stuttering and responded to as such by parents. This reaction results in greater anticipation of stuttering moments and increased struggle behaviour. Other learning theories at the time included Operant Behaviour theory (Brutten,1967). In this view, stuttering was shaped by the positive or negative responses it received. Again, the response of the listener was believed to reinforce the occurrence of stuttering (Guitar, 2006; Manning, 2010).

Multifactorial models of stuttering arose following the failure of any one of the above models to sufficiently explain the origin and development of stuttering. In a multifactorial model the focus is on the many and varied intrinsic and extrinsic factors that are integral to the development of a child's speech. Starkweather's 'Demands and Capacities' model (Gottwald & Starkweather, 1995) highlighted both the child's capacities for fluent speech and the extrinsic demands placed on the child by the environment: when the extrinsic demands exceeded the child's intrinsic capacities, dysfluent speech was the result.

1.3.2 Research Evidence.

Research in support of these theories yielded varying results. The physiological understanding of stuttering has been enhanced by detailed research that currently indicates that there may be a strong genetic basis to stuttering (Ambrose & Yairi, 1997; Kraft, Cox, Evans, Gamazon, Ambrose & Yairi, 2012; Kraft and Yairi, 2011; Rowden-Racette, 2012), and there is also progress in identifying specific genes that may be responsible for stuttering (Kraft et al., 2012; Kraft & Yairi, 2011; Bernstein Ratner, 2010). Approximately 70-85% of stuttering may be attributable to genetic effects (Guitar, 2006; Rautakoski, et al., 2012), yet research to date cannot conclusively indicate in which instance stuttering will persist beyond childhood and for whom it will resolve. Consequently, two separate issues have emerged in current studies: (a) etiology in relation to the emergence of stuttering exploring cognitive, linguistic and temperament factors close to onset of stuttering; and (b) etiology in relation to persistence of stuttering, contrasting these factors with children and later adults where the stuttering has resolved.

Current functional neuroimaging researches undertaken with adults who stutter provide three different groups of findings. Firstly, a number of studies have reported atypical activations in cortical motor areas and deactivations in both hemispheres of people who stutter (S. Brown et al., 2005; De Nil, 2004; De Nil & Kroll, 1996; De Nil, Kroll, Lafaille & Houle, 2003): there is some evidence that people who stutter show hypoactivity in cortical areas associated with language processing but hyperactivity in areas associated with motor function compared with control groups (Sandek & Frez, 2000). Secondly, there may be anomalous lateralization, such that speech-related brain areas that typically have left hemisphere dominance in fluent speakers are active bilaterally or with right-hemisphere dominance in people who stutter (Brown et al., 2005). Finally, there may be auditory suppression such that primary and secondary auditory areas that are normally active during speech production are not activated in people who stutter.

In addition (and linking to the neuroimaging research), structural anatomical and neurological differences between people who stutter and people who do not stutter have been identified; these include differences in the left hemisphere of regions such as the superior temporal gyrus and Rolandic Operculum (Foundas, Bollich & Corey, 2001; Sommer, Koch, Paulus, Weiller & Buchel, 2012) and the left and right Planum Temporale (PT), where size and symmetry for people who stutter and people who do not stutter differ significantly. Chang (2008) reported differences in white matter integrity between children who persisted stuttering and those who recovered. Gyrification of the perisylvian fissure region was also found to be atypical (Buchel, 2004). In a series of controlled studies Foundas et al. (2001), Foundas, Bollich and Feldman (2004) and Foundas (2004) reported differences in the size of the Planum Temporale between people who stuttered and people who did not stutter. For those speakers who do not stutter, the left Planum Temporale was found to be larger (Foundas, Bollich, & Corey, 2001; Foundas, Bollich, & Feldman, 2004) and there is a strong link between asymmetrical Planum Temporale and auditory feedback disturbance (Foundas et al., 2004; Rautakoski et al., 2012).

The is also evidence to suggest that the corpus callosum may be larger in adults who stutter than those who do not stutter (Choo, Kraft, Olivero, Ambrose, Sharma, Chang & Loucks, 2011) and yet there is no difference in the corpus callosum of children who stutter, children who have recovered from stuttering and children who do not stutter (Choo, Chang, Zengin-Bolatkale, Ambrose & Loucks, 2012). The increased size of the corpus callosum as reported (Choo et al., 2011) is linked with right hemisphere dominance, which might explain the reporting of increased right hemisphere activation patterns in people who stutter (Choo et al., 2012; Fox & Ingham, 1996; Fox, Ingham R.J., Zamarripa, Xiong & Lancaster, 2000). The right hemisphere changes and activation may be ‘a response to the presence of stuttering’ (Choo et al, 2011: p 471) an adaptive response or a maladaptive response as a consequence of reduced left hemisphere dominance.

With regard to the psychological theories of stuttering, there is currently no evidence to support the psychological theory of stuttering onset in childhood (Alm, 2014; Bloodstein & Bernstein Ratner, 2008; Manning, 2010). In contrast with this, there is some mixed evidence in support of the learning model, although learning models of stuttering cannot explain the complexity of stuttering. For example while it is possible to manipulate secondary behaviours of stuttering, learning theories do not adequately explain the cause of the dysfluency in the first place. Furthermore it is acknowledged that the stuttering experience occurs for the speaker at times when the listener is unaware or unable to perceive the actual moment of stuttering and therefore there is deemed to be no ‘conditioning response’. There is evidence that for some children, stuttering behaviour can decrease on receipt of contingent responses (as promoted in the Lidcombe programme) (Franken, Schalk & Boelens, 2005; Harrison, Wilson & Onslow, 1999; Onslow, Andrews & Lincoln, 1994). It is theorized that the reduction of stuttering behaviour as a result of verbal contingencies may be related to high levels of parental involvement within the home setting and other as yet unknown factors (Bernstein Ratner, 2005; Manning, 2010). In contrast to learning theories of stuttering, the Demands and Capacities Model (Starkweather and Gottwald, 1990), a multifactorial approach to stuttering, has been criticised for the difficulties inherent in testing the model. The capacities required for fluency is not clearly defined or measurable (Adams, 1990). No critical threshold for the disruption of fluency resulting in stuttering has as yet been identified, resulting in a challenge to empirical testing (Ingham & Cordes, 1997a; Adams, 1990).

1.3.4 Current Perspectives on etiology

By its very complexity, one single theory to explain the etiology of stuttering eludes researchers at this time. Each of the previously described theories influenced clinical decision-making at different times with emphasis on indirect parent-led intervention (as in the Diagnosogenic theory (Johnson, 1949)) or direct intervention with children targeting the overt symptoms (operant conditioning as in The Lidcombe programme (Onslow, Andrews & Lincoln, 1994)). For adults who stutter, the physiological models lead to approaches that focused directly on the overt symptoms (Hasbrouck & Lowry, 1989; Ingham, Kilgo, Ingham, Moglia, 2001; O’Brian, Onslow, Cream & Packman, 2003) in contrast to the psychoanalytic theories in programmes such as Sheehan’s approach avoidance programme which identified stuttering as a false-role disorder (Sheehan, 1970). Elements of each model can be seen in current research trends (Fox et al., 2000; Harrison, Onslow & Menzies, 2004; Iverach et al., 2009; Jansson-Verkasalo et al., 2014). These early theories of stuttering have led to research in genetics and neuroimaging to further our understanding of how stuttering arises and why it persists for some people and not for others. Temperament and anxiety are the focus also; to explore the factors that may be influential in determining the impact stuttering has on individuals (Iverach, Menzies, O’Brian, Packman & Onslow, 2011; Kraaimaat, Vanryckeghem & Van Dam-Baggen, 2002; Manning & Beck, 2013; Tran, Blumgart & Craig, 2011)

1.3.5 Impact of Perspectives on Etiology on Intervention

An understanding of causal factors assists therapists and researchers in attempts to define stuttering and has implications for intervention. Despite the ongoing research in this area however, a persistent unanswered question remains as to why some children who stutter recover and others do not. An enhanced analysis of neurophysiological and genetic factors may lead to the development of subtypes of stuttering long suggested in the literature, and enhance our understanding of persistent stuttering and the factors linked to early recovery ensuring the early identification and intervention with at risk groups (Ambrose, Yairi, Locks, Seery & Throneburg, 2015). Another interpretation of this research application is provided by Bloodstein and Bernstein-Ratner (2008), who suggest that fluency therapy might reorganise connections for speech and language production within the left hemisphere and reduce compensatory activity of the right hemisphere.

A greater understanding of the issues of persistence and recovery – issues which are felt to be influenced by genetics and neurophysiologic development – will give insight into the causes of stuttering and also may lead to clinical interventions that result in greater recovery rates (Choo, Chang, Zengin-Bolatkale, Ambrose, & Loucks, 2012). Current understanding of etiology is not sufficient to explain, “what stuttering becomes” for those people who continue to stutter past childhood (Bernstein Ratner, 2005). For Bernstein Ratner and others, the focus on etiology is acknowledged as only a part of the puzzle, a greater part of the puzzle is the impact of stuttering on the lives of people who stutter, that is unrelated to the percentage of their speech that is stuttered. Conventional intervention targeting the moment of stuttering may not be sufficient to address the impact of stuttering on the everyday life of an individual. Intervention that is focused on the overt may neglect the impact that stuttering has on the person who stutters resulting in the maintenance of many of the covert features such as situation avoidance, fear and negative thoughts about speaking. Conversely intervention that focuses on the covert aspects may not result in any reduction in overt stuttering behaviours.

1.4 Intervention in Stuttering

Intervention goals vary according to the stated and evaluated needs of the client, the available evidence for intervention, and the beliefs and experience of the therapist. Goals frequently mentioned in the literature include: reducing the frequency of stuttering (Guitar, 2006); achieving “normal human speech” (Ryan, 1979; p138); reducing negative feelings about stuttering and about speaking (Van Riper, 1973); reducing negative thoughts and attitudes about stuttering and about speaking

(Manning, 2010); and reducing avoidance and increasing overall communication abilities (Guitar, 2006). How therapeutic goals are defined can reflect the therapist's beliefs regarding the nature of stuttering, in combination with the client's desired wishes. What constitutes successful intervention for an individual client may not be the same for another client.

The issue regarding whether the appropriate approach to stuttering is to *speak more fluently* or to *stutter more fluently* remains controversial over thirty years since it was first identified (see Gregory, 1979). In a *stutter more fluently* approach, the person modifies the moment of stuttering, stuttering in an easier, less tense way, addressing the avoidance of situations and feelings that accompany the overt, observable stuttering behaviour. In *fluency shaping*, it is the manner of speaking that is modified, focusing on eliminating overt observable stuttering behaviour (Guitar & Peters, 1980). However, more recent focus has been on what constitutes successful intervention (Bernstein Ratner, 2005), with particular attention placed on common components of the process across different approaches, as in the common factors model (Manning, 2010). This has led to the dissection of different interventions (e.g., the Lidcombe programme (Jones, Onslow, Packman, O'Brian, Hearne, Williams & Schwartz, 2008; Onslow et al., 1994)) to identify what is its successful component (Bernstein Ratner, 2005). Understanding the successful component of an intervention is required, in part to explain why so many different interventions appear to be successful yet no one intervention programme is successful for all.

Successful intervention appears to interact with all levels of the disorder, the behavioural, the cognitive and the affective. However, despite this multifaceted acknowledgement (Manning, 2010), a behavioural (fluent speech) focus of intervention has dominated the 20th Century, and continues into the 21st century (e.g. Block, Onslow, Packman, Gray & Dacakis, 2005; Carey, O' Brian, Onslow, Jones & Packman, 2010; Cream, O' Brian, Onslow, Packman & Menzies, 2009; Latterman, Euler & Neumann,2008; O'Brian et al., 2003; Onslow et al., 1994; B.P Ryan & Ryan, 1995).

Van Riper (1973) provided an historical account of the many kinds of approaches that people who stutter experienced in their quests for fluency. Falling under headings of suggestion, distraction and persuasion, different therapies included exercises to strengthen the muscles that were 'weak' (e.g., Demosthenes climbing mountains with lead plates strapped to his chest to improve his breathing musculature as he practised speaking (Van Riper, 1973). Other techniques used involved reading distinctly and loudly to counteract the ‘bad habit’ of stuttering. Appliances and prostheses were frequently advertised in centuries past. Novel ways of speaking, for example accent therapy or talking with continuous voicing, provided temporary fluency. Each approach arose from the therapist’s understanding of what stuttering was and how it developed, be it learned or physiological in origin.

Reports in recent literature and in current practice are not so dissimilar to these early earlier attempts to provide intervention for stuttering, for example, teaching prolonged speech using audiotapes (Carey et al., 2010); the use of appliances, for example, auditory feedback devices (Pollard, Ellis, Finan, & Ramig, 2009; Stuart, Kalinowski, Rastatter, Saltuklaroglu & Dayalu, 2004); personal construct therapy to address the meaningfulness of the fluent speaker role (Evesham, 1985; Hayhow & Levy,1989) and the Camperdown programme to modify behaviour (Block et al., 2006; Block et al., 2005). However, increasing emphasis on the thoughts and feelings of the person who stutters within therapy programmes (Plexico, Manning & DiLollo, 2010) and the reporting of individual case studies (Leahy & Warren, 2007; Stewart, 1996) has resulted in adaptations of some of the behavioural programmes to include cognitive behavioural therapy (Menzies ,O’Brian, Onslow, Packman, Clare & Block, 2008), and other psychological approaches (Boyle, 2011; Evesham, 1985; Huinck, Langevin, Kully, Graamans, Peters & Hulstijn, 2006; Stewart, 1996).

This focus on the perspective of the person has extended to outcome measures resulting in increased reporting from clients’ perspectives (Block et al., 2005; Guntupalli, Kalinowski & Saltuklaroglu, 2006). Venkatagiri’s (2009) study regarding what people who stutter want from therapy describes ambivalence, where people opt for fluency (fluency shaping) in some situations, but desire freedom from the fear of stuttering (stuttering modification) in others. The substitution of stuttering and fear of stuttering for a technique (such as prolonged speech requiring maintenance in everyday communication situations), may be seen as trading ‘one set of constraints for another’. Of the people interviewed by Venkatagiri (2009), those who had not received therapy were more likely to opt for fluency shaping than those who had experience of therapy (Venkatagiri, 2009). It is possible that those who had experienced therapy are aware of the demands of maintaining an unnatural speech pattern (O’ Brian et al., 2003), and so opted for reducing fear of stuttering as a therapy approach.

1.4.1 Principles of intervention

There are three primary objectives when working with clients who stutter according to Manning (2010): increasing fluency, improving communication, and developing greater personal autonomy. Stewart and Leahy (2010) describe the therapeutic approach as deriving from cognitive, behavioural and psychological techniques or involving a combination of all three.

There is some agreement in the *stutter more fluently* literature (Manning, 2010; Stewart & Leahy, 2010; Van Riper, 1973) about certain key elements in therapy for people who stutter: identification (requiring in-depth awareness of stuttering thoughts, feelings and behaviours for both client and therapist); desensitization (the process by which the person is made less sensitive to stuttering through identification and exposure to stuttering and situations); modification of stuttering behaviour from tense feared stuttering to easy controlled stutters in combination with cognitive restructuring. Cognitive restructuring is the process by which the client’s thoughts and feelings towards stuttering are addressed. The management of stuttering requires the therapist and client to examine all aspects of communication and particularly to pay attention to the ‘bigger picture’ where speech occurs (Stewart & Leahy, 2010). Despite the emphasis on the individual in therapy and the increasing variety of approaches offered for people who stutter, many of which have documented success in the literature, there is uncertainty about what actually works in therapy.

1.4.2 Common Factors in Successful Intervention

The *common factors* model (Manning, 2010, 2010b) describes different components as contributing to successful therapy experience. Two of the crucial common factors noted are the client-therapist relationship and therapist competence (Plexico et al., 2010). Similarly, Stewart and Leahy (2010) identify these as essential factors in therapy, adding the therapy approach as a major part of the process.

1.4.2.1 Client-Therapist Relationship. The relationship between the client and the therapist has been singled out as a major factor in the process of change (Rogers, 1995). Meta-analyses to date (Baxter et al., 2015; Andrews, Guitar & Howie, 1980; Herder, Howard, Nye & Vanryckeghem, 2006) provide evidence that one approach cannot be singled out above others, when determining successful outcomes therapy for people who stutter, leading to further emphasis on the therapist's role in intervention. Stewart and Leahy (2010) identified key prerequisites in therapists' clinical competencies, including: adopting a hypothesis-testing approach; access to evidence from up to date literature; the ability to critically evaluate the literature; and crucially, to be able to discuss assessment results and options in a meaningful way with the client. Bernstein Ratner (2006) described how the task of the therapist is twofold: to understand the client and understand the disorder. In order to fulfil these requirements the therapist must be open about his/her understanding of what stuttering is.

The effective therapist has been described as one who is not inhibited about the different aspects of stuttering (Manning, 2010) and who is willing to explore with the client these different aspects of the disorder. An analysis of the characteristics of therapists that were perceived as effective and ineffective by people who stutter are discussed by Plexico et al., (2010), who indicated that effective therapists have belief in the client's ability to accomplish therapeutic change. In their study, the alliance between client and therapist is one of trust, encouraging participation and agentic behaviour by the client.

1.4.2.2 Therapist competence. The therapist's expertise is discussed by Bernstein Ratner (2005, 2006), who asserted that there is evidence that specific therapies cannot be valued over one another in the treatment of disorders (Millard, Edwards & Cook, 2009; Onslow et al., 1994) (Millard, Edwards, & Cook, 2009; Onslow, Andrews, & Lincoln, 1994). She emphasized that the key factor is the therapist rather than the approach. It is suggested that the therapist-client relationship may be particularly important to treatment outcomes (Ebert & Kohnert, 2010). This relationship, commonly described by Speech and Language therapists as rapport may include flexibility, motivation and communication with the client's family, on the part of the therapist. This flexibility includes a willingness to change direction or goals therapy in response to the person's needs. Therefore, the therapist's clinical decision-making is influenced by clients' needs, capabilities and goals. Thus acknowledging Manning's (2010; p10) observation that: "experienced therapists know what success looks and sounds like, while placing the person who stutter's goals and understanding of outcomes at the centre of the process". Following on from this acknowledgement of the individual's goals, the complexity of how to identify and measure therapy outcomes in a way that reflects the individualised intervention arises.

1.5 Measuring Outcomes from Therapy for Stuttering

1.5.1 Outcomes

Outcomes are described as the measurable results of an intervention or care (Wong, Cummings, & Ducharme, 2013). Choice of target outcomes by a client reflects a value-based decision rather than a scientific one (Granlund, Bjorck-Akesson, Wilder & Ylven, 2008). Outcomes can be selected based on the person's own identified needs and wishes. However, the intervention suggested for a person who stutters is usually linked directly to the therapist's definition of stuttering and theoretical understanding of how stuttering develops. Therefore, it is important when discussing outcomes to address particular questions. Firstly, who, if anyone chose or desired this particular outcome? What was the original intended outcome of the intervention? Were there unintended outcomes? How were the outcomes measured?

1.5.1.1 Who chooses the outcome? Satisfaction with therapy outcomes is directly linked to the goals selected in therapy. When targeted goals in therapy do not fit with individual priorities they become extra tasks to include in already busy lives (Granlund et al., 2008) and their relevance diminishes along with the likelihood of a positive or maintained outcome. The challenge for people who stutter in choosing an approach focusing on fluency as its primary outcome is maintaining that level of fluency and practice of techniques (Cream, Packman & Llewellyn, 2004). Speech restructuring involves the adoption of a novel speech pattern that reduces or eliminates stuttering (Cream et al, 2004; p182). Prolonged speech is one particular technique commonly described in the literature (O'Brian et al., 2003; B.P. Ryan & Van Kirk Ryan, 1983). However, in a discussion of the experience of adults after therapy with prolonged-speech, Cream, Onslow, Packman and Llewellyn (2003) described how users must continue to attend to various aspects of speech production in order to exert control over their stuttering. Further, stuttered speech occurs to some extent after treatment and relapse is a common occurrence with participants expressing dissatisfaction with the attention to speech required when using prolonged speech and the quality of their naturalness of speech (Cream et al., 2003).

Conversely, for people who stutter who choose to manage their stuttering by eliminating or reducing the negative attitudes and resultant behaviours in order to minimize the occurrence and expectation of stuttering, the challenge is to accept that stuttering may always be present. This second approach, described as stuttering modification, has as a core goal that a person may stutter easily without tension or avoidance. The two approaches are in direct opposition to each other. In research of 216 participants who stutter by Venkatagiri (2009), 20% of people who stutter opted for fluency as a goal and 23% opted for freedom from the need to be fluent in (34 % in the fluency group and 23% in the freedom group were ambivalent). It is important for the person who stutters to recognise these choices and for the therapist to discuss with that person what the likely outcomes for therapy may be, in order that the choices made reflect the managing their stuttering. In selecting goals for therapy, desires and needs of the person are paramount.

1.5.1.2 What was the original intended outcome? Clinical outcomes can be defined variously as the measures of the intended effect of the treatment (Shenker, 2006) or the intended health benefits of the treatment (Onslow, 2006). The effect of a treatment (for example in a fluency-shaping programme) is considered by its proponents to be a reduction in stuttering behaviours. The health benefits of such treatment may be increased social participation. Other desired outcomes may be reduced anxiety about speaking situations or stuttering easily without tension (Yaruss & Quesal, 2006). The outcomes in stuttering therapy that we choose to measure are closely linked to our understanding of the disorder (Einarsdóttir & Ingham, 2005). This understanding can validate our understanding of stuttering and fit with our beliefs as to “what stuttering becomes” following therapy (Bernstein Ratner, 2005).

Research studies to date have focused primarily on outcomes that are quantifiable, such as reduction in the percentage of stuttered syllables and changes in speech rate. The challenge in recent times has been to acknowledge that there may be more than one outcome from intervention. There is also the strong possibility that research studies do not document or report on other desired outcomes or unintended outcomes from speech and language therapy for people who stutter.

1.5.2 Unintended Outcomes

Unintended outcomes have been described as those outcomes not intended by a purposeful action (Manojlovich, Lee & Lauseng, 2014) and fall under three categories: positive with unexpected benefit; negative with unexpected detriment and thirdly a perverse effect, opposite to the intended outcome. Granlund, Bjorck-Åkesson, Wilder and Ylven (2008) describe the stated goal of an intervention typically as a planned and desired outcome. However, any intervention may also result in other effects than the original identified goal (Granlund et al., 2008). These effects may be considered unplanned or unintended outcomes; they may be desirable or undesirable.

In a systematic review of unintended consequences of planned interventions in relation to nursing care, Manojlovich et al., (2014) identified a lack of reporting of such outcomes across studies. To date, there is a lack of reported studies describing unintended outcomes for people who stutter. One could hypothesize that unexpected positive benefits could relate to social participation or making connections with other people who stutter through therapy itself or through support groups. Negative outcomes could include an increased self-awareness that is unsupported by significant others. The perverse effect might be an increase in dysfluency, negative thoughts and feelings resulting in impaired function and a decrease in participation in everyday situations.

1.5.3 How are these outcomes measured? As previously outlined, if the goals of an intervention are, for example, the elimination of stuttered speech, then outcome measures need to reflect that goal, in order to evaluate the impact of the intervention in relation to that target. In intervention for people who stutter, measurement of the most commonly known aspects of covert symptoms (i.e., repetitions, prolongations and blocks of stuttering) has dominated the literature in outcomes research (Carey et al., 2010 Cream et al., 2009; Druce, Debney & Byrt, 1997; Jones et al., 2008). Successful intervention when viewed through this lens is indicated by a significant reduction in these overt stuttering behaviours (Guntupalli et al., 2006). These measurements however may not reflect what is of value to the client.

Having an evidence-based approach to treatment of stuttering does not absolutely require that we use frequency of stuttering moments (e.g., percentage syllable stuttered) as our outcome measure (Bothe, 2003). The impact of stuttering reaches beyond that of repetitions, prolongations and blocking behaviour. Complementing these measures of overt behaviours are assessment tools that describe and measure the feelings, attitudes and reactions that accompany stuttering. Granlund et al. (2008) suggested that in order to facilitate the selection of desired outcomes, it is helpful to consider the ICF.

1.6 The International Classification of Functioning, Disability and Health (WHO, 2001)

The International Classification of Functioning and Health (more commonly known as the ICF; WHO, 2001) replaces the ICIDH (International classification of Impairments, Disabilities and Handicaps; 1980) and is a landmark in the shift towards creating a distinction between aetiology and consequences (Yaruss & Quesal, 2004). The ICF acknowledges that everyone experiences some degree of decrement in health from time to time. By shifting focus from cause of disability to its impact, the ICF framework places all health conditions on an equal footing. Furthermore, it acknowledges the social aspects of disability and does not frame disability only as a ‘medical’ or ‘biological’ dysfunction. The ICF records the impact of the environment on the person’s functioning by the inclusion of contextual factors, in which environmental factors are listed, thus providing a “standard language and framework for the description of health and health-related states” (WHO, 2001; 2). Referring to the ICF allows the therapist to examine what a person can do in an optimal environment, (i.e., his/her level of capacity), and what they can do in their usual environment, (i.e., the person’s level of performance). It broadly defines disability as an umbrella term for impairments, activity limitations and participation restrictions. The focus is on the individual’s level of health, thereby emphasizing not the disability but its impact, as opposed to the impairment itself, or its cause. The development of a framework by Yaruss and Quesal (2004) applying the ICF to stuttering, supported the development of instruments for assessing treatment outcomes that directly relate to the life of the person who stutters. The Overall Assessment of the Speaker's Experience of Stuttering (OASES) focuses on the speaker's experience of stuttering as defined by the ICF (Yaruss & Quesal, 2006). Similarly, the Wright-Ayre Stuttering Self-Rating Profile, (WASSP, Wright & Ayre, 2000) is based on the ICF framework, and was developed to assess the person who stutter's perceptions of stuttering behaviours, thoughts and feelings about stuttering, avoidance of speaking situations and any perceived disadvantage due to stuttering. The development of these tools such as OASES (Yaruss & Quesal, 2004) and the WASSP (Wright & Ayre, 2000) and preceding both of these, the S24, a questionnaire that measures the ideas and beliefs of people who stutter regarding different kinds of situations where oral communication is required (Stipdonk, Lieftink, Bouwen & Wijnen, 2014), reflect the influence of the International Classification of Functioning, Disability and Health (ICF) (2001).

1.6.1 Outcome Measures and the ICF

Disagreement exists over what should be measured in evaluating stuttering or outcomes of programmes focused on changing stuttering, and who should do the measuring (Guntupalli et al., 2006; J.C. Ingham, 2003). Research into outcomes to date has focused on behavioural outcomes, for example changes in stuttering frequency, in randomised controlled trials (RCTs) to measure treatment efficacy. Behaviours that can be quantified, the overt symptoms, (e.g. syllables that are stuttered) are favoured when it comes to measurement. Some researchers assert that those studies that are most strongly supported by evidence are those that consist only of behavioural measures, for example stuttering frequency and rate (Ingham, 2003).

However, how Speech and Language therapists diagnose and measure these stuttering events has implications for research and requires consistency (Einarsdóttir & Ingham, 2005). This consistency has been the subject of many articles and much debate (Cordes, 2000; Cordes, 1992; Cordes & Ingham, 1995; Ingham & Cordes, 1997a; Ingham, Cordes & Finn, 1993). Research studies comparing stuttering measurement from different sources (Ingham & Cordes, 1997b) (Ingham & Cordes, 1997), have shown discrepancies between the judgements made by adults who stutter of their own speech, the judgments adults who stutter make about the speech of others and ‘authorities on research and treatment’ (Ingham & Cordes, 1997; p583) with differences in judgements across speakers, judges and situations. Earlier research (Cordes & Ingham, 1995; Ingham & Cordes, 1997b) involving experts in the field found agreement in clinical judgement between pairs of experts working within the same centre, but significant differences in judgement between one centre and another. High levels of consistency for counts of disfluency (Cordes, 2000) but ‘unacceptable levels’ of disagreement of disfluency types have been reported. Research indicates that with training, inter-judge accuracy on these measures can increase (Ingham et al., 1993). Differences in judgement may reflect the lack of a consistent definition of stuttering by those who stutter and by professionals working in the area. There are considerable implications arising from the lack of agreement on what counts as a stuttering event, not least for research that claims treatment effects (Ingham et al., 1993). Variation in systems of measurement impedes direct comparison of stuttering intervention programmes and their relative effectiveness (Baxter, Johnson, Blank, Cantrell, Brumfitt, Enderby, Goyder, 2015). The disagreements between the people who stutter and the professional (Ingham & Cordes, 1997b; p593) that is, “differences between what the person who stutters sees as stuttering and what the professional sees as stuttering”, have implications wider than that of any single research study.

1.6.2 Measuring the Impact of Stuttering

The impact of stuttering on people’s lives is more that just syllables stuttered (Yaruss & Quesal, 2006) and the negative consequences of stuttering remain long after the visible features have reduced (Yaruss, 2010). Research suggests that stuttering impacts on work performance and opportunities for promotion (Klein & Hood, 2004; Klompas & Ross, 2004), as well as activities of daily living (Koedoot, Bouwmans, Franken & Stolk, 2011) often resulting in an identity dilemma as people who stutter attempt to maintain and yet develop their identity in the face of intermittent emergence of a stigmatized identity (Butler, 2013). This struggle may involves concealing, drafting in unwitting others (for example allowing others to order for them) and role-playing in an attempt to achieve consistency in personal identity (Butler, 2013).

Therefore, one must ask if focusing on behavioural outcomes as the focus of measurement necessarily addresses what the client perceives to be of value. Reduction in syllables stuttered may have no impact on the everyday experiences of a person who stutters and may not have been their goal for therapy. For older speakers who have been stuttering for many years, changes in overt symptoms may not necessarily be accurate indicators of change. A decrease in the frequency of overt stuttering does not always equate with the successful change desired by the speaker (Manning, 2010b). Guntupalli (2006) highlighted the importance of client self-report, as experiential data from the people who stutter can provide valuable information about the sense of loss of control experienced by them in the moment of stuttering. Examining the anxiety, frustration and fears that Van Riper (1973) identified as contributing to the development of stuttering are key components to full assessment. Feelings of shame, helplessness, fear and avoidance are part of the themes identified in personal accounts of suffering (Corcoran & Stewart, 1998) by people who stutter. Anderson and Felsenfeld's (2003) research provides thematic analysis of recovery from stuttering in which the participants identified shame and low self-esteem when recalling their experience of stuttering. The detection of the person's cognitive and affective responses to stuttering is important to understanding how stuttering impacts upon the speaker's functioning and quality of life (Yaruss, 1998, 2010). Guntupalli et al., (2006) go as far to say that overt measures of stuttering behaviour should not be the primary tool when looking at outcome measures, but that self-report from the people who stutter can provide extensive information. Finn (2003), states that noticeable changes in symptoms do not always result in meaningful changes for the client. Speech and Language Therapists need to take “the view from within” (Vanryckeghem et al., 2006; p202) and utilize outcome measures that go beyond measures of the stuttering moment and its frequency.

If a clinically significant outcome for the client is meaningful change (Finn, 2003) this leads to questioning what this *meaningful change* is and looks like for a client. It is necessary to measure the behaviour that represents the client's complaint; however the problem of treating the ‘whole person’ can create a sense of “fuzziness” in dealing with evidence (Bernstein Ratner, 2005) because of the wide range of factors that can be considered as part of the stuttering problem. Outcome measures have implications beyond the identification of the therapeutic approaches that are best suited to our clients. The choice of a particular outcome measure highlights the therapist’s theoretical understanding of stuttering and the importance the therapist attributes to the overt and covert aspects of stuttering. In measuring outcomes, it is important to remember, however, that both success and failure are useful outcomes though in different ways (Abrahams, 1986). Relapse following attendance at intervention is referred to in the literature but with few exceptions (Stewart, 1996) has not been explored in depth.

1.6.2.1 Recovery

One cannot discuss the concept of relapse without first addressing the issue of recovery in stuttering. Although young children are more likely to spontaneously have a reduction in disfluency (Yairi and Ambrose, 2005; 2013) and have been described as recovering from disfluency (as discussed earlier in chapter 1), it is less likely that an adolescent or adult will become spontaneous and fluent speakers. A restricted definition of recovery might refer to completely spontaneous fluency though this represents a limited view of the change process. Recovery for adults from this researcher’s viewpoint refers to the successful management of stuttering. This may include an increase in fluency and a reduction in anxiety and avoidance of communication situations becoming competent, confident communicators.

1.6.2.2 Relapse. Relapse is a term often used to describe a return to original status or remission as in the case of a disease. Use of the term may be perceived as indicative of a medical model of intervention. For people who stutter, it has been proposed that “relapse and remissions are the rule not the exception” (Van Riper, 1973; p178). The difficulty in determining whether relapse has occurred is linked to the original or earlier difficulty in determining severity and defining stuttering. Definitions of stuttering are not necessarily provided with each outcome study published and consequently a definition of relapse can also elude the therapist.

People who stutter are best placed to evaluate what relapse means. Relapse as experienced by the client may be linked more with fear and avoidance of speaking situations than with an increased amount of stuttering. How progress is measured and success quantified by its very nature determines how relapse is identified. For example, if the outcome measured is percentage of syllable stuttered an increase in the number of syllable stuttered after therapy would indicate relapse. However, if the outcome measured is participation in a variety of social situations, reduction in participation would indicate that relapse had occurred. Inferring relapse on the basis of the recurrence of certain behaviours may be simplistic and not reflect the complexity of the disorder.

People who stutter may experience periods of increased stuttering for many reasons. Authors have speculated regarding reasons for relapse, and suggestions include the required continued effort to maintain a fluency enhancing technique and maintenance procedures (Manning, 2010; Venkatagiri, 2009); adjusting to a new role, that of fluent speaker (Evesham, 1985; Hayhow & Levy, 1989); lack of support for the new patterns of communication within the social and home environment (Kuhr & Rustin, 1985) and speaking in a non-habitual manner (Manning, 2010). Studies exploring outcomes from intervention for stuttering require, at a minimum, six months' follow up post-treatment, as the response to an intervention programme may be transient increased fluency that does not persist beyond the initial months. Awareness of the need for an extended follow-up post-intervention highlights the requirement for suitably detailed assessments for measuring both frequency of stuttering and the impact of stuttering.

1.6.3 Standardised assessments for measuring outcomes

The methods of measuring outcomes are subject to as much debate as the outcomes selected for measurement. As detailed above, measures that focus only on speech behaviours do not give a complete picture of the experience of stuttering for a person (Davidson Thompson, McAllister, Adams & Horton, 2009). In a comprehensive review of assessments for the non-behavioural or covert aspects of stuttering by Franic and Bothe (2008), seventeen instruments were identified through a comprehensive literature search: ten were selected for complete review based on specific criteria from previous publications and evaluated using fifteen measurement standards. None of the available instruments met more than eight of the fifteen criteria assessed (Franic & Bothe, 2008).

Onslow (2006) argued against the development of ever-increasing numbers of measures, preferring an inductive development of outcome measures driven by the concerns of persons who stutter. Measuring the effects of intervention on attitudes to speech, anxiety levels, locus of control and quality of life can be difficult to do with validity and reliability, and lack pertinent published research (Ingham, 2003). At the time of the publication of Ingham’s article, there was no one consistent standardised measure in use across reported outcome studies to measure effects of intervention on the consequences of stuttering. Yaruss (2010) suggested that the lack of focus on the consequences of stuttering in outcomes research is not due to the lack of measurement tools, but because the focus of treatment outcome research has primarily been on measuring the changes to observable stuttering behaviours.

In summaries of available research (Bothe, 2003), some approaches have been identified as having better research support than others, namely those referred to as operant or behavioural or fluency shaping procedures. Yaruss and Quesal (2006; p91) mentioned a number of potential explanations for the lack of treatment outcomes research focused on the “less-observable components of stuttering”. Historically, they were more difficult to define and measure; secondly, despite the availability of suitable measures there is uncertainty about the validity of many assessments (Franic & Bothe, 2008), their usefulness (Ingham, 2003), and their theoretical framework (Yaruss, 2006). However, “it is important to consider the speaker’s self- perception of their situation and, in many cases qualitative measures of the speaker’s narrative can provide valuable insight into the extent stuttering influences the person’s ability to communicate and participate in daily activities” (Manning, 2010; p236). In a recent systematic review (Baxter et al, 2015) a diverse range of intervention types delivered by clinicians demonstrated evidence of effectiveness underpinning their use for people who stutter. This review highlighted individual variability and acknowledged that no one programme meets the needs of all people who stutter. This review echoes Blomgren (2010)’s assertion that ‘no single approach to stuttering treatment can claim universal success with all adults who stutter’ (2010; p272).

Narratives of people who stutter have been used for thematic analysis (Corcoran & Stewart, 1998; Plexico et al., 2010) to explore experiences of stuttering and of successful therapy. While the use of Narrative Therapy for people who stutter has been documented (Leahy, O’Dwyer, & Ryan, 2012; Leahy & Warren, 2007; Ryan, O'Dwyer, & Leahy, 2015) this approach has yet to be explored as a means of evaluating change (i.e., measuring outcomes) for people who stutter.

Summary

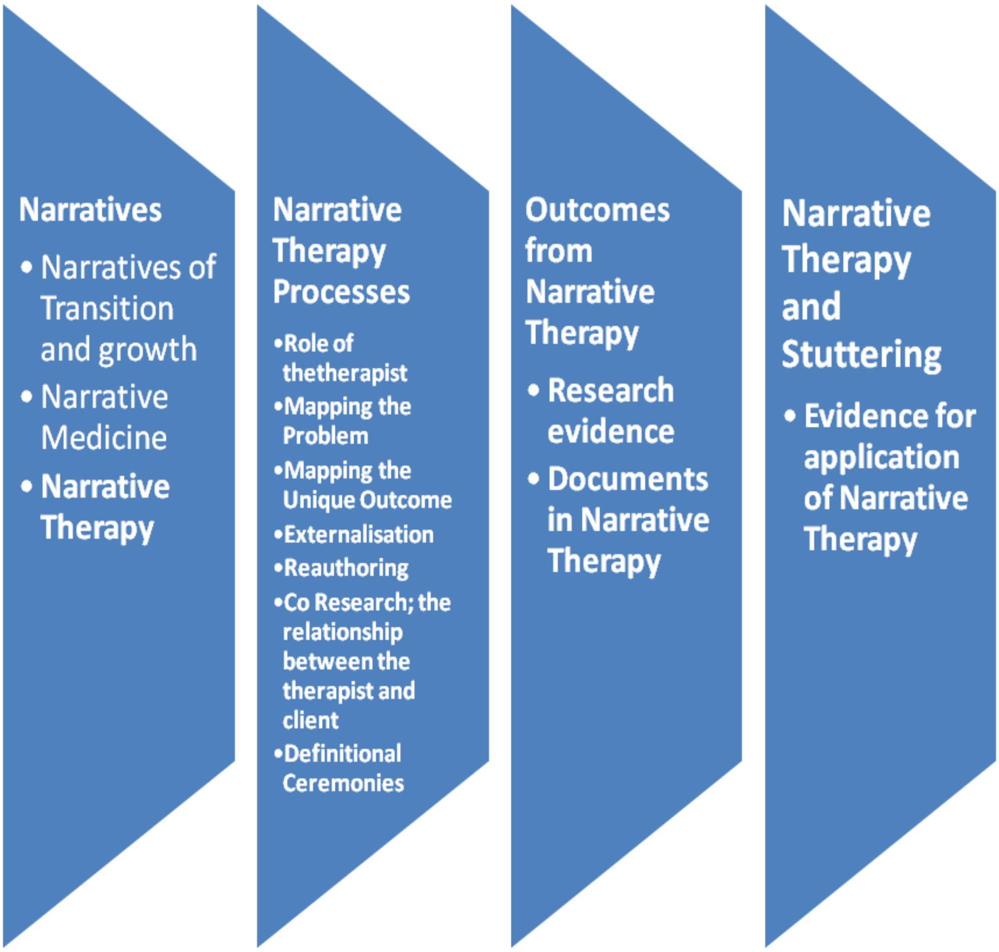
In sum, stuttering is more than the overt symptoms that are apparent to both the speaker and the listener. The ICF (WHO, 2001) recognises that while an understanding of etiology is important, it is the impact the disorder has on an individual’s participation in daily life and the influence of environment that are significant for the person. Despite increasing awareness of etiological factors in stuttering (both genetic and neurological), the lack of any clear explanation as to why stuttering persists with such significant consequences for some people who stutter, has resulted in many different theoretical models and a variety of therapeutic approaches, some targeting overt symptoms only, others targeting a combination of both overt and covert symptoms. In addition, concerns have been expressed at approaches that measure overt symptoms as the only barometer of change following intervention. Narrative Therapy has been suggested as a means of addressing these cognitive and emotional aspects of stuttering (Manning, 2010) and indeed may provide a means of measuring change for people who stutter.

Chapter 2

NARRATIVE THERAPY for Stuttering

In this chapter I outline the philosophy and development of Narrative Therapy. I discuss the processes involved in Narrative Therapy, its links with a wider movement that acknowledges the power and transformative nature of narratives and stories in medicine and I explore outcomes from Narrative Therapy that have been reported**.**

Figure 2.1 Overview of chapter 2



2.1 Narratives

White (2007) described human beings as interpreting beings, active in how we interpret our experiences: “We live by the stories we have about our lives, that these stories actually shape our lives, constitute our lives, and that they embrace our lives” (White, 2007; p14). In this way, narratives have been described as the organising principle of all human action with a structure that organises and gives meaning to experience (Bruner, 1986; Mattingly & Garro, 2000). The purpose of narratives is so that we as human beings can attempt to make sense of our subjective experience. Labov described narrative as a fundamental means by which humans make sense of the world, particularly in the creation of selves and social identities in discourse. His research showed that the everyday narratives of people are significant in the detailing of their lives, Labov, 2016; p593)

‘As a rule, my narrative analysis does not intersect with the quantitative study of variation, but is concerned with how experience is transformed in the interest of the narrator’.

Narratives themselves are subject to individual variability, coming in many guises, shapes and sizes, both familiar and unfamiliar. The term ‘Narrative’ itself is subject to many interpretations. The purpose of narrative in allowing us to interpret our experiences differs from the focus on the structure of the narrative itself. For Labov (1967) ‘narrative’ was a sequence of clauses with at least one temporal juncture, but a “complete,” “normal”, or “fully-formed” narrative included orientation and evaluation as well (Johnstone, 2016). Labov demonstrated that a certain kind of personal experience narratives have a predictable, describable structure.

Stories[3] or narratives allow a person to link aspects of these experiences over time (Epston, 1998). They teach where we come from, where we are going, and “assist in how the meaning of our lives is understood” (Charon, 2006; p42). When a person is asked how they are, the response given is a summary of their present condition in the light of past memories and bearing future anticipations in mind (Kearney, 2002). Every narrative therefore is under the influence of past actions and brings with it future possibilities. Narratives by their very nature are transitional, time dependent and influenced by many individual permutations, including the audience and the context in which the narrative is being performed.

2.1.1 Narratives of Transition and Growth With this perspective of how narratives are used to make meaning, narratives of transition have been examined for themes of personal growth and wellbeing (Bauer & McAdams, 2004b; King, 2001; King & Napa, 1998; King, Scollon, Ramsey & Williams, 2000). Narratives of transition are concerned with an individual’s sense of identity and identity in transition.

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[3] Stories and narratives are used interchangeably to describe how experiences are arranged in sequences across time.

2.1.2 Identity. The development of our sense of identity is not a discrete stage but rather a process that occurs over time (McAdams, 1993; Pulkkinen & Kokko, 2000). Identity is ‘storied’ and narrated: as new experiences occur, they are assimilated and integrated into the story of our self (Bruner, 1986; McAdams, 1993; Speedy, 2008; White, 2007; White & Epston, 1990). Some experiences may not fit with the dominant story of the self and may challenge the storied identity; such challenges create space for growth and reauthoring the narrative (White, 2007). As people mature, identity becomes concerned with generativity, and the need to pass on to the next generation. Generativity is partly as a result of societal demands and also of concern for the future generations. The desire for generativity draws on the individual’s sense of agency and communion (the need to be needed). This desire for generativity is reinforced by belief: belief in our species and belief in our sense of self. The end result of this desire is action and this action is narrated (McAdams, 1993).

Contingent on attaining this personal growth is the use of mature narrative processing which takes place when a difficult experience is encountered, followed by the construction of a positive resolution narrative (Bauer & McAdams, 2010; Bauer, McAdams & Pals, 2008; King et al.,2000; McAdams, 1993; Pals, 2006; Pals & McAdams, 2004). These difficult experiences may also be referred to as ‘transitional events’.

2.1.3 Transitional Events and Well-being Transitional events may be stories of trauma and grief through which people deepen their self –understanding and gain a deeper perception of the world (King, 2001). The impact of trauma on narrative identity is described as leading to personal growth (Bauer & McAdams, 2004b). In times when the environment or experiences we have do not conform to our expectations, there is potential for personal growth (King, 2001). This personal growth may be reflected in the stories told by individuals. Such stories of growth are not necessarily linked to gender, ethnicity or social economic status. If stories told have positive closure and acknowledge the changes made, there is evidence of higher levels of resistance to initial problem-based narratives over time (Bauer et al., 2008).

Bauer and McAdams (2004) in an exploration of personal growth in adults’ stories of life transitions identified four themes of personal growth in the narratives of life transitions: integrative, intrinsic, agentic and communal. Integrative themes are consistent with ego development and social cognitive maturity, involving new perspectives on one's self and others. Intrinsic themes however relate to social-emotional well-being, being concerned with personal growth and happiness. Agentic themes were found to be linked with satisfaction with transitions, having at their core, the achievement of desired outcomes and self-mastery; whereas communal-themes related to global well-being. Bauer and McAdams's research suggested that people whose narratives emphasized learning through times of transitions had higher levels of social cognitive maturity as a result; that is they viewed themselves and others with increased complexity. Bauer (2008) described how eudemonic well-being arises when stories emphasize personal growth, and transformative life experiences with a culturally shaped script of redemption. People whose stories emphasized intrinsically meaningful concerns had higher levels of well-being (Bauer & McAdams, 2010) that is their view of themselves was linked to their meaningful relationships and their contributions to society. King (1998, 2000, 2001) described the richness that emerges from a life filled with challenges including suffering, regret and mixed experience; "a life without loss is a life without meaningful investment" (King, 2001; p 64). Recognition of the rich significance of these narratives has resulted in development of Narrative Therapy and in a wider context, Narrative Medicine. As Narrative Medicine evolved on one continent (America) as a means of acknowledging the impact of chronic illness on the lives of people, Narrative Therapy developed on another continent (Australia) as part of family therapy, to assist people in the creation of solutions to the problem based stories that were impacting on their lives.

2.2. Narratives and Illness.

Illness and its story are governed by a set of rules described by Weingarten (1999) as a politics. The narrative that is told about an illness is affected by this, as are the storyteller and the audience (Weingarten, 1999). Franks (1995) identified three narratives of illness: restitution, chaos and quest. Restitution narratives anticipate getting well again and give prominence to the idea of cure; in a chaos narrative, illness seems to stretch on forever, with no respite or redeeming insights, and a "quest narrative" occurs where illness is transformed into a means for the ill person to become someone new. Restitution and chaos narratives may be associated with acute illness, whereas a quest narrative may align itself to narratives of chronic illness.

In Weingarten's description of illness narratives; she contrasts her own experience of breast cancer with her daughter's experience of living with a rare genetic disorder. The narrative concepts used to make sense of both their experiences include narrative coherence, narrative closure and narrative interdependence. Coherence describes the relationship between plot, characters, themes and values. The aspect of narrative closure that is described is cultural resonance; for example breast cancer has high cultural resonance unlike Beckwith-Wiedermann syndrome (her daughter's condition). Interdependence relates to how one person's narrative relates to another narrative.

Bell (2013) in a dialogical analysis described stages towards recovery in the narrative of a person with an eating disorder: firstly, recognition described as a growing sense of tension, or dissatisfaction, with the eating disorder; then a move to distanciation—distancing or separating from the eating disorder self; followed by articulation—defining an alternative way of being, a recovery self; and, finally, appropriation—where the recovery self is taken as one's own (Bell, 2013). In an essay on chronic illness, Hunt (2000) documented the disruption imposed by living with chronic illness, and how it presented a challenge to identity through the loss of existing roles. Her studies of people's adaptations to chronic and long-term illness identify how narratives are a means through which people can "restructure their sense of self' (Hunt, 2000; p89) thereby linking with Franks' (1995) quest narrative. Hunt describes the individual as entering different periods, starting with one of self-reflection and reorientation. This period provides an opportunity to redefine the self and social roles, allowing the person to address broader conflicts. Hunt gives as an example from her research into gender roles and reproductive cancers, where strategic use of illness stories allowed people to address pre-existing conflicts about roles within their family or community.

Kirmayer (2000) describes narratives in acute illness as broken by the intrusion of symptoms and the debilitating effects of illness on cognitive functions such as creativity; the narratives have not yet been developed or exist as several fragmented threads yet coherent narratives emerge with chronic illness. This description of fragmented threads echoes Franks' (1995) description of chaos narratives, where the uncertainty lends itself to anxiety about uncertain future and lack of respite. The stories told about a person’s life are subject to many influences, cultural, interpersonal and linguistic, and may have a common formal structure (J. Bruner, 2004). The stories told of chronic and acute illness may also be subject to similar influences.

With these examples of how narrative offers a structure for the understanding of illness, the development of both Narrative Therapy and Narrative medicine is contextualised. Both Narrative medicine and Narrative Therapy emerged over a period of time in the 1970s and 1980s, but on different contents and with differing foci.

2.3. Narrative Medicine and Narrative Therapy

Narrative medicine has emerged from a basis intertwining literature, medicine and narratives to develop a clinical practice which is fortified by the knowledge of what to do with stories, such as using narrative skills to absorb and interpret “stories of illness” (Charon, 2012). Narrative medicine emphasizes narrative knowledge as providing a frame for clinical work, joining with the client in obtaining a detailed picture of their situation at that point in time, or as Charon (2006; p4) proposes; “absorbing, interpreting and being moved by the stories of illness”.

Narrative medicine, by recognising the value of narratives in the depiction of chronic illness places emphasis on the role of the therapist and the narrative skills employed in bearing witness to such narratives. Narrative Therapy moves beyond this recognition and has developed processes to enable the therapist or therapist to assist in the transition from problem-based narratives to narratives that fit with the hopes, values and dreams of the person.

Narrative Therapy goes beyond the story of an event but exposes the “double landscape” of inner and outer worlds highlighting how events have meaning for the individual. This dual or double landscape refers to the landscape of action on which events occur, and the landscape of consciousness that is the inner world of the person involved in the action (Bruner, 2004; Mattingly & Garro, 1994; White, 2007). Narratives are used to understand the influence of social life and identity on people’s experience and can also be explored to address responses to particular situations or experiences such as long-term illness (Stephens & Breheny, 2013).

2.3.1 The Development of Narrative Therapy

Narrative Therapy has its origins in social constructionism that recognises that people construct their lives and identities socially and culturally, through language, discourse and communication (Speedy, 2008; White & Epston, 1990). Within this paradigm, people speak themselves into existence by inhabiting or performing a specific discourse or discourses (Madigan & Law, 1992) .The inhabiting or performance of a discourse reflects the prevailing social and power relationships present in the wider discourse in society (Foucault, 1980). As with any narrative, the key points are the story itself, the discourse and the telling of the story (E. Bruner, 1986; Turner, 1986) and each "telling" is influenced by the context and the audience.

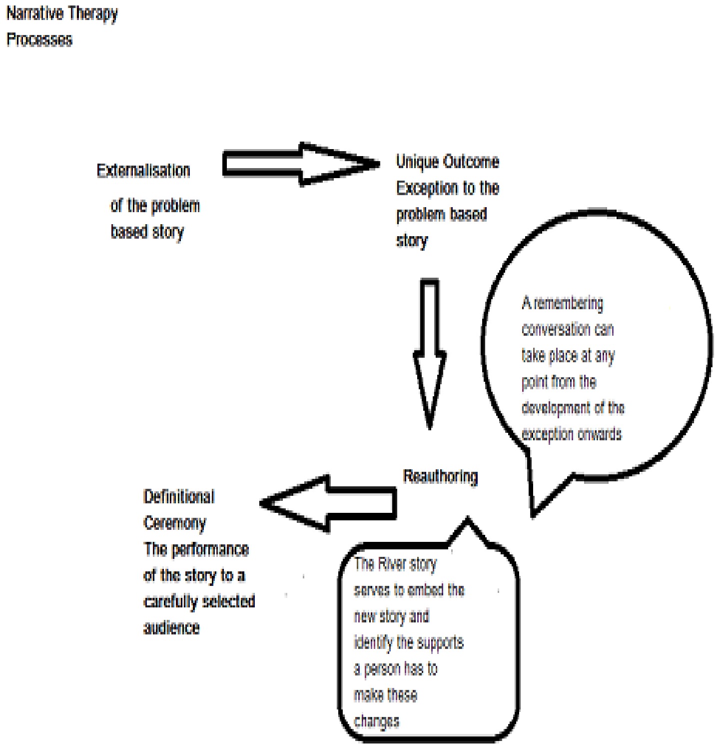
Narrative Therapy (NT) was developed by White and Epston in the 1980s and their book, *Narrative Means to Therapeutic Ends*, was published in 1990. As family therapists, White and Epston were concerned with recognising and centring the knowledge and experiences of people in therapy. Narrative Therapy was developed to provide an alternative view on the problems that people experience thus allowing tor the development of alternative stories and solutions to the problem based story. The use of narratives in therapy challenges the idea that we know how it is for others (Crocket, Drewery, McKensie, Smith & Winslade, 2004) and instead challenges us to become involved in the process of discovery of how certain experiences are for other people. White and Epston (1990) acknowledged the twin influences of anthropology and philosophy on their work in developing Narrative Therapy, drawing from Foucault's work on power and Bruner's anthropological studies (E. Bruner, 1986; Foucault, 1980; Myerhoff, 1986; White & Epston, 1990).

As a post-modern therapy, Narrative Therapy aspires to the acceptance of many possible truths; it recognises that there are many ethics to live by, multiple cultures and various forms of social organisations. This recognition leads to a focus on what it terms "local" knowledge that the person has rather than universal knowledge. This focus on "local" knowledge places the person at the center of their own story and the story of their lives. As a post-structuralist therapy, Narrative Therapy maintains that as words have no absolute meaning, any text is open to an unlimited range of local interpretation (Speedy, 2008). This process in Narrative Therapy, by which a conversation is open to infinite variety of possible meanings is referred to as deconstruction; stories are taken apart to look at the assumptions that lie behind them in exploring what White, (2000; 36) called the “absent but implicit”. The concept of “absent but implicit” refers to the implied “other” that exists behind every story. As an example, a person who stutters may refer to valuing being “perfect”, but what is implied in the valuing of perfection is the alternative of not being “perfect”. For example, in one Narrative Therapy session, a person who stuttered identified that for him the alternative to valuing being perfect was “trust” (i.e., in giving value to perfection he was letting go of ‘trust’: the trust that he could stutter with friends and that it would be ok). In Narrative medicine, Charon (2006) echoes this understanding of the implied “other” behind every story highlighting the importance of receiving the whole story “even the unsaid hints”. Narrative Therapy is also part of a wider movement incorporating Narrative medicine that recognises and gives value to the stories that people tell about what is significant in their lives.

2.4 Narrative Therapy processes

Narrative Therapy contains key processes that include the externalisation of the problem, identifying the unique outcome, reauthoring the story and definitional ceremonies. The processes do not necessarily follow in a linear fashion though it is generally accepted (White, 2007) that the externalisation process is the starting point. The identification of the unique outcome and the reauthoring conversation follow but may not be discrete processes with some overlap. The Definitional ceremony involves the performance of these stories in front of a select audience and as such links with all the processes. These processes are detailed further with examples below. Within each of these processes, the therapist takes a particular stance in order to lead to agency on the part of the person at the centre of the narrative.

Table 2.1 Narrative Therapy Processes



2.4.1 Role of the Therapist

The role of the therapist in Narrative Therapy is to facilitate the development of an illness narrative that makes sense of and gives value to the experience of the person at the centre of the narrative by recognising possibilities and sites for transformation (Charon, 2006, 2012; Kleinman, 1998; Mattingly & Lawlor, 2001). Mattingly and Lawlor (2001) suggest that the therapist creates moments in therapy which are open to possibilities and recognition of the client’s capabilities. These moments are referred to as healing dramas, moments when something is at stake for the person. A healing drama emerges initially through talk supported by the therapist, which becomes embodied and performed within the session. Mattingly and Lawlor (2001) give examples of such healing dramas and recognise how such dramas can be suppressed by a clinical culture given to valuing the routine over the dramatic, where diagnosis may frame what we recognise as appropriate treatment, and where there is a disconnect between what we believe to be important for our client at one level, and what our professional knowledge claims to know.

White (2007) describes the narrative therapist as decentralised and yet influential. The therapist embraces the role as an investigative reporter, not directing, not advising or problem solving but engaged in picking apart the workings of the problem (White, 2005, 2007). The therapist provides scaffolding by asking incremental questions that support movement from the known and familiar to what is possible to know and do (Ramey, Young & Tarulli, 2010). This therapeutic stance challenges the routinized therapeutic context as described by Leahy (2004), with its well-defined and expected roles and standard features. The therapist's act of bearing witness to narratives, particularly narratives of suffering, builds community; this community bridges the divides between client and therapist (Charon, 2006). Divides may exist in relation to beliefs about stuttering and its causality and the emotions that may include for example shame, fear and blame that isolate clients from those that provide a service for them. The role of the therapist in Narrative Therapy as co-researcher, invested in the process of excavating the problem jointly with the client, may address this divide and result in more meaningful outcomes. Leahy (2004; p71) describes how the discourse between client and therapist is the strongest element of the working relationship "through which the therapeutic healing or restorative process occurs".

2.4.2 Co Research: the Relationship between the Therapist and Client.

The role of the therapist in Narrative Therapy is in assisting the person to step into preferred stories, by encouraging them to re-author their lives according to alternative knowledges and practices that have preferred outcomes (Epston, 1998). This relationship between therapist and client is described by Epston (1989) as one of a co-researcher. Co-research involves reflexivity which represents the relationship between the researchers and researched, between researchers and texts, between researchers and the "stuff" of their research (Speedy, 2008). Epston (2004) describes co-research as being predicated on the belief that people can find their own solutions to some of the effects of their problems. For the therapist, taking the position of co-researcher recognises that the contribution made as a therapist is significant to the outcome of therapy (Denborough et al., 2004) but in an equal capacity to that of the person engaged in therapy. The therapist adopts a position of curiosity; both therapist and client are engaged in an exposé of the problem, picking apart the workings of the problem. In adopting this stance, the therapist creates a space in which the person can focus on the character of the problem and map its activities and effects.

2.4.3 Narrative Therapy and Terminology

Within Narrative Therapy, Michael White utilised very particular language to describe the unpicking and detailing of the problem and its effects. He encouraged the therapist to elicit a “thick” description of the problem, one which avoids the use of the therapist’s own words but rather highlights and gives value to the client’s understanding of the problem. This “thick” description is both detailed and particular to the person themselves. A “thick” description is one in which a detailed rich and meaningful (for the client) story unfolds. He describes this as an “experience-near” (White, 2007; p40) definition of the problem. It is based on an individual’s own understanding of life developed within the culture of their own family, community and life world. White (2007, 1990) utilises language in a particular way to honour the accounts of the people within whom he has excavated problem-based stories (externalisation); identified alternative stories and created the space for these stories to be heard.

2.5.1 Mapping the problem: Externalisation

Proponents of Narrative Therapy posit that there is a dominant story in life (White & Epston, 1990) and conflicts can emerge when this dominant story is one which is problem-saturated. The process of Narrative Therapy begins with this dominant problem-saturated narrative, which for the person who stutters may be a narrative saturated with the problem stories of stuttering and its effects (Leahy et al., 2012). As a great deal of one’s lived experience is not expressed within this dominant story, there are stories that fall outside the problem-saturated one. These other stories may be preferable to the dominant one. With every “performance” or telling of a dominant story within Narrative Therapy, that story can be re-authored (Epston, 1998).

The starting point in Narrative therapy is a process of separation (Morgan, 2007) beginning with an externalising conversation. A “thick and rich” description of the problem is elicited (White, 2000b) using White’s statement of position map 1 as seen in Table 2.1. The person at the centre of the therapy process starts by naming the problem, followed by a rich description of the manifestations and effects of this problem. This rich description requires a detailed examination of all facets of the problem. The development of the problem-saturated narrative is examined by the therapist and the person at the centre of the story, with past and present examples described in detail (White, 2007). This process allows the person to be aware that *the problem is the problem; the person is not the problem* – a fundamental shift in understanding aspects of identity for the person with the problem (White & Epston, 1990). In the final stages of the externalisation process, the person is asked to take a position on the problem, on whether they are satisfied with its influence on their life and to justify this evaluation of its influence. An example of this externalising conversation is detailed in Table 2.1, taken from Ryan et al. (2015, p. 272). In this table, RT identifies the problem as a "pest". This "pest" has resulted in early school leaving and reduced employment opportunities. In describing the effects, RT is encouraged to explore the impact of the "pest" on his social and emotional relationships. This leads to a 'thick' and 'rich' description of the workings of the problem. RT was asked to take a position on the problem. Typical questions at this point might include 'where do you stand on this issue? Is it OK with you that the "pest" has had such an influence? For RT it is not OK, he describes how he "got angry" as a result. The final piece is about justifying this evaluation of the problem. RT is not OK with it because it goes against his values; his speech, his wellbeing and his own mind.

Table 2.2: Statement of position Map 1 Summary of RT's externalisation (Ryan et al., 2015)

Category of Enquiry	RT's response
Characterization of the Problem/Naming	'*The pest'*
Effects across domains of living	"*Left school… (Stutter) had taken control… couldn't concentrate.* *Used to think …will always be in control'* *'Stutter stopped me from getting jobs I wanted, ended up working in jobs bad (sic) paid, working for people who treat me badly'* *'Wouldn't talk about it'.*
Position – Where do you stand on this?	'*I got angry'*

Justifying this position – Why? Linking with hopes, values ambitions	*‘Frustration that’s kind of doing something‘* *‘my speech, my wellbeing, happiness, my future’*

2.5.2 Unique Outcomes

Once the problem has been described or “mapped” in detail, the focus turns to exceptions to the problem. White (1990) describes people as being “rich in lived experience” but this experience may fall outside the dominant story that clients tell about their lives. Only a small amount of lived experience may be expressed at any one time and the stories and lived experiences that fall outside the dominant one are described as “unique outcomes” (White, 2007; White & Epston, 1990). This exception or “unique outcome” (sometimes described in the Narrative Therapy literature as a “sparkling moment”) is a time when the problem was not present or dominant. In the externalisation process, a space is created that allows the person telling the story to stand back, separated from the problem and the rich detailed map of the problem’s effects (White, 2007). This space in arts-based research is more usually described as creative or “liminal” and represents the threshold relationship between performer and audience.

Liminal spaces are the imaginative sites in which “to extend, provoke, and create knowledge in new ways” (Speedy, 2008; p33). It is in this transformative space that contact is made with the alternative stories that are available to the person. Charon (2012) describes this as a “clearing” in the woods where the person has time to stand out of the glare of the problem.

These previously neglected stories provide the basis for the re-authoring process. In one clinical example, in recognising the value he placed on “trust”, one person who stuttered was able to provide examples of when he had trust, in himself and others, and how this trust had allowed him to experiment with talking freely, thus leading the way to future actions, in his case re-engaging with therapy. By the therapist honouring the neglected story and attending closely, the client is moved to action

(Charon, 2012). The second map (Table 2.2) described by White (2005) outlines the conversation eliciting the exceptions to the problem-based story. These exceptions or "unique outcomes" are those occasions when the problem was not dominant and the person could act or perform in a way that he/she felt was preferable. This conversation details the negotiation of an "experience-near" definition of the unique outcome, a detailed description that is linked strongly to the experience of the person who stutters.

This identification of a "unique outcome" is the turning point in Narrative Therapy; it is the entry point to the reauthoring process, the creation of an alternative story. This exception to the problem story is then linked over time to past actions, embedding this exception into the person's new story and creating the possibilities of future actions. As the exception or "sparkling moment" (Leahy et al, 2012; p235) is mapped by detailed close questioning, the person is asked to take a position on it and then to justify the position. In taking a position on the problem, the person identifies the values that are important to him and connects these values to the action taken and in doing so possible future actions are identified.

This unique outcome is also "mapped" in White's statement of position Map 2. Statement of position map 2 in contrast to the first map (Table 2.1) outlines a rich and detailed description of the time when the problem is *not* present. This exception to the problem begins with a characterisation of the initiative or step taken. It is expanded further by exploring the impact of this step on relationships with him and others. As with statement of position map 1, RT is asked to describe his experience of this step, would he like more of this initiative? Finally he is asked why; why take this position on it, what it tells others about what he gives value to.

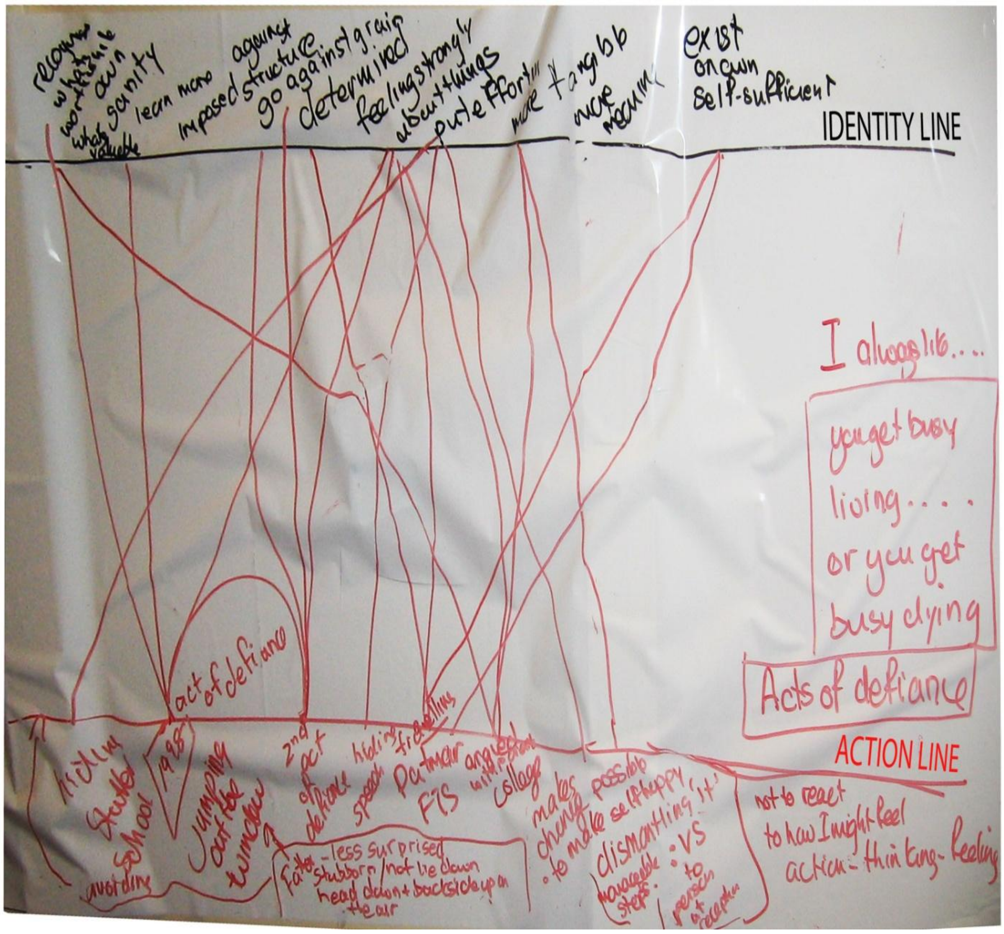
Table 2.3: Statement of position Map 2 (White, 2005): RT's unique outcome

Category of Enquiry	Response
Intentional understandings of this experience and understandings of what is accorded value (Why was this important for you, what does it tell me about what you value?)	Eccentric kind of. My mind the way I think Inside like, I'm laughing I don't do the obvious
Experience of this development (Tell me how this was for you?)	I just (clicked fingers) happened, I just got the idea I was just like (demonstrates motorbike).
Initiative in relationship	I laughed but I remember my mother's face. She was red. My Dad decided he would take me to football matches every Saturday instead
Characterisation of initiative (what was the step you took that day?)	Without words, I turned left and exited the stage.

2.5.3 Re-authoring

As outlined earlier, the unique outcome is linked to past actions (history) and to possible future ones (see Figure 2.2), linking thoughts and feelings to action along two lines of identity and action. This is known as a re-authoring conversation. The ultimate objective of Narrative Therapy is to re-author the problem-based story. The process of re-authoring begins with externalising the problem, (i.e., assisting clients to re-evaluate their relationship with the problem, through recognition that the problem is not an integral or necessarily dominant part of the person, and is developed further by the close questioning from the therapist). This questioning encourages the person to reflect on their lived experiences and employ their meaning-making resources. In this way, as the unique outcome emerges, it is linked through past actions to thoughts, feelings and values, emphasizing that this alternative story is linked to previous actions and to possible future actions. As with the previous Narrative Therapy conversations, the reauthoring conversation is "mapped". This map consists of two lines, the first described as the line of action, where steps taken by the person are written, and the second, referred to as the line of identity, whereupon the values ascribed to each action is highlighted. On completion of the map, the person at the centre of the re-authoring conversation is asked to name the story. The following map of a re-authoring conversation (Figure 2.2) is entitled "You get busy living or you get busy dying; acts of defiance" and outlines a re-authoring conversation between this researcher and one of the research participants, described later in greater detail.

Figure 2.2 Re-authoring Conversation



Embedding the new preferred narrative is furthered by a particular Narrative Therapy ceremony described as a Definitional Ceremony originating in the anthropological work of Myerhoff (1982, 1986).

2.4.4 Definitional Ceremonies

Definitional ceremonies provide people with the opportunity to tell or perform the stories of their lives before a select invited audience (White, 2007). White (2007) draws on the work of Myerhoff (1982, 1986) a cultural anthropologist, who coined the metaphor of definitional ceremony when working with an isolated Jewish community in Venice, California. The definitional ceremony was developed to address the problems of invisibility and marginality within a community, in this case an isolated Jewish community who felt marginalised by the wider community. It offers strategies that provide opportunities of being seen and heard on one's own terms with witnesses to this development (Myerhoff, 1986).The definitional ceremony has four distinct parts, with distinctive shifts in the roles of the teller of the story and the audience listening to it.

The first telling of the story involves the client telling a significant event in their life story at the invitation of the therapist, with the outsider witnesses as audience. The outsider witness then responds to what she/he heard, prompted by four lines of enquiry to enrich the retelling of the story: expression, images, resonance and transport. These lines of enquiry provide the outsider witness the opportunity to personalise the story, retelling it (to the client, now in audience role), with emphasis placed on elements of the story that struck the witness as important and that presented the witness with an insight into the client's life. This account of the story (as told by the outsider witness) is then followed by the client retelling the story, but this time, with the outsider witness's emphases, using the same four lines of enquiry. The final part of the ceremony involves both outsider witness and client in discussion with the therapist, reflecting on the first three parts of the ceremony.

Transitions between each stage of the ceremony are relatively formal, following specific traditions of acknowledgement (White, 2007). The therapist asks questions of the person in the speaker/witness role, such as: Would you begin by talking about what you heard that you were most drawn to (expression)? What came to your mind while you were listening to this (images)? What is it about your own life that explains why you were drawn to these particular expressions (resonance)? Where did the story take you to in your mind, as you listened (transport)? Each retelling enriches and thickens the new preferred narrative by providing evidence that counters the dominant problem-saturated narrative. It is also important to indicate that witness responses are not about the usual way of responding: they are not shaped by applause, or about making judgements about other people's lives, or about giving advice.

An example of a particular definitional ceremony has been published (Leahy et al., 2012) illustrating this process in detail. In the intervention programme *Free to Stutter ...Free to Speak* for people who stutter that will be described further in this chapter, the definitional ceremony occurs in the final days of the programme.

2.5 Outcomes in Narrative Therapy

White (2007) identifies the finishing point in therapy as that stage when the therapist is discharged from therapy. This happens when the therapist has become decentralised from the process because the client is performing the alternative and preferred stories of his/her life. These alternative stories allow the person who stutters to develop a multivoiced sense of identity. Identity is not a fixed entity but rather acknowledges life experience and skills of living that are co–constructed with others, thus providing a basis for the person to develop clear ideas on how to proceed with their lives (White, 2007). The metaphor of *migration of identity* has been used in Narrative Therapy to describe how a person carries with them their "cultural training" and yet must learn the culture of the "new land" which they now inhabit as they make significant changes in their lives (Crocket, 2004). For the person who stutters, this migration may include bringing past experiences of being a person who has struggled with communication in some situations, yet is now a person who can experience fluency or easy stuttering with reduced tension in these same situations. Therefore, a successful outcome might be described as leading to the client's improved self-mastery in functioning (Ramey, 2009, 2010).

2.5.1 Research evidence

There are few published studies detailing outcomes from Narrative Therapy. Those that are reported in the literature explore the experience of Narrative Therapy from the client's perspective (O'Connor, Meakes, Pickering & Schuman, 1997), the process involved in Narrative Therapy (Ramey, Young, & Tarulli, 2010) and particular unique outcomes of therapy (Matos, Santos, Goncalves & Martins, 2009). Gaddis (2004) explored research in Narrative Therapy from the clients' perspective, honouring their accounts of therapy. A central point of his research was to question whether the participants of the research found Narrative Therapy useful or relevant to them. A key finding reported in Gaddis's paper is that research into outcomes needs to acknowledge the steps taken by people in their own lives, homes and relationships rather than focusing on the developments within the therapy room. The benefits that emerged from Gaddis's (2004) co-research model were threefold: firstly, clients reported benefiting from the research itself, developing a richer understanding of their lives. Secondly, the therapists involved learned about how their clients experience them as therapists. Thirdly, new ways of working with clients emerged as a result of asking the clients what is meaningful for them in therapy.

Young and Cooper (2008) re-visited Narrative Therapy sessions with clients, by reviewing videoed therapy sessions with the participants of the research. The primary aim of their research was to identify what clients identified as useful and meaningful in therapy. The participants identified the narrative posture of collaboration and partnership as significant to the therapy process. In particular, the use of verbal summaries by the therapist was identified as facilitating openness. Similarly, O'Connor, Meakes, Pickering and Schuman (1997) explored clients' experiences of Narrative Therapy with emphasis on what the clients found helpful or unhelpful.

Six major themes were identified through the thematic analysis of interviews with research participants: externalising conversations; unique outcomes and alternative story; developing personal agency; consulting and reflecting teams; building the audience; helpful and unhelpful aspects of therapy. Time in therapy impacted on the outcomes, with increased time resulting in a greater reduction in the presenting problem. The deconstruction of problem-based narratives and the construction of alternative narratives take time. The audience as referred to in O'Connor et al.'s (1997) research is the narrative based "reflecting team". A reflecting team is a group of narrative therapists that observe sessions and provide feedback to the client and the therapist. This feedback may take the form of further questions to thicken the alternative preferred narrative or throw greater light on the workings of the problem story. Alternatively, the feedback may highlight or give recognition to the changes made by the family at the centre of the therapy (White, 2000, 2007). A reflecting team may also sit and discuss the problem-based narrative while observed by the therapist and client. O'Connor et al.'s (1997) research found that the presence of the reflecting team serves to embed the new narrative in context for the client providing support for the changes they are making.

Particular outcomes from Narrative Therapy have been reported in the literature (Matos et al., 2009; O'Connor et al., 1997; Ramey, Tarulli, Frijters & Fisher, 2009; Ramey et al., 2010; Young & Cooper, 2008). Matos et al.'s (2009) research into victims of domestic violence explored the relation between the unique outcome described by the person at the centre of therapy and the positive or indeed negative outcome from the intervention. In particular, Matos et al. explored the difference in unique outcomes (which she describes as innovative moments), between people with good outcomes and those with poor outcomes. Outcomes were delineated with reference to ongoing domestic violence and action by the women; for example cessation of violence and victimization was a good outcome; continued suffering and no alteration to pattern of violence was a negative outcome.

Two particular unique outcomes were identified in Matos et al.'s (2009) research as important for therapeutic change: re-conceptualization and new experiences. Re-conceptualization is where the client not only manifests thoughts and behaviours separate to the problem–dominated story but also understands the processes that are involved in it. New experiences are described as new intentions, projects, activities or investments that are planned or in progress. In good outcome cases, re-conceptualization and new experiences emerged in the middle of therapy and increased through the final phase, whereas they were almost absent throughout the entire process in poor-outcome cases. New experiences were almost absent from cases with poor outcomes. Matos et al., (2009) identify that change can be tracked using unique outcomes starting with action, reflection and protest, followed by re-conceptualization and action. They identified that this process can be cyclical.

These particular forms of unique outcomes are identified as increasing the likelihood of positive outcomes. Matos et al. (2009), deviate from White's metaphor-driven approach to unique outcomes and develops their own descriptors of unique outcomes referring to them throughout as innovative moments. The study addresses some interesting questions about outcomes in Narrative Therapy and whether they are indeed measurable in a conventional sense. Taking one aspect of the narrative process and linking it to outcomes, however, does not account for the other elements involved in the Narrative Therapy session. One particular aspect of the Narrative

Therapy process would be the role of therapist (Manning 2010, Stewart & Leahy, 2010); another would be the development of the richly described problem-based narrative that is the starting point of all Narrative Therapy intervention. This starting point is described by White (2000, 2007) as the map of externalisation. Matos et al. do not explore externalisation in relation to outcomes; however, their research does highlight the relationship between a specific process and positive outcomes. Ramey (2009, 2010) addresses the process of externalisation with children in Narrative Therapy in particular the linguistic scaffolding that is at the centre of the externalisation process. Ramey sought to examine whether narrative sessions demonstrated the type of conversation described in White's (2007) scaffolding conversations map. To study externalisation, Ramey analysed pre-recorded therapy sessions that were transcribed verbatim and coded according to the corresponding step on White's (2007) scaffolding conversations map. Despite small numbers in this particular study, it suggests that scaffolding can lead to externalisation within one session for children.

Kogan and Gale (1997) completed a textual analysis of a Narrative Therapy session. They explored how language and discourse function to create possibilities for meaning and interaction. They described therapeutic strategies including matching and self-disclosure; reciprocal editing; managing turns to de-objectify; expansion questions and the use of reversals to de-center accounts. Both Ramey (2009, 2010) and Kogan and Gale's (1997) studies explore the processes that are integral to a Narrative Therapy session in an attempt to link the processes to the outcomes.

Outcomes from Narrative Therapy for stuttering are not reported in the literature to date, no doubt because Narrative Therapy and its application for stuttering is as yet under-reported with few published articles (Ryan et al., 2015; Leahy et al., 2012). Outcomes from Narrative Therapy in general, as reported, do not use consistent frameworks of measurement. Some studies report on predictors of outcomes based on a Narrative Therapy process (Matos, 2009); others explore the process involved (Ramey, 2009; Kogan & Gale, 1997); and finally some studies explore in a co-research model what clients report as useful in therapy in obtaining desired outcomes (Young et al, 2008; O Connor et al, 1997), however none of these reported studies are in relation to people who stutter.

Outcomes may relate to identity as a competent communicator, with successful peer relationships and positive educational and work experiences (Plexico & Burrus, 2012). For people who stutter, the term recovery may have connotations of "cure" but in fact recovery may not mean regaining what once was lost, but reclaiming a "body" (Mattingly & Lawlor, 2001). Mattingly (1994, 2008, 2010; Mattingly & Lawlor, 2001) describes how recovery is not a cure but the recognition that; "despite a body lost, broken or largely silent there still exists a self worth making, worth struggling for" (Mattingly, 2001; p53).

Speedy (2004, 2008) suggests some potential outcomes in narrative practice from her work with clients as including the following: living a "more peopled" life (i.e., a larger cast involved with the know-how and knowledge to support and sustain the person in times of trouble), talking more openly about themselves, the problem and their resources and the importance of recognising their own resources. Speedy suggests that written documents to and by clients around the themes of outcomes could produce an extensive narrative practice outcomes archive (Speedy, 2004a). These written documents could offer thick descriptions of the outcomes, aftermaths and reverberations of the experiences in the lives of people in relation to the "therapeutic exchanges" (Speedy, 2004a).

2.5.2 Documents in Narrative Therapy

Documents in Speech and Language Therapy are traditionally reports written following assessment or at the completion of therapy to referral sources, for example to schools or General Practitioners. Typical documentation involves formal appointment letters advising of time, date and location of an appointment with warnings about non-attendance. Clients, particularly children, have been awarded certificates of achievement on completion of sessions of therapy. In Narrative Therapy however, documents are used in different contexts to further develop the reauthoring process, therapeutically increasing the impact of therapy "fourfold" according to Epston (1998, 1999). They can be used to supplement the face-to-face sessions by providing a permanent record of key moments. They are tangible and can be re-read. Documents can remind people how their stories change over time, giving a sense of history. They are conversations carried out on paper (Pentecost, 1998). Documents can thicken stories and lend more authority to the stories being told (Speedy, 2008; Stevens, 2010; Sue, Mem & Veronica, 1999). The power of documents has been described as acting as “a life-line to the self” (Sue, Mem, Veronica, 1999; p118).

Documents may be in the form of written letters or emails from the therapist to the client following a session. The letter or email may have further questions about the working of the problem to develop a rich description or may recall something particular the client said that the therapist wishes to question further. The use of documents in this way encourages the process of reflection both on the session and the narrative itself, serving to thicken the new preferred story. The written document therefore involves listening for the unexpected nuances within the session that can subtly shift the conversation and extend the context for the person.

Documents are core to the process of thickening narratives in the *Free to Stutter...Free to Speak* programme (outlined in detail later in this chapter). Following individual Narrative Therapy sessions, letters are written summarizing what has taken place highlighting points for reflection and possible future lines of enquiry. At the end of the intensive residential week, each person on the course is given a photographed copy of all their narrative maps as part of their own records and remembrances. These maps are added to the folders of informational material, artwork and supporting documents collated by the people attending the programme.

Documents, particularly those documenting events, can be seen as a declaration of facts (Sue, Mem, & Veronica, 1999). Epston (1999) describes as “archives of resistance” a collection of documents from the “anti- anorexia and anti-bulimia league”. The archives include documents from many clients about their process in resisting the influence of their eating disorders. In Narrative Therapy, Epston (1999) has used these to develop a community of clients who have resisted anorexia and bulimia to support those undergoing therapy for these eating disorders. The archives function both as a resource and a platform for anti-anorexia developments. These documents record “knowledge in the making”, they do not supply all the answers (Epston, 1999). The documents created by people who stutter record their changing stories through words and pictures.

2.6 Narrative Therapy and Stuttering

The complex multifactorial nature of stuttering with its unpredictable presentation has been reported as resulting in stigma (Boyle, 2013a). It has impact socially, emotionally and occupationally on the person who stutters and on their relationships with others (Iverach et al., 2009; Klompas & Ross, 2004; Koedoot et al, 2011; Kraaimaat et al., 2002; Manning & Beck, 2011). Behavioural stuttering treatments that focus on the elimination of stuttering behaviour do not address this impact or indeed the person's sense of being a person who stutter's and all that that entails.

Narrative Therapy has been used to address problem-saturated narratives that dominate the lives of people encouraging a sense of agency as they rewrite and re-author their story to one that fits with their hopes, values and dreams. For this reason, Narrative Therapy was identified as a possible means of addressing the impact of stuttering on the person who stutters and was introduced as a core component of the intervention programme *Free to Stutter...Free to Speak.*

2.7 Free to Stutter...Free to Speak (FTS)

Free to Stutter ….Free to Speak (FTS) is a six day annual residential programme for people who stutter offered in the Health Service Executive (HSE) South, established in 2009 by the researcher and a colleague. Narrative Therapy is a key component of the programme. Stuttering treatment is considered most effective when implemented in an intensive manner (Blomgren, 2013) and FTS is an intensive residential programme. It is an in depth approach that addresses both the surface elements of stuttering and the cognitive and emotional aspects that are considered part and parcel of the disorder. It focuses on desensitization to stuttering (e.g., through voluntary stuttering) and includes stuttering modification techniques designed to reduce muscular tension associated with stuttering moments and is influenced by Sheehan (1979) and Van Riper (1973). Additional components of the programme have been detailed in presentations (European Clinical Symposium, 2014: Oxford Dysfluency Congress, 2011; International Fluency Association, 2012) and include a stuttering modification approach and mindfulness.

2.7.1 Narrative Components of Free to Stutter ...Free to Speak (FTS)

Over the six days of the programme, the person who stutters is invited to externalise the problem, identify unique outcomes, participate in definitional ceremonies and engage in the re-authoring process. A further four review days are offered annually to those participants able to attend.

The initial Narrative Therapy session in the intensive programme addresses the Externalization process. The person is invited to develop a rich and thick description of the problem and the effects of the problem. On conclusion of this description the participant is required to evaluate the effects of the problem and to justify this evaluation. This process is video recorded and documented as in Statement of Position Map 1 (Table 2.1). The mapping of the problem occurs during the Narrative Therapy session and is photographed and presented to the participant as a contemporaneous record of the Narrative Therapy session in their own words. The map provides opportunities for reflection. As the problem is externalised, exceptions to this problem-saturated narrative emerge. The second Narrative Therapy session takes its lead from the emergence of these “sparkling moments” or “unique outcomes” (White 2007). Exceptions are documented and mapped in Statement of Position Map 2 (Table 2.2).

This process of identifying the alternatives to the problem-based narrative is developed further in the Re-authoring process, taking place on the third or fourth day of the intensive programme. The participant is asked to give further examples of the exception (in the recent past, distant past and the present) and in doing so embeds the new preferred narrative into his or her life story. In taking a position and naming this new and preferred story participants identify what is possible for them in the future. Figure 2.2 provides an example of a Re-authoring map. The final piece to the Narrative Therapy process is the embedding of the new preferred story in front of an audience of carefully selected outsider witnesses. The Definitional Ceremony (Leahy et al., 2012) takes place on the final day of the programme.

Following the programme emails and or letters are sent to the participants to further the development of the preferred narrative. In this way a dialogue is maintained between the therapist and the participant until the following review day three months later.

2.7.2 Evidence for the application of Narrative Therapy

Narrative Therapy was suggested in the literature as a possible intervention approach by Manning (2010) following from a concern that addressing the impact of stuttering was a requirement of any in depth therapy programme. The application of Narrative Therapy and its processes in the *Free to Stutter… Free to Speak (FTS)* programme have been reported in the literature (Ryan et al, 2015, Leahy et al, 2012) and in conference presentations (IALP, 2016; World Congress of Fluency Disorders 2012, Oxford Dysfluency Congress, 2011; ASHA, 2013; Narrative Medicine Conference, 2013; and the European Symposium on Fluency Disorders, 2014). However outcomes from Narrative Therapy and the treatment of stuttering have not been reported in the literature. For this reason Narrative Therapy and stuttering became the focus of this current research. The focus of this research as outlined in the following chapters is on the outcomes from Narrative Therapy within this intensive programme, as they relate to the Narrative Therapy process.

Chapter 3

METHODOLOGY

This chapter outlines the methodological considerations required when undertaking research-exploring outcomes from the real world perspective of people who stutter. As such, the objectives of the research, the methodological options are discussed and consideration given to epistemological concerns. Qualitative and quantitative methodologies are discussed and critiqued. In the final sections, the philosophy and process involved in the chosen methodology are outlined; chapter 4 will outline the method employed in this research.

3.1 Research Objectives:

This study is focused on exploring the outcomes from Narrative Therapy for three people who stutter following attendance at a Narrative Therapy programme (FTS) and the outcomes from the standardised assessments for a total of eleven programme participants. As discussed in earlier chapters, when considered in the context of evaluating effectiveness of therapy, outcomes are often measured using standardised assessment tools, yet the outcomes valued by people who stutter may not be reflected in the measures used by Speech and Language Therapists. Outcomes from any speech and language therapy intervention can be highly individualised and unique to each individual. Taking this into consideration, the approach selected to analyse the data in the study reported here needed to acknowledge the person-centred focus of Narrative Therapy, seeking to understand outcomes for programme participants, yet simultaneously recognising the standardised tools that are administered by Speech and Language Therapists in measuring outcomes.

The main research question for this study was:

- What are the outcomes for participants from the use of Narrative Therapy as implemented within the *Free to Stutter...Free to Speak programme*?

This question leads to a number of sub questions explored in this study.

- How do the outcomes identified through analysis of Narrative Therapy sessions relate to outcomes measured by existing published (standardised) assessment measures, such as the OASES, or WASSP that are currently in use?

- Are there identifiable stages within Narrative Therapy for participants in the *Free to Stutter...Free to Speak* programme and how should such stages be described? Where does “relapse” fit within these stages or is there a Narrative Therapy explanation for participants in this programme for what is commonly described in the literature as relapse?
- How does the Narrative Therapy process lead to these outcomes?
- As therapy involves personal change for people who stutter, it is important to consult with people who stutter regarding their preferred outcomes from therapy recognising that the outcomes may differ from the person’s original stated goals. Such self-reports of outcomes are under-reported in the literature (Guntupalli et al., 2006). How do the participants in the FTS programme view the outcomes identified?

Exploring these questions involved identifying a methodology best suited to the task. The questions are diverse and it was recognised that no single methodology might suit. Both qualitative and quantitative approaches to data analysis were required.

3.2 Methodological options

The methodological choice for this study needed to acknowledge the interplay between narratives and people’s experience of stuttering, while accommodating the recorded outcomes from the standardized assessments that were used to monitor changes in cognitions, feelings and behaviours following intervention. Furthermore, the self-reported outcomes from people who stutter needed to be included in a way that acknowledged and represented their position. In exploring outcomes, I wanted to acknowledge the viewpoint from the client who has been engaged in Narrative Therapy, and explore whether there were points of contrast between that viewpoint and the record of change captured in the standardised measures used to record therapy outcomes. Combining these two views required consideration of both qualitative and quantitative research approaches.

The potential data available for the analysis of “outcomes” was diverse and drawn from many different sources. It included standardised measures (e.g. OASES, WASSP and S24) transcripts of Narrative Therapy sessions, Narrative Therapy maps, and Narrative Therapy correspondence between therapists and participants, and finally, written feedback from research participants in response to the themes emergent from the analysis. Clearly, the approach required the researcher to interrogate transcripts of therapy sessions, examine in detail the Narrative Therapy maps and correspondence, and reflect on the participants' responses. This analysis and reflection process differed considerably from that required to interpret change over time as captured in standardised assessment measures such as the OASES, WASSP and S24. These assessments provide objective information as to changes, if any that occur. The wealth of the qualitative data available provides an insight into the process leading to outcomes. The challenge was to identify a methodological approach that exploited these contrasting sources of data in a meaningful way, drawing on both qualitative and quantitative paradigms. The framework for this research needed to respect and reflect what each of these data sources brought to the research questions. In this process of considering methodologies, epistemological issues needed to be addressed.

3.2.1 Epistemological Considerations

Narrative Therapy arises from a post-modern background, taking a position firmly in the postmodernist camp with its appreciation that facts as people see them are co-constructed and co-authored (Speedy, 2008). This move from the tradition of modernism is a move away from structuralism and functionalism. Structuralism implies that it is possible to have a direct knowledge of the world because behaviour is a direct reflection of the mind, in this way, assuming a particular behaviour can be categorized according to specific cause. Functionalism suggests that a symptom is a response to a cause and may serve a function; for example, a child stutters to gain more time to talk or increased attention from a parent. For a Speech and Language Therapist, adopting a functionalist and structuralist approach places that therapist in the role of expert, the person who holds the knowledge and has a familiarity with expert language inhabiting a position of power, thus giving value to "expert" knowledges rather than the local knowledges of the other person in the therapy session. In taking this position, the therapist provides the assessment, diagnosis and determines the treatment (Madigan & Law, 1992).

The dominant discourse in healthcare for many years, the medical model has been used effectively in the diagnosis and treatment of biological disease (Charon, 2006), yet strict adherence to this model may result in failure to assist the client cope with the loss of health and wellbeing that accompany serious illness and disability.

The development of the ICF (2001) acknowledged the impact of disease and disorder, challenging health care professionals to explore the impact of both on the person and to create the tools to do so. Beyond the creation of measures however, the ICF provided a challenge to the thinking and behaviour of those working in healthcare. This challenge had also emerged from the work of the French philosopher Michel Foucault (Foucault, 1980).

Foucault directed the emphasis away from modernism and the language of experts and towards a post-structuralist theory and discourse. Within this understanding, discourse reflects the words used *and* the complex power and social connections that prevail in situations (Madigan & Law, 1992). This understanding of discourse is significant for the current research study not only when considering any analysis to be undertaken of the Narrative Therapy sessions but also the overarching methodology selection needs to be congruent with this position. Within postmodernism there is no overarching “truth” but a belief that there are many truths and belief systems that people live their lives by. Narrative Therapy as developed by White and Epston (1990) opened up this space, highlighting the infinite possibilities available when local non-expert knowledges are valued. In taking an epistemological position in line with Narrative Therapy and as a Speech and Language Therapist, the research process needed to reflect and work within this paradigm. Phenomenology too, takes its position from a post positivistic post-modern stance, reflecting that the knowledge and values of the researcher can influence the interpretation even with acknowledgement and bracketing. Therefore, the question arose as to whether the standardised assessments and the “objective” reporting of results and statistics had its place in this research and whether it is necessary or desirable to combine a phenomenological approach with quantitative analysis.

3.3 Qualitative Approaches

The main purpose of this research is to interpret and illuminate the experiences of the participant adults who stutter, at different points in Narrative Therapy, with a view to exploring the outcomes from Narrative Therapy. Given this focus, qualitative approaches to methodology were considered. When considering qualitative research methodologies, the methodology must be congruent with the beliefs of the researcher. As a researcher, I have an interest in understanding the world from the perspective of the participants who share a particular experience of the world. Human beings exist within a social context, and as human beings we interpret events and experiences within this context. A further requirement for this qualitative research is the acknowledgment not only of the person's interpretation of events, but also that of the role of the researcher in the interpretation of the experiences documented (Ochberg, 1996; B. Smith, 1999; Smith, Flowers & Larkin, 2009). A Speech and Language Therapist by profession, I recognise that the interpretation of events is mediated by our use of language, allowing us to make meaning and sense of the events of our lives and the research approach selected needed to reflect this position.

Qualitative research involves the in-depth exploration of a particular experience and as such information is sought from the participants with direct experience of the issue under examination. Qualitative research further acknowledges the context in which particular events and experiences occur. The results from qualitative research can be expressed in narrative form, exploring the meaning and understanding of these experiences. This emphasis on narrative reporting is congruent with the process of Narrative Therapy that is under investigation in this particular research. I also recognised the wealth of statistical data pertaining to the participants that could frame the qualitative analysis and provide valuable additional data about outcomes.

3.3.1 Approaches Considered:

Different qualitative approaches were explored before the research was undertaken. One key data source for the current study was previously recorded Narrative Therapy sessions taken at particular points in time and not contemporary sources. I wanted to explore the sessions with reference to that point of time in therapy for the participants. I did not want to interview the participants about what their impressions were about it at a later date.

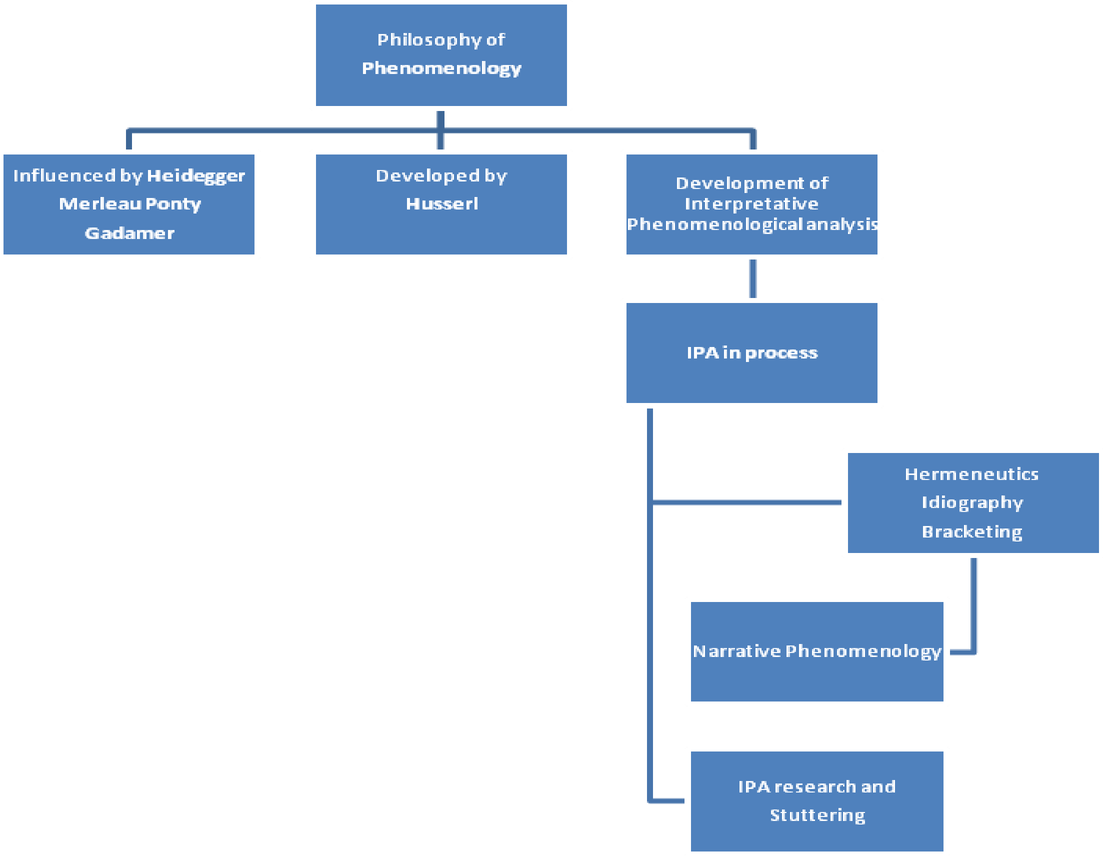
Following the presentation of a paper at the Oxford Dysfluency Congress in 2010, an article was published exploring a particular Narrative Therapy process: Definitional ceremonies (Leahy et al., 2012). For this paper, the application of Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009) for the analysis of a Narrative Therapy session was explored. It was contrasted with hermeneutic analysis applied by a second researcher (Leahy et al., 2012). Heidegarian hermeneutic phenomenological research (Cohen, Kahn & Steeves, 2000) studies peoples' interpretations of their lives and the meanings they give to their experiences. It involves a cycle of reading, writing, re-reading and re-writing and reflection. It also involves listening and responding to the story told. Both IPA and Heidegarian hermeneutic methods were used as a way of comparing different forms of analysis applied to Narrative Therapy in this paper.

As a result of this experience with the application of Interpretative Phenomenological Analysis, I felt that IPA would best address the experience of being a person who stutters. IPA is concerned with detailed examination of personal change (J.A. Smith et al., 2009) offering a way to reflect the person who stutters' engagement with Narrative Therapy over the time span of the intensive programme and the follow up sessions. In this study, I have collected data longitudinally from a small number of people who stutter, and this process was heavily idiographic with opportunities for triangulation from the many different sources available – narrative maps, Narrative Therapy sessions and narrative documents. As a result of this deliberation, the current research project employed a phenomenological approach, because this form of enquiry explores how things are in the real world for people. This approach to research requires systematic curiosity into how others live and experience their lives. For the second strand of the research (the comparison of the emergent themes with the outcomes from standardised assessments) a quantitative approach using statistical analysis was required.

3.4 Philosophy of Phenomenology

Phenomenology is both a life philosophy and a research process (Flood, 2010; Tuohy, 2013). Developed by Husserl, widely considered the father of phenomenology, as a philosophy it is concerned with life and living (Giorgi & Giorgi, 2008; Husserl, 1031, Tuohy, 2013). As a research method, phenomenology is inductive and descriptive, where researchers attempt to study phenomena, as they are consciously experienced (Giorgi & Giorgi, 2008; Jacobs, 2013; Larkin, Eatough & Osborn, 2011; B. Smith, 1999; J.A. Smith, 2011). Phenomenological research aims to clarify situations lived by people in everyday life (Giorgi & Giorgi, 2008). The assumption behind phenomenology is that there is a collective essence to shared experience, that this experience is complex, uniquely embodied, situated and perspectival (B. Smith, 1999; J.A. Smith et al, 2009). Phenomenology is concerned with the descriptive investigation of phenomena. The aim of phenomenological research is to explore experiences and meanings as close as possible to the context in which they occur. Although widely considered as having been first described by Husserl, the further development of phenomenology was influenced by the philosophers Heidegger, Merleau Ponty and Gadamer, each contributing in their own ways to its development, as outlined in the next section and in Figure 3.1.

Figure 3.1 Phenomenology Explored



3.4.1 Husserl and the development of phenomenology. As the founding father of phenomenology, Husserl was primarily interested in studying consciousness and the characteristics of the phenomena under investigation (Husserl, 1931). The purpose of his approach to phenomenology was to explore the realities of life and living (Tuohy, 2013) and Husserl's philosophy is referred to as "descriptive" or "eidetic" phenomenology. This approach involves putting to one side 'the taken for granted world' to concentrate on the researcher's perception of that world in order to view the data with fresh eyes. The aim is to describe the phenomenon in its purest form as it occurs, in its natural state and with fresh eyes so that the true essence of the phenomena is revealed. Researchers strive to put to one side their knowledge, so that there can be no influence from this knowledge on the instance being considered (Giorgi & Giorgi, 2008; Husserl, 1931). In this way they bracket and by this process of bracketing reduce, attempt to arrive at the essence of the phenomena before "any interpreting beliefs rush in" (Davidsen, 2013; p321).

In the tradition of Husserl, bracketing is the suspension of all presuppositions (Ashworth, 1999): in other words the researcher must identify and reflect on his/her own preconceptions and have a critical attitude to knowledge or facts that are taken as a “given”. Initial bracketing is followed by proceeding through a series of “reductions”, with each reduction offering a different lens or prism, a different way of thinking and reasoning about the phenomenon at hand (Husserl, 1931; J.A. Smith et al., 2009). Reduction involves treating all details with equal value, in an attempt to understand all phenomena at the same level. Reduction is not a reducing process but rather described as a “leading back to” the phenomenon in question resulting in a greater understanding of that phenomenon (Larkin et al., 2011; p5). If reduction is executed properly biases are minimised. Husserl asserts that the essence of the experience in question becomes apparent and the process then results in reaching “the stream of pure consciousness” (Husserl, 1931; p111).

The twin processes of bracketing and reduction were significant elements in the application of IPA in the research reported here. In the current study, as a researcher my aim was to put to one side my previous understanding of what outcomes might be for people who stutter (bracketing) and by the process of reading, and re-reading the transcripts, listening to the recorded Narrative Therapy sessions (on DVDs) reduce my initial thoughts on coding to core beliefs and themes that I feel are the essence of the experience.

3.4.2 The influence of Heidegger on phenomenology. Heidegger introduced hermeneutics, also described as interpretative phenomenology (Tuohy, 2013), to phenomenological philosophy. While Husserl was primarily concerned with individual psychological processes such as perception, awareness and consciousness, Heidegger was more concerned with the question of existence itself and the practical activities of life. He was primarily concerned with “Dasein” or being in the world. Heidegger asserted that we can never truly bracket off our experiences and the presumptions that we bring to a text (Karademir, 2013). All our descriptions involve interpretation (Davidsen, 2013); the process of making meaning in everyday life involves interpretation. Rather than put our understandings to one side, he argued that we need to be aware of and acknowledge them. In this way Heidegger further developed the process of bracketing.

According to Heidegarian philosophy all our experiences need to be understood in temporal context between past, present and future. It is only when we immerse ourselves in a text, and engage with the text that we know which of our thoughts and beliefs have influenced our interpretation. Analysis involves building thematic representations, constantly refining thoughts and ideas through discussion, writing and rewriting (Wilson, 2014). In this way, researchers have an active role in what is seen as a dynamic process (Davidsen, 2013; Jacobs, 2013; Wilson, 2014). Hermeneutics acknowledges the influence of researchers' own beliefs and perceptions. As a consequence of this understanding, bracketing in the research reported here was cyclical, returned to again and again, so that as the researcher, I was aware of my personal influence on the interpretation of the text.

3.4.3 Merleau Ponty and the situated perspective. Merleau Ponty (Smith et al., 2009; Davidsen, 2013) shared both Husserl and Heidegger's concern and interest in understanding of our "being-in-the-world". However he emphasized the individual's own situated perspective of this "being-in-the-world". He described the "embodied" nature of our relationships. How we see our world is from our own unique perspective and the position we take in viewing another individual's experience is always from a position of "other". Therefore although we can empathise, we can never truly share the other person's experience because it belongs to that person's own "embodied" position in the world (Smith et al., 2009). Acknowledging this position of "other" required that I consult the participants about the themes elicited from the analysis.

3.4.4 Gadamer and the language of meaning making. Gadamer recognised the importance of the language we use for meaning making and for interpreting. In an attempt to understand a phenomenon we are already bringing our own interpretation to that phenomenon. Our very existence is hermeneutic and it is not possible to keep a critical distance from the world and our experiences. Interpreting and understanding involves the person who is trying to understand and interpret, and this person occupies a position that is defined by past experiences (Davidsen, 2013; Smith et al., 2009). In order to acknowledge Gadamer's position on the hermeneutic position, a research journal was kept reflecting on the process involved in this study. Further discussions were held with supervisors and peers to clarify my position and interpretation of the themes emerging from the evolving analysis.

3.5 The Development of Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA) emerged from phenomenology and is influenced strongly by the philosophies and work of Husserl, Heidegger, Merleau Ponty and Gadamer. It is a method that has been informed by three areas from the philosophy of knowledge: phenomenology, hermeneutics and idiography (Davidsen, 2013; Eatough & Smith, 2006; Smith et al., 2009). IPA is concerned with “the human predicament” (Smith et al., 2009; p5) particularly focusing on how people engage with the world and reflect on their life experiences. As such the researcher is engaged with a double hermeneutic: in researching other people’s experiences she is trying to make sense of other people’s attempts to make sense of their own experiences.

IPA is a qualitative approach to research, focusing on the systematic examination of how people make sense of their major life experiences. IPA analysis involves interpretation and making sense of what is being said or written, involving close interpretative engagement on the part of a listener or reader. Primary research questions in Interpretative Phenomenological Analysis generally focus on peoples’ understanding of their own experiences. It follows therefore that, as an aim of this project was to gain an understanding of therapy outcomes for those who had participated in the FTS programme, IPA was chosen by the researcher as the primary interpretative paradigm for data analysis. Prior to the specific description of the procedures of the current research, I felt it was important to fully describe the development and some of the past applications of interpretative phenomenological analysis.

As outlined above, IPA attempts to capture particular experiences as experienced by particular people; it explores the meaning of the participants’ lifeworld and their personal experiences and perceptions (Davidsen, 2013; B. Smith, 1999). The researcher aims to understand the stories as they are experienced by the participant and to interpret and understand the interaction and context that the participant is part of. IPA is concerned with the detailed examination of human lived experience. The aim is that the examination itself is conducted in such a way as to enable the experiences be expressed in their own terms and as they are consciously experienced (B. Smith, 1999). IPA does not follow a prescribed path: the researcher must adapt the method to his or her own way and topic (Davidsen, 2013; Eatough & Smith, 2006; Larkin et al., 2011; Smith et al., 2009).

3.5.1 Interpretative Phenomenological Analysis in process. As IPA involves the detailed analysis of particular cases and particular experiences, studies involving IPA usually have small sample sizes (Plexico & Burrus, 2012; Plexico et al., 2010; Smith et al., 2009). The aim is to understand in detail what a particular experience is like for a particular person. Data collection may be in the form of interviews or as in this study, transcribed therapy sessions. Each recording is transcribed and the process begins with repeated reading and re-reading of the transcript. Each transcript is analysed in a systematic way. A narrative account is developed by the researcher and presented supported by direct quotes from the transcripts (Bricker-Katz, Lincoln, & Cumming, 2013; Larkin et al., 2011; B. Smith, 1998). IPA however does not follow a prescribed path, there is no "recipe" (Davidsen, 2013) and IPA must be adapted to the researcher's topic. Key to the process of IPA is adhering to the double hermeneutic, firstly by interpreting the stories as they are experienced by each participant and then interpreting the interaction and the context that the participant is part of. Hermeneutics, idiography and bracketing are integral to the process of interpretative phenomenology.

3.5.2 Hermeneutics. Hermeneutics, the theory of interpretation, is concerned with identifying the methods and purposes of interpretation itself. The hermeneutic circle is a way of thinking about "method" for IPA researchers. In IPA, the process is iterative: moving back and forth through a range of different ways of thinking about the data, rather than completing each step, one after the other. In hermeneutics the researcher has to be aware of his or her own feelings, values and beliefs (B. Smith, 1999), as the researcher acknowledges his/her own background and uses it in collecting and interpreting data (B. Smith, 1998). Following the initial reading of the transcripts and identification of emergent themes, the researcher returns to the study of the phenomenology texts (Engelland, 2012; Husserl, 1931; Jacobs, 2013; Karademir, 2013) to go beyond the search for method and explore a richer understanding of phenomenology. Interpretation is not a matter of following mechanical rules but requires the combination of a range of skills including intuition. Understanding does not emerge in a complete way or all at once (Smythe, Ironside, Sims, Swenson & Spence, 2008), the thinking is always “situated”. Recognition of this acknowledges the influence of Heidegger’s “Dasein”.

3.5.3 Idiography. Idiography is concerned with the particular details of a particular experience. Interpretative Phenomenological analysis is strongly idiographic, starting with the detailed examination of one case until some degree of closure has been achieved. IPA’s commitment to the particular operates at two levels: firstly analysis must be thorough and systematic, to focus on the detail. Secondly, IPA utilizes small, purposively selected and carefully situated samples, and may often make use of single case analyses in order to understand how particular phenomena (an event, a process or relationship) are interpreted from the perspectives of the people at the centre of that phenomenon. Researchers identify a closely defined group for whom the question will be significant. When taking an interpretative phenomenological approach, one case is examined, until closure has been achieved, before moving to a detailed examination of a second case (Eatough & Smith, 2006; Plexico & Burrus, 2012; Plexico et al., 2010; Smith, 2004, Smith et al., 2009). With each case, the hypothesis is revised and extended. It is an iterative procedure, allowing for reflection and modification of one’s thinking in the light of the next piece of evidence assessed.

3.5.4 Bracketing. In IPA, bracketing is a process in which theories, research presuppositions and ready-made interpretations are set aside, in order to reveal lived experience (Ashworth, 1996; Giorgi & Giorgi, 2008; Hamill & Sinclair, 2010; Jacobs, 2013, Larkin et al., 2011; Smith et al, 2009). In theory, bracketing allows the researcher to temporarily suspend what she thinks she knows. According to Ashworth (1996; p3) the aim is to allow “description to be carried out in as undistorted way as possible”.

Bracketing requires that two main categories of presupposition be acknowledged and dealt with (Ashworth, 1999): firstly the imposition of the claims of objective science and/or authorative sources, for example previous research, into the lived experience of people who stutter (Corcoran & Stewart, 1998; Plexico & Burrus, 2012; Plexico et al., 2010) and secondly, the imposition of the researcher’s own understanding of outcomes on the interpretation of the data. In this study, for example, it was necessary to bracket the presuppositions of the researcher relating to outcomes and what they might be for people who stutter; the researcher cannot adopt a position on the truth, or otherwise, of the claims of the research participant.

Bracketing also requires that the researcher's own personal experience with the phenomenon under investigation needs to be acknowledged. Presuppositions need to be brought to the level of consciousness before being acknowledged and then bracketed. Jacobs (2013) describes this as the phenomenologist seeing herself seeing, acknowledging that all our knowledge is fallible, yet not giving up on aspirations of uncovering the truth. This acknowledgement is part of the bracketing process where taken-for-granted assumptions for example linked to gender, race, socioeconomic status and personal beliefs are considered, acknowledged and "bracketed" to one side.

3.5.5 Narrative phenomenology: linking the narrative and the role of the researcher. The linking factor between the IPA of the client's narrative and analysis of the structure of the story is the role of therapist/researcher in the creation of narratives of transition. The role of the therapist/researcher provides the necessary understanding of context that is required for IPA. The use of IPA as a process and as a way of identifying themes emerging from narratives is further developed by identifying the narrative structures at play in Narrative Therapy sessions. Mattingly (1994, 2000, 2010) described in detail how the therapist co-creates a narrative space which Mattingly terms narrative emplotment. An essential component of narrative emplotment is the concept of narrative time, where plot, desire, transformation, trouble and suspense link, to create a healing drama. Beyond themes identified through the use of Interpretative Phenomenological Analysis, narrative phenomenology explores the healing drama itself. What Bauer (Bauer & McAdams, 2004a; 2004b; 2010; Bauer et al., 2008) describes as narratives of transition, Mattingly (2010; p11) describes as canonical breaches in a "cultural borderland". These breaches are spaces for transformation and transition. Narratives of transition are described as difficult experiences that lead to personal growth and awareness, resulting in a culturally shaped script of redemption. She gives examples from ethnographic studies in paediatric healthcare, describing in detail the moments when sessions turned and became spaces of transformation (2001, 2010), allowing the child at the centre of the session to present a different story of themselves and for this transformation to be recognised by the therapist (in these cases occupational therapists) and also by caregivers. This recognition of the role of the therapist/researcher is a key process in IPA. The awareness that the therapist/researcher brings in interpreting the narratives is acknowledged through the process of bracketing.

3.6 Interpretative Phenomenological Analysis (IPA) Research in Stuttering

Published IPA studies span a wide range of areas including aspects of therapeutic intervention dealing with issues that are life transforming and/or life threatening, along with identity “in all its guises, manifestations and complexities” (J.A. Smith, 2004;p 49). Interpretative Phenomenological Analysis has been applied to examine the experience of stuttering in the workplace (Bricker-Katz et al., 2013). Bricker-Katz et al. (2013) identified four superordinate themes relating to the work life experiences of people who stutter. They described three key components to their application of IPA in their research. These components were: the common experience shared by the participants at the core of the research (in this case stuttering); the description of the lived experience and its interpretation by both the person at the centre of the experience and the researcher (“the double hermeneutic”); and finally idiography, which has to do with seeking to understand both the experience and the interpretation of the individuals. The major finding was that the participants experienced stigma specific to stuttering that generated feelings of self-doubt and self-reproach in the workplace. Self-stigma develops when “beliefs perpetuated by public stigma become internalised and when these beliefs prevail throughout the years of growing up” (Bricker Katz, 2013; p352). The authors found that self-stigma can significantly limit goal setting in work situations and it may also limit goal setting in the therapeutic context.

The following themes emerged from the research reported by Bricker-Katz et al., (2013): stuttering is always there; stuttering at work reveals a problem; stuttering limits communication and stuttering limits occupational progression. In an earlier study also led by Bricker-Katz (Bricker-Katz et al., 2010), thematic analysis (rather than IPA) was used to explore the limitations to activity and participation experienced by older people who stutter. In this earlier study, factors that would assist better communication and preferred therapeutic approaches were explored (Bricker-Katz, Lincoln & McCabe, 2010). Previous research has suggested that the impact of stuttering lessens or reduces with age (Manning, Daley & Wallace, 1984); however there are no identified studies looking at the impact of stuttering with older people who stutter to support this hypothesis.

In a study presented by Plexico and Burrus (2012) the coping strategies of parents of children who stutter were explored, along with the functions that coping strategies serve, and the impact that different coping strategies chosen by parents had for the parents. Furthermore, in their study, as in the current study, IPA was the chosen methodological approach. A rich description emerged which detailed the "what and how" of coping, before the narratives were reduced to key themes. Plexico and Buruss's (2012) method was based on the work of both Moustakis (1994) and Colaizzi (1978). Colaizzi's method of phenomenological enquiry extended the work of Edwards and Welch (2011) to include symbolic representations as an additional information source. These symbolic representations included poetry, painting, music and artefacts which assisted in the articulation of experiences.

Two of these studies highlight the application of Interpretative Phenomenological Analysis to explore the experience of people who stutter. Although not specifically related to identifying therapeutic outcomes, the findings the studies yielded provide an important theoretical and methodological backdrop for research on the therapeutic outcomes for people who stutter. Identifying the impact that stuttering can have on the everyday life of people who stutter and the resources that people have to cope with the challenges that arise, suggests that successful outcomes may relate to work or education and may not be directly linked to speech outcomes. What these studies share is the light they throw on the experiences of people who stutter. They highlight that intervention can lead to many different places and that outcomes that are valued may be unrelated to speech production.

3.7 Quantitative Approaches

This study arose because of clinical curiosity and a desire to understand more about the outcomes from therapy and the assessments used by therapists to measure outcomes. Intervention was being provided for people who stutter that was innovative and as a central tenet of all clinical intervention is evidence based practice I wanted to know not just whether this intervention was effective but what the outcomes looked like for people who stutter. Evaluating clinical effectiveness involves in the first instance reviewing the measures that were administered to provide a clinical baseline pre- and post- intervention. As a Speech and Language Therapy professional I strive to maintain and develop the provision of services in line with best practice and supported by the best available evidence according to *IASLT Code of Ethics*. Evidence-based practice involves the integration of the best available research evidence with clinical expertise and patient values (Langevin & Kully, 2005). In my role as a Speech and Language Therapist providing a service for people who stutter, I am aware that there are different stakeholders involved. The client requires the best available evidence-based service and the service provider wishes to ensure that such service is provided in a timely and equitable manner. Outcome measures are a valuable clinical tool in ensuring that these requirements are met. Standardised assessments are tools to measure progress in therapy, providing clinical evidence of the effectiveness of interventions. Such standardised assessments (as outlined in chapter 1) are designed to answer specific questions relating to the experience of stuttering. Acknowledging the importance of such measures clinically and their impact on decision-making (both clinical and with regard to service provision), I decided that they provided a valuable context to this research. The qualitative analysis of some participants' data embedded in the wider statistical analysis of a larger group of participants would contextualise the results and allow for a greater understanding of therapy outcomes from Narrative Therapy. Three participants were selected for this purpose across age ranges and gender, in order to provide the necessary context. Participant numbers were limited to three because of the nature of the detailed IPA process and the extensive material that was available (Figure 4.2 and Table 4.3). I was also curious as to whether themes identified by the researcher, changes reported by participants and outcomes from the standardised assessments were related to each other. If they were found to align, it might reduce the need for repeat administration of standardised measures (such measures are administered to monitor progress in therapy). Or indeed it might highlight the discrepancies between the narratives and the assessments resulting in exploration of narrative stages rather than the re-administration of the assessments.

3.8 Mixed Methods Studies

Smith et al. (2009) identify that IPA and quantitative analysis have “something constructive to say to each other” (p 192) and highlight the need for studies of mixed design highlighting the combination of “insights and leverage” that arise when IPA is combined with quantitative studies. Single method studies provide only a limited view of the complexity of human behaviour (Cohen et al., 2007). A single method study, for example quantitative only, might miss how the intervention worked or didn’t, from the perspective of the participants involved. In engaging with qualitative methodology, the participant’s voice and experiences within the process can be acknowledged. The quantitative measures selected for their rigour, standards of design and measurement, are there to demonstrate the effectiveness or not of an intervention. Quantitative measures capture and measure observable phenomena or behaviours particularly in outcome studies and offer a recognisable form of evidence but this evidence may lack the direct insight available through the IPA process, from the people themselves. IPA’s insight into the meanings of outcomes for people provides the missing voice in evidence based practice. Kovarsky (2008; p47) describes how the privileging of objective testable variables in evidence-based practice excludes the voices of clients:

“The dismissal of subjective, phenomenally oriented information has functioned to marginalise and silence voices from the life-worlds of clients when constituting proof of effectiveness”.

Narratives of personal experience once analysed may represent the outcomes that are relevant to the person and the real world changes they have made. Flowers et al. in 1997 followed a quantitative review of 36 studies of the adoption of safer sex among gay and bisexual men (Flowers, Sheeran, Beail & Smith, 1997) with an IPA analysis of 16 interviews (Flowers, Duncan & Knussen, 2003) to explore decision making among men with positive HIV status. The IPA analysis gave critical insight into why these participants made the decisions they did, and the initial quantitative study highlighted the types of decisions people were making relating to safer sex. In a further study with a mixed design Newton, Larkin, Melhuish, and Wykes (reported in 2005 and cited in Smith, Flowers and Larkin, 2009) were concerned with quantitative analysis to explore whether an intervention programme for young people with auditory hallucinations, in this case cognitive behavioral therapy, had worked (Newton, Larkin, Melhuish & Wykes, 2007). They then used IPA analysis to explore the experiences of these young people in therapy (Newton et al, 2007).

IPA acknowledges what is important to the participants and what has meaning for them. In this way IPA provides insight when used alongside quantitative measures. However, the challenge with a mixed method study is in the maintenance of rigour and quality without sacrificing the emergence of potentially rich data. It is also possible that in combining two approaches, neither is fully engaged with, and something of the essence of both, is lost. Brocki and Wearden (2006) in a critical evaluation of IPA highlight the importance of researchers acknowledging their own position in the dynamic process that is the analysis. In raising this issue they also acknowledge that IPA explicitly recognises the interpretative facet of the approach and suggest that researchers who choose to utilise this method are thus under a certain obligation to address this issue. Within this research study, measures were required to ensure rigour and quality to bring out the best of both methods, allowing the voices of the research participants to be heard and reflecting the results of the statistical analysis.

IPA's flexibility allows for different data collection methods; interviews, journal entries and emails though this flexibility might affect the data obtained (Brocki & Wearden, 2006) or perhaps provide a rich seam of information to the research question. Indeed its flexibility and the fact that IPA is an inductive approach, able to engage with both new areas without a theoretical pretext and existing theoretical frameworks is one of its strengths (Reid et al., 2005).

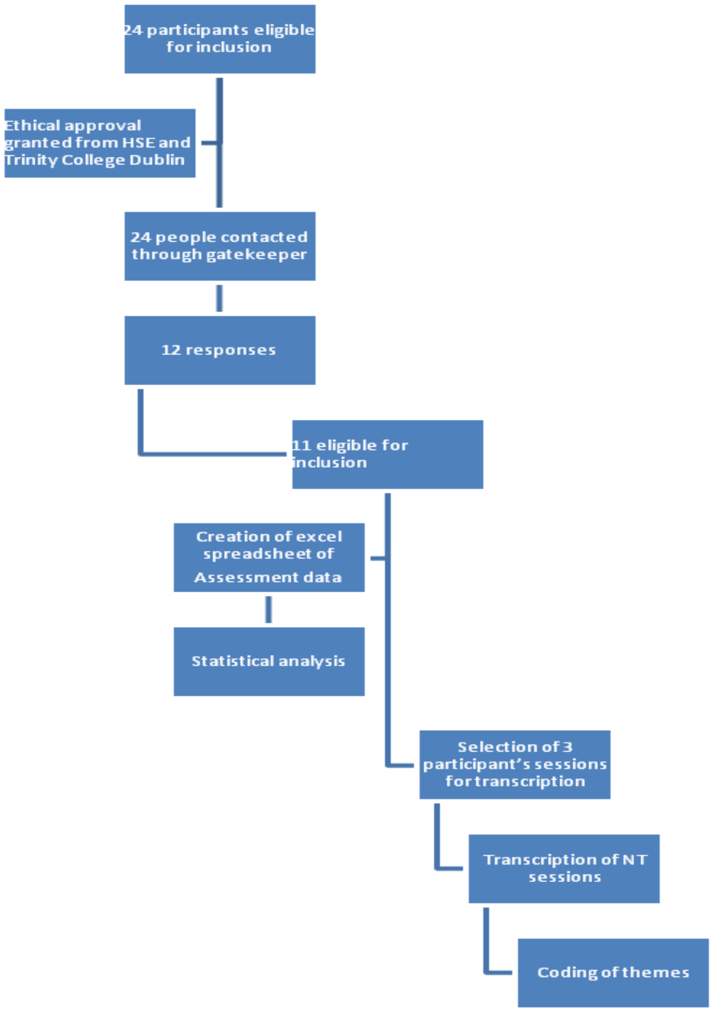
The combination of quantitative measures and IPA analysis is particularly suited to this current study of outcomes from an intervention programme for people who stutter. It is postulated that the IPA analysis as an equal partner to the quantitative analysis will elaborate on the results of the statistical analysis. The quantitative analysis potentially offers information about the observable changes arising from the intervention, the aim of the IPA analysis was to explore the process in achieving those outcomes and to explore which outcomes are meaningful for the participants. In this way mixed methods can complement and enhance the interpretation of the phenomenon under study.

Chapter 4

METHOD

In this section I outline the research design for this particular study highlighting participants, data sources, ethical approval, data analysis, and the process involved in the transcription and analysis of each of the three participant's Narrative Therapy sessions. A description is included of the process involved in ensuring the quality of the research process. Excerpts from the research journal kept during this process are included in text boxes. I discuss further the process involved in the statistical analysis of the data from the standardised assessments. Figure 4.1 provides and overview of the research method highlighting the process involved and detailing the stages from participant selection to the coding of themes.

Figure 4.1 Overview of Research Method



4.1 Ethics approval.

Ethical approval for this research was granted by the Ethics Committees of School of Linguistics, Speech, and Communication Sciences, Trinity College Dublin (Appendix A) and the HSE South (Appendix A2). The Data Protection Commissioner's office was consulted about the use of videotaped material before the Ethics application was made. The procedures recommended related to the return of the recordings to the files following completion of the study.

At any time during data collection or up to the point when data analysis began participants had the right to withdraw. Confidentiality refers to information that has been communicated in trust of confidence (Giordano, O'Reilly, Taylor & Dogra, 2007) and the data provided by the participants was respected. In this research, names of participants were replaced by pseudonyms. Data including video recordings were stored in a locked filing cabinet. Transcripts and analysis were kept on an encrypted computer. Video recordings were returned to HSE Speech and Language Therapy files once the study was completed.

4.2 Participants

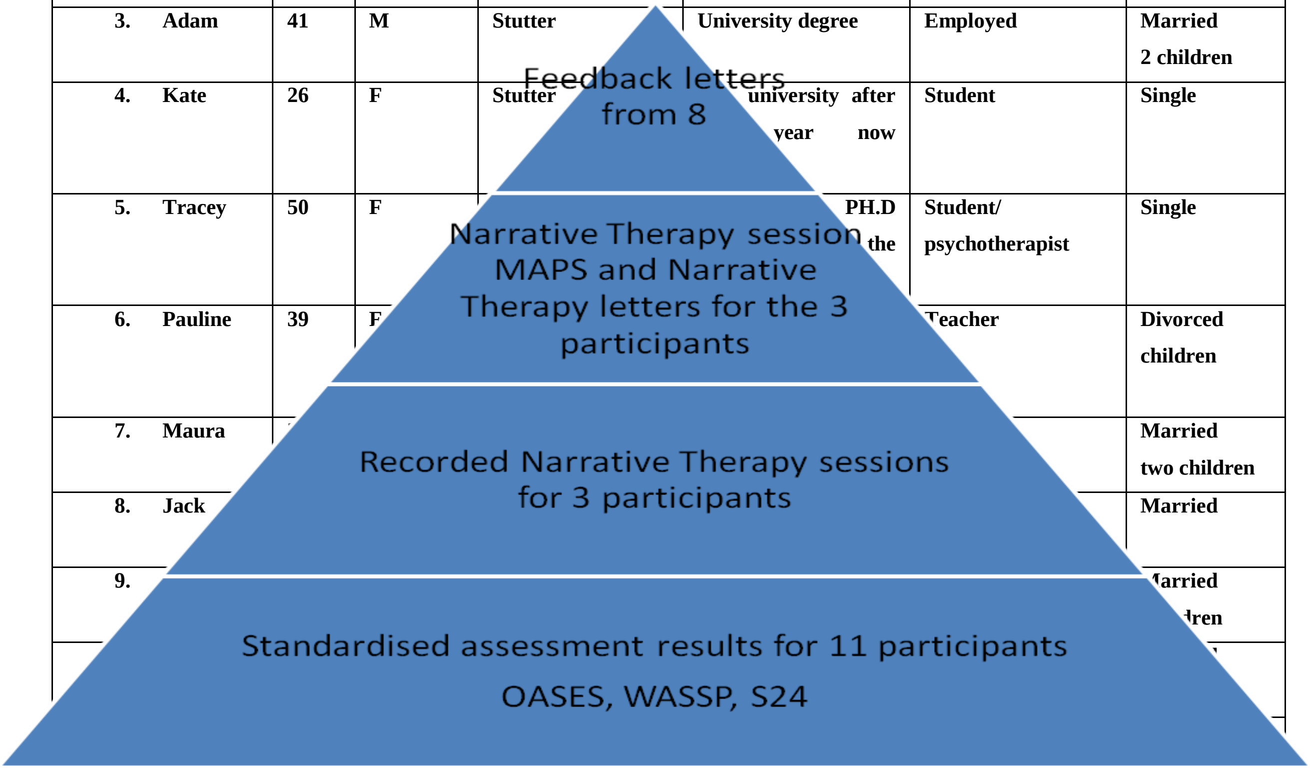
The sampling for this study was purposive. As a researcher, I was interested in the particular experiences of people who stutter, who had taken part in the intervention programme, outlined in chapter three. All participants had a primary diagnosis of stuttering from a qualified and practising Speech and Language Therapist specialising in the treatment of stuttering.

The sampling method employed by Plexico and Burns (2012) was similar to the process undertaken in this current study, in that participants were selected through their attendance at clinics. Twenty-four people had participated between the years 2009 and 2012 (the time the sampling occurred) and were eligible to be contacted. These people were contacted by letter (Appendix B) through a gatekeeper selected by the researcher. Twelve people responded and were initially included in this study. Of the twelve participants, eleven had sufficient follow up data to be included in the study. One participant did not attend any reviews days following the intensive programme and so did not have the data to include in the research and as a consequence was excluded from the study. Of the group of eleven, three participants were selected for the analysis of their Narrative Therapy sessions. They were chosen on the basis of gender, age and attendance at review days. As previously acknowledged in chapter 2, there is a significant gender distribution bias among people who stutter, with a ratio 5:1 in favour of males (Yairi & Ambrose, 2013). For this study, one female was selected alongside two male participants. The age range of the participants was from 25 years to 50 with the majority of the eleven participants aged between mid-twenties and thirties and the three participants identified for further analysis were selected to reflect this range. Participants were also selected on the basis of their attendance at more than two review days in order to monitor changes over time. The final consideration was the identity of the therapist involved in the Narrative Therapy sessions. Two of the participants were directly involved in Narrative Therapy sessions with the researcher. In attempt to address possible bias, while recognising the challenge of eliminating bias in qualitative analysis, the third participant selected had a different lead therapist (also a specialist in the treatment of stuttering) in his Narrative Therapy sessions.

Table 4.1 Participant details

Name	AGE	Gender	Diagnosis	Education	Employment	Marital status

1.	RT	43	M	Stutter	Left prior to Leaving certificate	Unemployed	Single, 1 child
2.	Mac	24	F	Stutter Social anxiety	Leaving certificate, attended college	Unemployed	single
3.	Adam	41	M	Stutter	University degree	Employed	Married 2 children
4.	Kate	26	F	Stutter	university after year now	Student	Single
5.	Tracey	50	F		PH.D the	Student/ psychotherapist	Single
6.	Pauline	39	F			eacher	Divorced children
7.	Maura						Married two children
8.	Jack						Married
9.							arried dren



4.3 Data sources

The potential data available for the analysis of ‘outcomes’ was diverse and drawn from many different sources (Table 4.2). It included standardised measures across a range of assessment tools, transcripts of Narrative Therapy sessions, Narrative Therapy maps, and Narrative Therapy correspondence between Therapists and participants, and finally written feedback from research participants in response to the themes emergent from the analysis.

Figure 4.2 Data sources for this study

4.3.1 Standardised assessments

The first source of data was performance records on the standardised measures the OASES (Yaruss & Quesal; 2006), WASSP (Wright & Ayre, 2000), and S24 (Andrews & Cutler, 1974a) that were taken at four time points for the eleven people who had participated in the intervention programme. These four time points included (i) pre-intervention, (ii) immediately post-intervention, (iii) one year later and (iv) a final measure 2-3 years later. This data was suitable for quantitative analysis.

The second source of data was the recorded Narrative Therapy sessions for each of three participants. Each of these participants had between three and five recorded sessions available for qualitative analysis. Each recorded session had a Narrative Map taken at the time of the session as a visual record of the words spoken. Following on from these sessions Narrative documents in the form of emails and letters were available for two of the participants. The Narrative Maps served to support the transcription of the sessions. The Narrative documents were suitable for qualitative analysis. The data from each of the three participants in included in Table 4.2. The final data source was the responses of eight of the programme participants received by the researcher following feedback about the emergent themes from the IPA.

Table 4.2

The Data sources for the three participants

Participant	**DVD Record of Narrative Therapy sessions**	**Standardised assessments**	**Narrative Maps**	**Emails/letters**	**Triangulation response**
RT	**4**	**Pre and post**	**Yes**	**Yes**	**No**
Mac	**3**	**Pre and post**	**Yes**	**Yes**	**Yes**
Adam	**4**	**Pre and post**	**Yes**	**No**	**Yes**

4.3.2 Transcription of Narrative Therapy sessions

Following IPA guidelines (Eatough & Smith, 2006; Plexico & Burrus, 2012; Plexico et al., 2010; Smith, 2004, Smith et al., 2009), one set of data from one participant was selected for transcription and analysis and a second set of data was not introduced until closure was achieved. Each DVD contained the recorded Narrative Therapy sessions of the three chosen participants. For each participant there was a minimum of three sessions including an Externalization conversation, the emergence of a unique outcome leading to reauthoring conversation and either a Definitional Ceremony or a Remembering conversation. An initial participant was chosen from the three selected as described earlier and all material relating to his Narrative Therapy sessions was collated. He had been the one of the earliest participants in the programme and had a large quantity of data between standardised assessments and recorded Narrative Therapy sessions. The Narrative Therapy videotaped sessions were transcribed in chronological order, starting with the first session on the first day of the programme, through to the final session on the final day of the residential programme. There were four sessions available for transcription. The second session was not transcribed until completion of the initial coding. In this way a second set of data was not introduced until closure was complete for that first set of data. The length of each Narrative Therapy session varied from half an hour to approximately one hour's duration with the exception of the definitional ceremony which took up to an hour and a half involving feedback from witnesses, as outlined in an earlier chapter (see also Leahy et al., 2012). Subsequent review day Narrative Therapy sessions were transcribed in chronological order. Following transcription, the transcript for each session was then transferred into table format with four columns (Table 4.3). This table format is adapted from the work of Smith et al., (2009). An extra column (the first) was included to ensure transparency of coding.

As the transcription of each Narrative Therapy session was completed by the researcher it was transferred into the columns. The first column outlines the coding procedure; underlined text refers to exploratory coding in terms of description and content; italic text refers to exploratory coding focussing upon thinking about language use and bold text refers to exploratory coding which addresses conceptual and interrogative coding, the second column the initial comments and coding. The third column contained the transcribed sessions. The fourth column contained the superordinate themes identified following immersion in the data and detailed coding (Appendices C, D and E). Following the transcription of the Narrative Therapy sessions for the first participant, and subsequent IPA analysis, the documents (Narrative Therapy letters) were transcribed into the tables for interpretation and analysis. The full process is outlined in Figure 4.3.

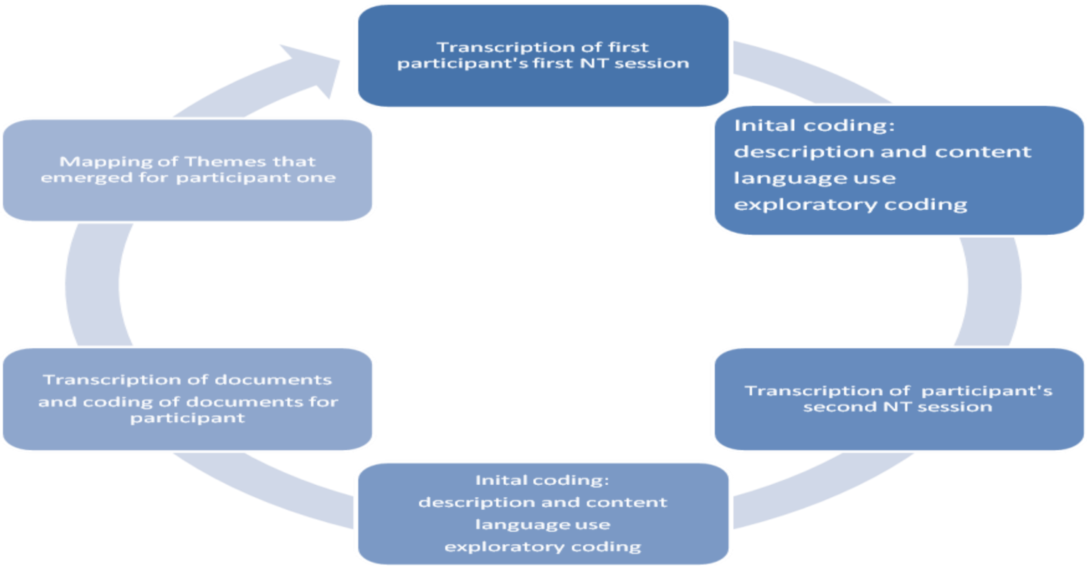
Table 4.3 Sample Table format

Bold text refers to exploratory coding which addresses conceptual and interrogative coding Underlined text refers exploratory coding in terms of description and content *Italic text refers to exploratory coding*	**Being different** **awareness of sense of self** Difficult experiences Road trip *Dark and dreary reflecting state of mind?*	**Mac**: 1. It was one of the first few times I have gotten the bus down to Roscommon. 2. As it was evening time dark and dreary, I was unsure about what exactly stop I was aiming to get off at. 3. At this time in **my life. I knew I was different** in a way, but couldn't put my finger on it.	**Narrative phenomenology** **Difference/outsider**

focussing upon thinking about language use			

Procedures

Figure 4.3 Overview of IPA process for each participant's Narrative Therapy sessions



4.4 Data Analysis: Qualitative Analysis

There were four fundamental steps to the qualitative analysis of the data in this study. The first step involved the transcription of the recordings. The second, required close reading and re-reading of the transcripts while noting initial units of meaning (Plexico & Burrus, 2012; Plexico et al., 2010). The third step involved transformations, made by looking at the description from the ‘lifeworld’ perspective of an individual, identifying issues that appeared important to the person (Giorgi, 2012; Giorgi & Giorgi, 2008) and paying close attention to the language used by the participant to describe their experiences. The fourth step involved reviewing the last transformations of the meaning units and determining what constituents were essential to account for the concrete experiences reported (Bricker-Katz et al., 2010; Giorgi & Giorgi, 2008; Larkin et al., 2011; Plexico & Burrus, 2012).

In this current study, the first step was the transcription of the initial Narrative Therapy session for the first participant followed by close and detailed reading of the transcript (Edward & Welch, 2011; Klompas & Ross, 2004; J.A. Smith, 2004; Smythe et al., 2008). Each manuscript was read through while listening repeatedly to the DVD to ensure accuracy of transcription and immersion into the data. The transcript was also compared to the contemporaneous map taken at the time of the Narrative Therapy session and photographed for the participant and his records. Each map contained key elements of the session and in this way an accurate representation of the session was ensured.

Once accuracy was ensured, the second step began, re-reading the transcript and noting units of meaning (i.e., initial notes and ideas relating to specific themes or phrases) both on the transcript form and my response to themes and phrases in a notebook which formed the basis of a research journal. This journal contained both notes taken at the time of the analysis and my thoughts on the process involved. Initial thoughts were in this way recorded, to address potential bias and for further discussion in supervision as required.

While the early stages of analysis require the researcher to be thorough and painstaking, the third stage consists of further reducing the data by establishing connections between the preliminary themes and clustering them appropriately (Eatough and Smith, 2006). These clusters are given a descriptive label (higher-order theme title) that conveys the conceptual nature of the themes therein. In this way it becomes possible to identify how different aspects of the experience relate to each other. Smith et al. (2009; p 92) describe how themes are usually expressed as phrases that “speak to the psychological essence of the piece and contain enough particularity to be grounded and enough abstraction to be conceptual”.

The fourth step involved reviewing the last transformations of the meaning units and determining what constituents were essential to account for the concrete experiences reported (Bricker-Katz et al., 2010; Giorgi & Giorgi, 2008; Larkin et al., 2011; Plexico & Burrus, 2012).

On the completion of the above steps for the first participant’s initial therapy session, I progressed to the second session and followed the same procedure as outlined for the first transcript and continued until each session was completed and a degree of closure achieved. Only when that had been achieved, was there an attempt to conduct across-case analysis. Once the first participant’s Narrative Therapy sessions and documents had been transcribed, analysed and coded (see Appendix C), transcription of the second participant’s narrative therapy sessions began (see Appendix D). On completion of the second participant’s transcription and analysis, the third participant’s analysis and transcription commenced (see Appendix E).

Identical processes were followed for the data of each participant. Eleven Narrative Therapy sessions were transcribed and analysed in this way. Narrative documents (maps) as described in chapter two were used to supplement the face–to face sessions by providing a permanent record of key moments thus supporting accurate transcription and reflection of key therapeutic moments. Documents of the three participants over a three-year period were also analysed to supplement the analysis of the Narrative Therapy sessions. Documents for the first participant were analysed in sequential order following the analysis of the Narrative Therapy sessions. These documents included the Narrative letters/emails (Appendix F) exchanged between RT and his therapist and Narrative Maps (Appendix G) for Adam, Mac and RT. The documents, once transcribed were added to the table for analysis.

4.4.1 Emergent Themes

As more data was transcribed and analysed the types of themes became more transparent and enriched. Common constituents emerged between the themes, but they still were not identical across participants or sessions. The data was coded initially in terms of event description and language use. Exploratory thematic coding followed addressing conceptual and interrogative concepts with reference to Smith et al.'s text (Smith, et al., 2009). Emergent themes that were felt to be significant were noted in the journal for further reflection. Following this process for the Narrative Therapy sessions, coding of the Narrative documents commenced as the following excerpt from a log kept at that time describes.

Excerpts from the process log for the participants: RT, Mac and Adam

RT: IPA, the process for the first participant

The method for analysis of RT's taped sessions follows Colaizzi's seven steps for initial phenomenological enquiry. The data was transcribed; significant statements were extracted that directly related to the phenomenon; meanings were formulated and then aggregated into theme clusters; finally the fundamental structures of the phenomena were identified (Edward & Welch, 2011). Crucial to the process was the immersion in the data, reading the transcripts while listening repeatedly to the DVDs of each Narrative Therapy session.

Due to the severe overt nature of the stuttering that RT presented with on the tapes, manual transcription was initially selected as the most accurate method of creating a manuscript. The transcript from each session was read in its entirety to gain an understanding of the data (Giorgi, 2012), then re-read. The text was revisited repeatedly, focusing on the particular details of RT's experience, his use of language, in particular the chorus like cadences before moving back and forwards between different sections and then different sessions. A separate document was kept by the researcher recording thoughts and reflections on the transcript and emerging themes. On completion of the Narrative Therapy sessions the Narrative documents written by RT were analysed following the same procedure of re reading and thematic coding.

Mac and Adam: IPA the process

The method for analysis of Mac's and Adam's intensive week Narrative Therapy sessions also followed Colaizzi's seven steps for initial phenomenological enquiry. The data was transcribed and themes identified as previously outlined. Crucial to the process again was the immersion in the data, reading the transcripts while listening repeatedly to the DVDs of each session.

Mac presented with covert stuttering. Her overt symptoms were few thereby enabling the use of technology to transcribe the data. Dragon technology was used to transcribe the sessions. The researcher spent 15 hours training the device to accurately record and transcribe her voice. The sessions were reviewed for accuracy of transcription. As was consistent with the first participant, the data from each session was read in its entirety to gain an understanding of the data (Giorgi, 2012), then re-read while listening to the DVD. The data was coded initially in terms of description and content and then coded for language use. The text was revisited repeatedly, focusing on the particular details of Mac’s experience and moving back and forwards between different sections of the first session before moving onto the second session. A separate document was kept by the researcher recording thoughts and reflections on the transcript and emerging themes. Notes were kept highlighting the emergent themes that appeared to relate to RT’s themes. Differences were also highlighted. Areas for further reading were identified.

The above process was replicated for Adam’s sessions including the use of Dragon technology. Reoccurring themes common to all participants were noted, as were differences in themes and experiences.

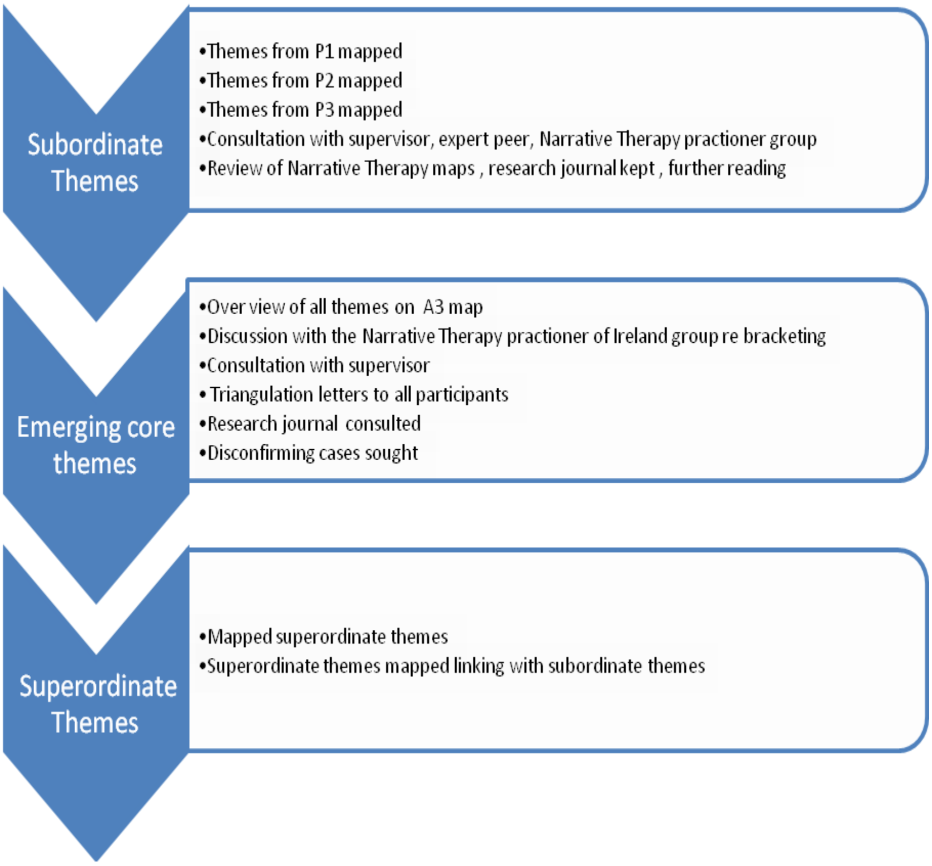
4.4.2 Emerging Core Themes

An overview of all themes emerging from the three participants’ analysis was mapped on an A3 magic whiteboard and photographed (Appendix H2). Further discussion took place with members of the Narrative Therapy practitioner of Ireland group with regards to bracketing the researcher’s assumptions about outcomes. The research journal was maintained and consulted at this time to address possible issues of bias relating to the role of the therapist, the role of the person in therapy and outcomes expected by the therapist. This research journal became at times, a process log that described the dual nature of the research undertaken: providing information about the context of the researcher and the research

4.4.3 Superordinate Themes

The first step was to map the themes that emerged for each of the three participants on individual A3 sheets of paper. The earlier process of documenting thoughts and responses to themes and the process involved in a journal was continued. This journal was consulted throughout the process. In addition, issues that arose relating to bracketing and potential bias were discussed at the Narrative Therapy practitioners’ group. This process was supported at different times by the group of Narrative Therapy practitioners, research supervisor and an expert peer (this peer is another Speech and Language Therapist experienced in the use of Narrative Therapy). Disconfirming cases were sought and discussions held with supervisors. The themes were printed on separate pieces of paper and placed on a large floor in order to explore the spatial representations of how the themes related to each other in a process suggested by Smith et al., (2009). The final stage involved the creation of an A3 map of the Superordinate themes (Appendix H2) demonstrating how they linked to the subthemes as suggested by Eatough and Smith (2006). They describe how when conducting IPA analysis, a table is produced that shows each higher-order theme and the subthemes which comprise it. A separate Word document (Appendix H1) was created detailing the quotes supporting each of the themes. Throughout the process from the early stages of transcription through to the final mapping of superordinate themes a commitment towards ensuring reliability and validity was undertaken. Smith et al., (2009) report how the systematic following of the above procedure (transcribing, reading, rereading, mapping and documenting each step) ensures rigour and a commitment to the quality of the research. Figure 4.4 outlines the process involved in the emergence of superordinate themes.

Figure 4.4 Process for emergence of Superordinate themes



4.5 Auditability

Qualitative analysis using IPA consists of an inductive process of identifying themes and patterns within the data. Smith et al., (2009) describe how Yardley's (2008) four principles to assess the validity and reliability of qualitative research (sensitivity to context; commitment and rigour; transparency and coherence and impact and importance) can be met by IPA. Sensitivity to context is addressed through my clinical expertise as a specialist in the area of stuttering treatment and my in-depth knowledge and understanding of the clinical issues involved. It is demonstrated in the careful collection of data; in particular, this sensitivity to context is further demonstrated by my awareness of the interactional nature of the therapy sessions and my decision to include the Narrative Therapy sessions of another therapist to address bias. The importance of reflexivity is acknowledged; the explicit consideration of specific ways in which it is likely that the study was influenced by the researcher. Furthermore, making sense of how a participant makes sense of their experiences, requires "immersive and disciplined attention" (Smith et al., 2009; p 180) to the accounts of others, and in doing so demonstrates a sensitivity to the context that is their lives.

Commitment and Rigour: Commitment is demonstrated in the degree of the attentiveness and care given to the data analysis. For example, once a set of themes and patterns had been identified, I engaged in the process of seeking "disconfirming instances" or "negative cases", searching for data that did not fit the themes and patterns. This ensured that all data was taken into account. Such exceptions were noted in the results chapters, which were written first. Extracts were selected to give some indication of convergence and divergence, representativeness and variability (Smith, 2011).

Smith (2011) suggests that for papers with small sample sizes (up to three participants) each theme should be supported with extracts from each participant and in this research reported here each theme was supported with quotes as recommended.

Commitment and rigour were ensured throughout the process by ongoing discussion and debate regarding the data with supervisors, an expert peer and the therapists from the Narrative Therapy practitioners of Ireland group.

The importance of field notes in qualitative research is recognised (Phillippi &Lauderdale, (2017). Field notes serve many functions: to encourage researcher reflection and identification of bias, to facilitate coding and increase rigour and trustworthiness. In this research, the notebook kept, functioned to ensure awareness of the researcher's position, perspective and interpretation of data collected. Excerpts from this personal journal were kept as an audit trail (Hamill & Sinclair, 2010; B. Smith, 1999; Yardley, 2008). The thoroughness of the study, the appropriateness of the sample to the research question and the completeness of the analysis described above reflect the rigour of this study.

To ensure *coherence and transparency*, the process logs explored the responses of the researcher to the coding of data. In this mixed methods study different approaches were used as internally coherent parts of a "composite analysis". *A paper trail* was maintained and the raw data was linked to the final report combining a complete set of coded transcripts (see Appendices C, D and E) together with a description of the development of the Superordinate themes (Appendices H1 and H2) and interpretations included. Narrative Maps created at the time of the Narrative Therapy sessions are included in the appendices (G) as supporting documents to the transcriptions.

Impact and Importance: all eleven of the research participants were consulted about the themes that emerged from the research to explore their responses to the outcomes from this research and to consult with them about how they viewed and experienced outcomes from Narrative Therapy. Two separate articles, one on the externalisation process (Ryan et al, 2015), and one detailing the definitional ceremony (Leahy, O'Dwyer & Ryan, 2012) were submitted and published during the research process.

4.5.1 Bracketing. Original texts by Husserl (1931) detailing the concepts of bracketing and reduction were explored in order to go beyond a superficial level of reduction and reflect on the process of reflection and reduction. Prior to commencing the research I explored the literature in relation to outcomes, in this way bringing current studies to the level of consciousness and creating an initial awareness of my own biases with regard to therapy outcomes. This was assisted at the midway point by the creation of the confirmation document that is an integral part of the doctoral process in Trinity College, Dublin. Revisiting this confirmation process involving an oral interview ensured that the values and knowledges that I have as a Speech and Language Therapist did not take precedence over those of the research participants. The literature review was completed after data collection and analysis to eliminate bias towards pre-existing themes in the literature relating to outcomes. As a researcher I bring foreknowledge as a Speech and Language Therapist that may impact on my ability to research the issue without bias.

4.5.2 The acknowledgement of identity and power. Usher (2000) suggested that identities are learned and that people understand each other through relationships that are defined by certain values. Building on the work of Foucault (1980), Usher (2000) suggested that power and knowledge coexist and what we count as truth arises or is constructed through discourse. These discourses create meanings, and produce identities and it is through these meanings and identities that power relations are created and maintained. In research there is a need to be aware of the power balance, how we speak 'of' and 'for' the narrative that is under analysis. A discussion on identity and power within the Narrative Therapy practitioner group created awareness for me that power differentials do not disappear because the desire to subjugate them exists. It is important therefore to be aware of my positionality as the researcher through the process of bracketing and acknowledge the influence I bear on the analysis of data and the ethical issues that might arise as a result. I aimed to address potential bias through the reading and reading of transcripts; the following of a detailed process for the elicitation of themes as documented above; the discussion of issues that arose with bracketing with other Narrative Therapy practitioners and research supervisors and a constant process of documenting my responses to the research process and the themes that emerged.

4.5.3 Triangulation

Triangulation has been defined as “the use of two or more methods of data collection when studying some aspect of human behaviour” (Cohen et al., 2007; p141). It can be a process by which we attempt to explain the richness and complexity of human behaviour taking more than one standpoint into consideration. Triangulation can be used in research to corroborate and verify the accounts of the participants. To ensure *validity and reliability,* participant feedback was obtained by asking participants to comment on the outcomes from the analysis. Obtaining such feedback helps to ensure that each research participant’s voice is acknowledged and referenced in the results (Forbat & Henderson, 2005), though a text once in writing takes on a ‘life’ of its own with meanings and intentions often hidden from its original author or narrator (B. Smith, 1999). Participant feedback or member checking is not universally implemented in phenomenology. The researcher’s position, perspective and interpretation are acknowledged as uniquely ‘valid’ (Bradbury-Jones, Irvine & Sambrook, 2010) and there is dispute over the involvement of other perspectives. Although another’s interpretation of the data may be acknowledged as equally valid, it is felt that the key to the analysis is the researcher’s description (Husserlian) or interpretation (Heidegarian) of the phenomena that are the subject of the research. There is a difference between one’s lived experience and deriving the meaning of that experience. Giorgi (2006) queried which perspective would take priority in the event of a discrepancy between participants’ perspectives and a researcher’s analysis.

Despite a number of studies documenting participant involvement in data analysis (Forbat & Henderson, 2005; Gaddis, 2004; Ingamells & Ljsseldijk, 2013; O’Connor et al., 1997; Ramey et al., 2010), there have been disagreements in the literature about the involvement of participants in the analysis. Giorgi (2006) argued that participants would view the data from a life world perspective and the researcher’s analysis views the data from a phenomenological perspective. However, when a story is listened to, the researcher’s intention is to bring his/her own interpretation to it, even if co-researchers are asked to corroborate the interpretation (Josselson, 1996). Reproducing voices in research necessitates the sharing of transcripts with research participants; this implies joint ownership and may be valuable for the research participants as well as the researcher (Forbat & Henderson, 2005). Returning to the participants can be viewed as consistent with the hermeneutic circle, moving between interpretation and the text, or between interpretation and the participants (Bradbury-Jones et al., 2010). Having considered and reflected on the participants’ role in this research, I felt it was essential to the research and the research process to consult with the participants about not only the outputs from the analysis, but what they felt were the outcomes of their experiences of Narrative Therapy. Therefore, following reflection and consultation the research participants were consulted regarding the outputs of the analysis.

The initial interpretative findings of the data were incorporated into an email to the research participants describing emergent findings that sought clarification and validation (Appendix I). This consultation provided the participants with an opportunity to respond to the themes, to acknowledge or challenge them, to provide further information about their understanding of what outcomes were for them. It gave me, as researcher an opportunity to summarize my findings from the analysis providing clarity for my own research process and allowed me to follow up on questions that I felt might not have been fully addressed in the analysis. Therefore, the participants were actively involved in the research process through participant validation. The first purpose of the triangulation process was to summarize themes and stages emerging from the data analysis and to identify if these fit with the participants' understandings of outcomes. This process ensured transparency and coherence in the research process. The second purpose was to address questions the research participants have about outcomes and what questions they feel the research might explore in relation to outcomes. The most rigorous and sustaining support for this research is through the consultation with the research participants.

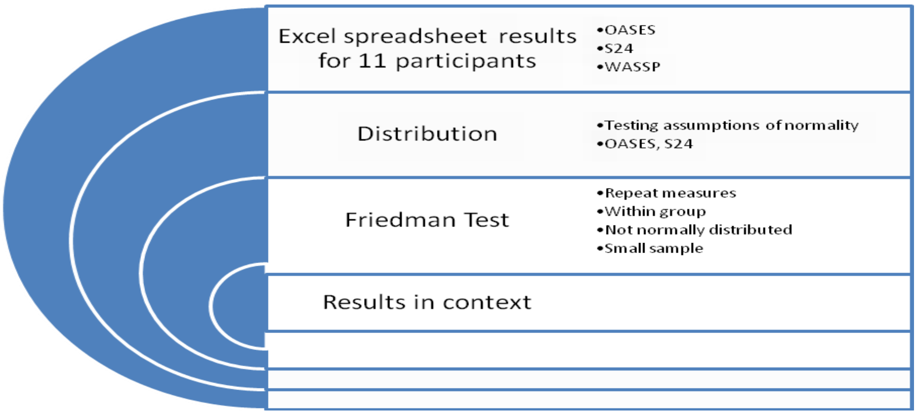
4.6 The Research Process: ensuring Quality and Validity

The Superordinate Themes were mapped linking them to the subordinate themes (see Appendix H2). A journal was kept, documenting my thoughts and feelings throughout the research, acknowledging my own responses to the data and the phenomenological process. An audit trail was developed, combining the narrative maps from the Narrative Therapy sessions (Appendix G) with the initial transcripts and handwritten notations from the initial read through to the summary of each individual's themes as they emerged to the final A3 map of themes (Appendix H2) for all participants. Supervisor support and peer feedback was engaged to check my interpretation of data as noted in previous writing (Leahy et al., 2012). As discussed earlier, feedback was sought from the participants about the interpretation of data following the mapping of the superordinate themes. On the completion of the qualitative analysis and the mapping of the Superordinate themes, the statistical analysis was addressed. The process involved in this analysis in highlighted in Figure 4.5. Initially excel spreadsheets were created for the eleven participants detailing the results of their standardised assessments (OASES, WASSP, S24). Assumptions of normality were tested for both the OASES and WASSP and a decision made with regard to the statistical procedures.

4.7 Quantitative Analysis

The availability of long-term data (for up to five years for some participants) from these standardised assessments offered a wealth of information. The participant sample for the statistical analysis is a relatively small one with N=11. There were repeat assessments administered at different time points: pre programme, immediately post programme and on every review day attended by participants. For this group of 11 participants, there were a minimum of three data collection points. Therefore, the analysis required involved one-way repeat measures of variance. To ensure reliability and validity, however, the analysis must be dependable, consistent and replicable. In order to ensure this, assumptions of data normality had to be tested to explore the most appropriate statistics to employ. Before any ANOVA could be undertaken, it was necessary to establish whether or not the data were normally distributed in order that the appropriate analysis is undertaken.

Figure 4.5 Processes for Statistical Analysis



4.8 Selection of Statistical Techniques: Assumptions of normality

4.8.1 Distribution of scores for the OASES. Normality of the distribution of scores for the entire sample was assessed for total experience of stuttering (Total OASES score pre Free to Stutter Free to Speak (FTS)).

The output from the assumption of normality testing is detailed in the appendices (Appendix J). The skewness value provides an indication of the symmetry of the distribution. The kurtosis provides information about the “peakedness” of the distribution (Pallant, 2013). For the OASES, the positive skewness values indicate positive skew (scores clustered to the left at the low values). The Kurtosis values are below zero, indicating that the distribution is relatively flat with too many cases in the extremes, indicating that the sample is not normally distributed. It can be hypothesized that people who stutter will choose to attend a therapy programme when their self-rating of their speech is in the severe range. This sample is small and variances in output data from skewness and kurtosis can be expected in a sample of this size.

The choice of appropriate test is of key importance in the assessment of assumptions of normality of distribution (Ahmad & Khan Sherwani, 2015). The Kolmogorov-Smirnov statistic assesses the normality of the distribution of scores; a non-significant result, in this case .154 (sig. value of more than .05) indicates normality, in contrast with the earlier skewness and kurtosis values. In the current implementation of the Kolmogorov-Smirnov test, given data are compared with a normal distribution that uses the sample mean and the sample variance (Drezner, Turel & Zerom, 2010). However, in this test it has been reported that the *p* values are highly biased upwards (Steinskog, Tjostheim & Kvaamsto, 2007) In a study contrasting tests of normality, the Shapiro Wilk was found to be more powerful (Mbah & Paothong, 2015; Oztuna, Atilla Halil & Tuccar, 2006). The results from the Shapiro Wilk were also considered in assessing the normality of this sample. The results from the Shapiro Wilk of .235 also indicate normal distribution. An inspection of the normal probability plot (labelled Detrended Normal Q-Q plot of PREFTS) indicates that the scores appear to be not normally distributed as the observed value for each score is plotted against the expected value from the normal distribution. The Detrended normal probability plot along with positive skewness and kurtosis results indicate that the data is not normally distributed indicating that non-parametric measures may be required.

4.8.2 Distribution of scores for the S24.

Normality was then assessed using the pre FTS results from the S24.

Negative skew was inferred from the cluster of scores at the high end of the S24. High scores on the S24 are indicative of significant perceived difficulties with communication suggestive of people at the commencement of therapy. The positive Kurtosis suggested distribution was rather peaked (clustered in the centre). An inspection of the normal probability plot (labelled Detrended Normal Q-Q plot of PREFTS S24) indicates that the scores were not normally distributed as the observed value for each score was plotted against the expected value from the normal distribution. The Kolmogorov-Smirnov statistic gave a non-significant result. In this case .200 (sig. value of more than .05) indicates normality. The Shapiro Wilk's result of .678 also indicates normal distribution.

However, one outlier was identified on boxplot. The data was checked to ensure accuracy. To further explore the outlier the histogram was examined. The scores dropped away in a reasonably even slope though negative skew can be identified (the scores are clustered to the right at the high values). There were no extreme points indicated (by SPSS with an asterisk) on the boxplot. The mean and the trimmed mean on the Descriptives table were not dissimilar. The values were not too different from the remaining distribution and a decision was made to retain the case in the data file.

4.8.3 Assumptions of Normality

There was evidence of positive skewness for the OASES and negative skewness for the S24. The kurtosis indicated distribution was relatively flat for the OASES and peaked for the S24. There was a wide distribution of the scores on the Detrended Q-Q plots for both assessments indicating that the sample was not normally distributed. Although the Kolmogorov-Smirnov and Shapiro Wilk's results indicate a normally distributed sample, the variations in skewness and kurtosis between the two assessments indicated that the data was not normally distributed. This concern, combined with the small sample size meant that an ANOVA could not be run with confidence. As a result of these factors non-parametric testing was explored. The statistical analysis was required to look at within group repeat measures. The non-parametric analysis suitable for this process is the Friedman test.

4.9 Friedman test

The Friedman test is the non-parametric alternative to the one-way repeated measures analysis of variance. It is used when the same sample of participants is measured at three or more points in time or under three different conditions.

4.9.1 Data Analysis: Friedman Test

As this research design draws on mixed methods, outcome measures from assessment procedures used over the period of five years of the intervention programme were analysed using the Friedman test for non –parametric data. These outcome measures of therapy for stuttering include published tests or procedures which measure aspects of behaviour, attitudes and cognitions. These were used to record baseline measures and changes over time. From the previous three to five years of the programme assessments which had already been completed as part of the programme were analysed. These assessments included: the Overall Assessment of the Speaker's Experience of Stuttering, (Yaruss & Quesal, 2006); the S24, developed by Erickson and modified by Andrews and Cutler (Andrews & Cutler, 1974b) which also examines attitudes and feelings about communication situations; the Wright Ayre Stuttering Severity Profile (WASSP) (Wright & Ayre, 2000) a twenty item self –rating scale for thoughts, feelings, emotions and stuttering behaviors.

Initially an excel spreadsheet was created containing all the outcome data from each assessment across every time point available for the 11 participants. This included the different subtests from the OASES and the WASSP because I was interested in exploring the variability in change across subtests.

The challenges with statistical analysis for this study included the small sample size available, yet a large number of repeated measures were available for some participants who attended nearly all the review days over the five years. Key to the process was having a baseline measure, an immediate post programme measure, and a measure taken at a one-year time point to observe maintenance of long-term changes. An additional time point could add further information yet exclude people who were unable to participate for various reasons, e.g., emigration, health or discontinuation of participation in the programme. I decided that long-term change could best be monitored with the inclusion of a fourth time point though it might reduce sample size and impact on the power of the test. Consequently, four time points were selected for the data analysis: (i) pre- *Free To Stutter* (FTS) programme, (ii) immediately post- FTS programme, (iii) one year after the programme and (iv) a final outcome measure taken two or in some cases three years later (the final assessment for each participant was taken and some had data from a three year time point).

IBMM SPSS statistics 22 was used to apply the Friedman test to the results from the standardised assessments. Post hoc testing was applied to control for type one error (rejection of the null hypothesis) following the Friedman test.

Given the availability of a fourth time point for some participants and not others, the Wilcoxon signed ranks test was applied to the data. This test is the non-parametric alternative to the repeated measures *t*-test. It is designed for use when participants are measured on two occasions or under two different conditions. It was applied to pre-FTS and post-FTS results, followed by a comparison of assessment results one year later and then again for the final results two/three years later where available. This allowed the results to reflect changes over the different time points and between the different time points to identity the time of greatest change for the research participants and also any return to the original severity of the pre intervention assessments.

The final output from the SPSS process was considered in conjunction with the themes that emerged from the Interpretative Phenomenological Analysis. The SPSS output described whether or not the intervention programme was successful in terms of the quantification of measurable change using standardised instruments; it is the IPA analysis of the Narrative Therapy sessions that illuminates the stages the participants went through in the process and the perceptions of the participants of outcomes arising from the intervention.

Summary

This research reports on therapy outcomes for eleven participants in an intensive residential intervention programme, *Free to Stutter….* A mixed methods approach was taken, given that contrasting sources of evidence were available: scores on standardised assessments and recordings and documents related to Narrative Therapy sessions of three programme participants. Interpretative phenomenological analysis was selected as the qualitative method of analysis for this research study. The philosophy that underlies its development was felt to be particularly appropriate for the analysis of Narrative Therapy sessions and documents, with its commitment to the particular and the detailed lived experiences of people living in the world and in a particular context, that of people who stutter. As the themes developed from the Interpretative Phenomenological Analysis for each participant, the process was refined and detailed rich findings emerged. This data will be discussed in the following chapters supplemented and complemented by the results of the statistical analysis that emerged from the Friedman non-parametric test.

Chapter 5

Framing the Stories: Outcomes as Measured by Standardised Assessments

Chapter 5 reports the results from the standardised assessments completed by the eleven participants on four separate timeframes.

5.1.1 Research Questions

The primary research question for this study was:

- What are the outcomes for participants from the use of Narrative Therapy as implemented within the *Free to Stutter...Free to Speak programme*?

A number of sub questions were also explored in this study.

Firstly exploring the relationship between the outcomes identified through analysis of Narrative Therapy sessions and the outcomes measured by existing published (standardised) assessment measures, such as the OASES, WASSP and S24.

Secondly, identifying whether there are stages within Narrative Therapy for participants in the *Free to Stutter...Free to Speak* programme , the description of these stages and considering where “relapse” fits within this process.

Finally, how do the participants in the FTS programme view the outcomes identified?

The traditional paradigm operating within a clinical context dictates that measurements are taken pre- intervention and post-intervention to determine whether or not the intervention has had the desired impact. It therefore seems fitting to present the data from the statistical analysis in the first instance and create a framework for the subsequent chapters detailing the results of the qualitative analysis.

The purpose of Chapter five is to address these questions by employing statistical analysis to the standardised assessments used pre-therapy, post-therapy, one year later and a final time point between two and three years after the original assessment. The null hypothesis predicts no difference across four time points for the OASES, WASSP and S24 (measures of attitudes to communication for people who stutter) following a programme of Narrative Therapy.

5.2 OASES results (Overall Assessment of Speaker's Experience of Stuttering (Yaruss & Quesal, 2006))

The OASES measures the impact of stuttering on a person's life. Impact Scores and Impact Ratings for four sections (General Information, Your Reactions to Stuttering, Communication in Daily Situations, and Quality of Life) and the Overall Score are provided in this assessment. The Friedman test was applied to all subsections of the OASES and to the total score. SPSS excluded data from the analysis for three participants with missing data for the final time point.

5.2.1 Results of the Friedman analysis of the OASES Total Impact Rating Score

The results of the Friedman test in Table 5.1 indicate that there was a statistically significant difference in total scores on the OASES across the four time points indicating a decreased impact of stuttering on the participants' lives following therapy *n*=8, *p*=.002, χ^2 =14.4 (2, n=8). Comparing the mean ranks for the four sets of scores, it appears the decrease in the impact of stuttering scores following the *Free to Stutter Free to Speak* (FTS) programme was maintained over a three-year time span.

Table 5.1 Friedman analysis of the OASES Total Impact Rating Score

	N	25th percentile	50th (Median)	75th percentile
PRE therapy	8	53.7500	66.0000	74.2600
Post Therapy	8	41.4500	42.9000	51.0500
One year follow up	8	25.2000	46.0000	57.6500
Two three year follow up	8	29.2675	40.4000	57.2500

Test Statistics$_a$ Ranks

N	8
Chi-Square	14.400
df	3
Asymp. Sig.	.002
a. Friedman Test	

	Mean Rank
Pre therapy	4.00
Post Therapy	2.00
One year follow up	2.00
Two three year follow up	2.00

5.2.2 Results of the Friedman OASES General information (GI) score

The results of the Friedman test indicate that there was a statistically significant difference in general information scores on the OASES across the four time points. *n*=7 *p=.004* χ^2 =13.348 (3, *n*= 7)

Comparing the mean ranks for all four scores it appears that there is an increase in general information about stuttering, particularly in the immediate aftermath of the programme. However, information about stuttering appears to decrease on the final two time points, thus suggesting that in the immediate aftermath awareness and understanding of stuttering is higher than on subsequent re-assessment.

Table 5.2 Friedman analysis of the OASES General information (GI) score

	N	25th	50th (Median)	75th
PRE therapy	7	57.0000	68.0000	72.0000
Post Therapy	7	38.0000	41.0000	45.0000
One year follow up	7	29.0000	47.0000	56.0000
Two three year follow up	7	29.4000	46.0000	60.0000

Ranks

	Mean Rank
Pre therapy GI	4.00
Post Therapy GI	1.71
One year follow up GI	2.07
Two three year follow up GI	2.21

Test Statistics$_a$

N	7
Chi-Square	13.348
df	3
Asymp. Sig.	.004
a. Friedman Test	

5.2.3 Results of the Friedman OASES: communication in daily situations (CD) score

The results of the Friedman test for communication in daily situations indicated that there was a statistically significant difference in scores related to daily situations pre and post *Free to Stutter Free to Speak* across the four time points (pre intervention, post intervention, one year follow up and two/three year follow up), *n*= 7 *p*=.004, χ^2 (3, n=7) = 13.348. Exploring the mean ranks over the four time points indicate that participants' perception of their communication in daily situations continued to improve after the programme was completed.

Table 5.3 Friedman analysis of the OASES communication in daily situations (CD) score

	N	25th	50th (Median)	75th
PRE therapy CD	7	52.000	55.2000	72.0000
Post Therapy CD	7	39.2000	49.6000	54.4000
One year follow up CD	7	31.2000	40.8000	59.2000
Two three year follow up CD	7	33.3000	40.0000	60.8000

Ranks

Test Statistics$_a$

	Mean Rank
Pre therapy CD	4.00
Post Therapy CD	2.29
One year follow up CD	1.86
Two three year follow up CD	1.86

N	7
Chi-Square	13.114
df	3
Asymp. Sig.	.004
a. Friedman Test	

5.2.4 Results of the Friedman test: Reactions to Stuttering (RS) score

The results of the Friedman test indicated that there was statistically significant difference in reactions to stuttering across the four time points (Pre intervention, post intervention, one-year post intervention and two/three years post intervention). *n*=7 *p*=.003 χ^2 (3, n=7) =14.13. Reactions to stuttering decreased on completion of the *Free to Stutter Free to Speak* programme with a small increase around the one-year follow up.

Table 5.4 Friedman analysis of the OASES Reactions to Stuttering (RS) score

	N	25th	50th (Median)	75th
PRE therapy RS	7	56.7000	73.3000	74.0000
Post Therapy RS	7	41.3000	48.0000	56.0000
One year follow up RS	7	28.0000	52.6000	62.0000
Two three year follow up RS	7	29.3000	52.0000	60.0000

Ranks

	Mean Rank
Pre therapy RS	4.00
Post Therapy RS	1.57
One year follow up RS	2.36
Two three year follow up RS	2.07

Test Statistics$_a$

N	7
Chi-Square	14.130
df	3
Asymp. Sig.	.003
a. Friedman Test	

5.2.5 Results from the Friedman test: Quality of life (QL) score

The results of the Friedman test indicated that there was statistically significant difference in perception of quality of life n=7 p=.004, χ^2 (3, n= 7) =13.103. Exploring the mean ranks indicates that the participants' perception of improved quality of life was maintained over the different time points and continued to improve up to three years after the programme.

Table 5.5 Friedman analysis of the OASES: quality of life (QL) score

	N	25th	50th (Median)	75th
PRE therapy QL	7	37.6000	64.8000	69.6000
Post Therapy QL	7	28.8000	43.2000	49.6000
One year follow up QL	7	20.8000	48.8000	63.2000
Two three year follow up QL	7	20.0000	40.8000	59.2000

Ranks

	Mean Rank
Pre therapy QL	3.86
Post Therapy QL	2.07
One year follow up QL	2.57
Two three year follow up QL	1.50

Test Statistics $_a$

N	7
Chi-Square	13.103
df	3
Asymp. Sig.	.004
a. Friedman Test	

5.2.6 Summary of OASES results

A summary of the Friedman test results for the subtests of the OASES and the total impact rating are outlined in Table 5.6. There is a statistically significant difference in all subtests across the four time points in support of positive changes and a reduction in negative attitudes towards communication experiences. The positive changes are maintained over the time frame of this research.

Table 5.6 OASES results Friedman test summary of all subtests

Subtest	*n*	Asymp. Sig.	df	χ^2
Total impact rating	8	.002	3	14.4
General information	7	.004	3	13.348
Communication in daily situations	7	.004	3	13.348
Reactions to Stuttering	7	.003	3	14.13
Quality of life	7	.004	3	13.103

5.2.7 The OASES total impact rating for participants.

The results in this table outline the pre- and immediate post-therapy outcomes from the OASES. Jack, Jason and Colm emigrated and were unable to attend further review appointments so data following the 2nd year was unavailable at time of compilation. An initial change is noted from pre- to post-test results for all participants. The extent of this reduction in impact of stuttering varies for each participant. Scores in the severe range are highlighted in red, in the mild to moderate range in green.

Table 5.7 OASES Total Impact of Stuttering

Name	Jason	Kate	Tracey	RT	Maura	Pauline	Jack	Mac	Colm	PJ	Adam
Pre test	**Mod**	**Mod**	**Mod-Severe**	**Severe**	**Mod-severe**	**Mod-severe**	**Mod**	**Severe**	**No OASES completed**	**Severe**	**Mod**
post test	**Mild-Mod**	**Mild-Mod**	**Mod**	**Mod**	**Mild-Mod**	**Mod**	**Mild-Mod**	**Mod**	**Mod**	**Mild-Mod**	**Mild**

1 year	**Mod**	**Mild**	**Mod**	**Severe**	**Mild-Mod**	**Mod**	**Mild-Mod**	**Mod**	**Mild-Mod**	**Mod**	**Mild**
3 years plus		**Mild**	**Mild-Mod**	**Severe**	**Mild to Mod**	**Mod**		**Mod**		**Mild-Mod**	**Mild**

5.3 Wilcoxon Signed ranks

Post hoc testing to control for type one error (rejection of the null hypothesis in error) was carried out. Further questions remained because the significance identified by the Friedman test in general does not highlight at which time point the most significant change occurs and whether this change is maintained. It had been noted clinically prior to commencing this research that significant changes in the participants' assessment results in the immediate aftermath are not maintained on the following review date (as demonstrated in Table 5.7). Four out of eleven participants on their first review date demonstrated a return to their original impact rating taken pre-programme. However, as participants continued in the programme (attending review days) further reduction in impact scores are noted, with nine of the eleven showing reduction in impact in comparison to their pre-programme rating. It was, therefore, hypothesized that post hoc testing would identify an initial significant result for the pre to post *Free to Stutter...Free to Speak* period and a drop in level of significance between the post FTS and one year assessment results. The level of significance was then hypothesized to increase in the one year to final follow up phase. To explore this one-tailed hypothesis, the Wilcoxon signed ranks test was administered. The hypothesis for the comparison of the pre-therapy and post-therapy *Free to Stutter...Free to Speak* results is in line with the findings of the Friedman test, that there would be significant reduction in impact of stuttering. The hypothesis for the pre-therapy FTS and results one year later was that the results would not be significant. Finally, the one-tailed hypothesis for the pre-therapy FTS and final results two /three years later is that there would be a significant reduction in impact of stuttering. The SPSS output of the Wilcoxon Signed Ranks are detailed in Appendix K.

5.3.1 Wilcoxon Signed Ranks

OASES total impact score Pre therapy FTS to Post therapy FTS.

A Wilcoxon Signed Rank test demonstrated a statistically significant difference in total scores on the OASES between the pre-intervention assessment and the immediate post course assessment, *p* =.005 and *z* = -2.8 (Appendix K, Table 1).

5.3.2 OASES total impact score: Pre-FTS and one year later.

A Wilcoxon Signed Rank test revealed that there was a statistically significant reduction in total score on the OASES between the pre-therapy FTS assessment and the assessment one year later, *p=.005* and *z*= -2.803 (Appendix K, Table 2).

A final test to explore significance between pre-therapy FTS and the total impact score from the OASES taken two to three years later was carried out.

5.3.3 OASES total impact score: Pre-therapy FTS and two/three years later.

A Wilcoxon Signed Rank test revealed a statistically significant reduction in total score on the OASES between the pre-therapy assessment and the two/three year assessments results, *p* = .012 *z* =-2.521 (Appendix K, table 3)

Following the Narrative Therapy programme *FTS* there was a statistically significant reduction in the impact of stuttering on participants' lives as reported by the Friedman Test and the Wilcoxon Signed Ranks Test. This reduction in impact was maintained up to three years after the programme was completed.

5.3.4 Effect Sizes

Effect size is the difference between the means of the therapy group and a control group divided by the control group standard deviation (Glass, 1977). In this study there was no control group so effect sizes were calculated for the OASES results using the formula *R*= *z* divided by the square root of N (R =z÷√N) (Pallant, 2010; Grande, 2015). An effect size was calculated for pre-FTS to the final post-FTS assessment (two/three years later).

In this calculation N = the number of observations over the two time points, not the number of cases (Pallant, 2010) for example *n*=8 but N=18 which is both pre and post –test observations combined. The Z score obtained from the Wilcoxon Signed Ranks is -2.803. The effect size calculated for the Total Impact score (pre-therapy to final assessment) was .612 indicating a large effect size using Cohen (1988) criteria of .5 moderate effect size.

5.4 WASSP (Wright Ayre Stuttering Severity Profile)(Wright & Ayre, 2000)

The WASSP is subdivided into five sections: Stuttering behaviours, thoughts, feelings, avoidance and disadvantage**.** It is a self-report scale. Scores in each subsection indicate the severity of perceived symptoms. Low scores indicate mild or moderate impact of stuttering symptoms. Reduction in stuttering behaviours, thoughts, feelings, behaviours, avoidance and disadvantage are identified by the re-administration of the WASSP in the immediate post-programme period. Three cases from the eleven were excluded from the analysis by SPSS for missing data**.**

5.4.1 WASSP: Results: Stuttering Behaviours

The results of the Friedman test indicated that there was no statistically significant difference in stuttering behaviours across the four time points (pre-intervention, post-intervention, one year post-intervention and two/three years post-intervention), *n*=8 *p=.055* χ^2 (3, n=8) =7.615. The initial post-therapy improvement in perception of stuttering was not maintained over the three-year period as evidenced by the mean ranks.

Table 5.8 WASSP: Results: Stuttering Behaviours

	N	25th	50th (Median)	75th
PRE therapy	8	26.7500	31.0000	38.2500
Post Therapy	8	19.0000	19.0000	26.0000
One year follow up	8	17.2500	23.0000	37.7500
Two three year follow up	8	15.7500	20.5000	39.5000

Ranks

	Mean Rank
Pre therapy	3.31
Post Therapy	1.56
One year follow up	2.56
Two three year follow up	2.56

Test Statistics

N	8
Chi-Square	7.615
df	3
Asymp. Sig.	.055
a. Friedman Test	

5.4.2 WASSP: Results: thoughts about stuttering

The Friedman test results indicate that there is a statistically significant difference across the four time points, with a reduction in scores for thoughts about stuttering following the programme and over the follow up period, *n*=8 *p*=.003, χ^2 (3, *n*=8) =13.658. Exploring the mean ranks indicates some increase in negative thoughts about stuttering over this time period.

Table 5.9 WASSP: Results: thoughts about stuttering

	N	25th	50th (Median)	75th
PRE therapy	8	9.2500	18.5000	20.000
Post Therapy	8	5.2500	8.0000	9.7500
One year follow up	8	4.2500	9.0000	9.7500
Two three year follow up	8	7.2500	10.5000	13.7500

Ranks

	Mean Rank
Pre therapy	3.81
Post Therapy	1.69
One year follow up	1.94
Two three year follow up	2.56

Test Statistics$_a$

N	8
Chi-Square	13.658
df	3
Asymp. Sig.	.003
a. Friedman Test	

5.4.3 WASSP results: Feelings

The Friedman test results indicate that there is a statistically significant difference in feelings about stuttering across the four time points. *n*=8, *p=.009* χ^2 (3, *n*=8) = 11.649. The mean ranks show a gradual in increase in negative feelings about stuttering though they do not return to the pre therapy levels.

Table 5.10 WASSP results: Feelings about stuttering

	N	25th	50th (Median)	75th
PRE therapy	8	15.5000	28.5000	33.0000
Post Therapy	8	10.0000	11.5000	14.5000
One year follow up	8	8.0000	14.5000	20.0000
Two three year follow up	8	6.7500	14.0000	16.7500

Ranks

	Mean Rank
Pre therapy	3.75
Post Therapy	1.69
One year follow up	2.19
Two three year follow up	2.38

Test Statistics$_a$

N	8
Chi-Square	11.649
df	3

Asymp. Sig.	.009
a. Friedman Test	

5.4.4 WASSP results: Avoidance due to stuttering

The Friedman test results indicate that there is a statistically significant difference in avoidance due to stuttering across the four time points. *N=8, p=.006* χ^2 (3, *n=8)* =12.506. The mean ranks indicate that avoidance due to stuttering continues to lessen following the intervention.

Table 5.11 WASSP results: Avoidance due to stuttering

	N	25th	50th (Median)	75th
PRE therapy	8	10.0000	15.000	20.7500
Post Therapy	8	6.0000	7.0000	7.7500
One year follow up	8	5.2500	9.0000	13.0000
Two three year follow up	8	4.7500	9.0000	11.0000

Ranks

	Mean Rank
Pre therapy	3.81
Post Therapy	1.88
One year follow up	2.44
Two three year follow up	1.88

Test Statistics$_a$

N	8
Chi-Square	12.506
df	3
Asymp. Sig.	.006
a. Friedman Test	

5.4.5 WASSP Results Disadvantage due to stuttering

The Friedman test results indicate that there is a statistically significant difference in disadvantage due to stuttering across the four time points. *n*=8, *p=.007* χ^2 (3, *n*=8) =12.247. Exploring the mean ranks indicates that a sense of disadvantage due to stuttering lessens over time following the therapy programme. The Wilcoxon Signed Ranks test was not applied to the WASSP scores, as it does not provide a total impact score but rather separate subtest results.

Table 5.12 WASSP Results Disadvantage due to stuttering

	N	25th	50th (Median)	75th
PRE therapy	8	9.000	13.5000	18.0000
Post Therapy	8	4.7500	7.5000	11.0000
One year follow up	8	4.2500	7.5000	12.2500
Two three year follow up	8	4.0000	8.5000	11.2500

Ranks

	Mean Rank
Pre therapy	3.81
Post Therapy	2.06
One year follow up	2.19
Two three year follow up	1.94

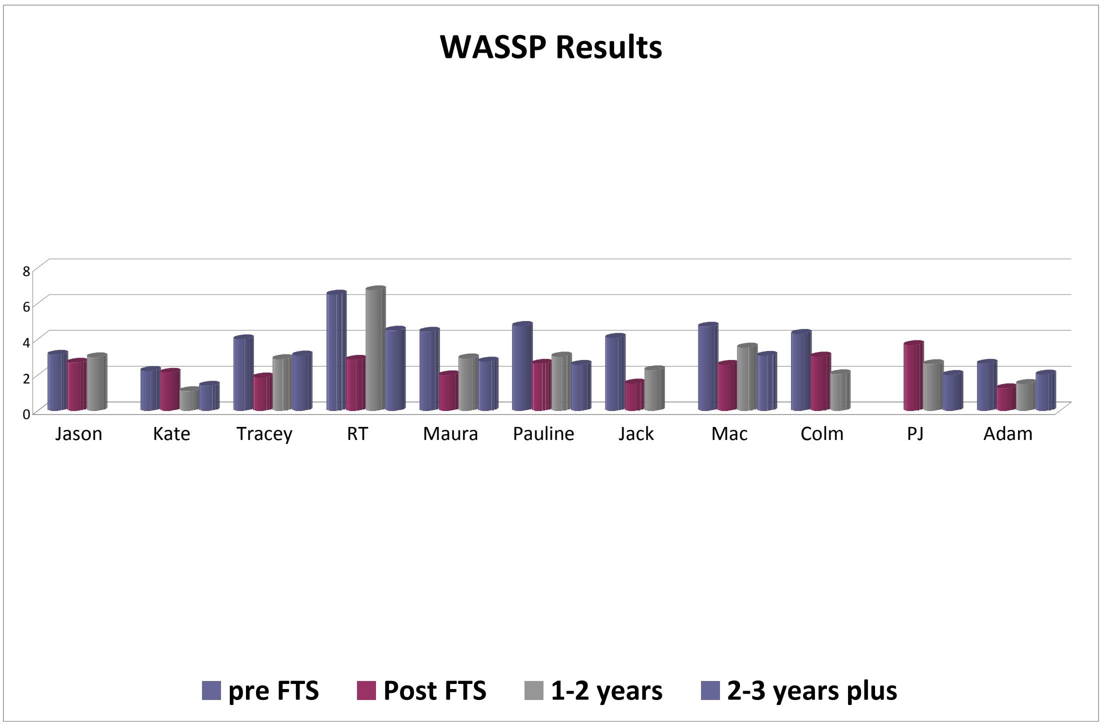
Test Statistics

N	8
Chi-Square	12.247
df	3
Asymp. Sig.	.007
a. Friedman Test	

Figure 5.1: Summary of WASSP results

Figure 5.1 provides a visual representation of the changes in the WASSP scores over the four time points measured in this study. All 11 participants have lower scores on the final time point signifying a reduction in severity of thoughts, feelings, avoidance and disadvantage due to stuttering.

Figure 5.1 Summary of WASSP results



5.5 S24 Results

The Erickson’s Modified S24 (Andrews and Cutler, 1974) is used to measure attitudes to communication. This 24-item scale distinguishes the extent to which a stuttering person’s communication attitude deviates from normed attitudes. Statements require a true or false answer. The higher the score, the greater the impact that stuttering has on the participants’ communication in daily situations.

Figure 5.2 S24 results high scores are indicated in red, low scores in green

Name	**Jason**	**Kate**	**Tracey**	**RT**	**Maura**	**Pauline**	**Jack**	**Mac**	**Colm**	**PJ**	**Adam**
PRE FTS	**15**	**12**	**16**	**20**	**17**	**22**	**10**	**20**	**18**	**17**	**17**
POST FTS	**11**	**11**	**10**	**15**	**8**	**16**	**10**	**18**	**19**	**12**	**6**
I YEAR	**9**	**2**	**14**	**24**	**10**	**14**	**8**	**17**	**10**	**12**	**10**
2-3 YEARS		**3**	**11**	**21**	**10**	**14**		**11**		**7**	**11**

Figure 5.2

Ten of the eleven participants on the pre therapy screening have results indicating strongly negative attitudes towards their communication in daily situations. On the final follow up, nine of the eleven participants have results within the average range for attitudes to communication.

Table 5.13 Results of Friedman test: S24

	N	25th	50th (Median)	75th
PRE therapy S24	8	16.2500	17.0000	20.0000
Post Therapy S24	8	8.5000	11.5000	15.7500
One year follow up S24	8	10.0000	13.0000	16.2500
Two three year follow up S24	8	7.7500	11.0000	13.2500

Ranks

	Mean Rank
Pre therapy S24	3.75

Post Therapy S24	1.94
One year follow up S24	2.31
Two three year follow up S24	2.00

Test Statistics$_a$

N	8
Chi-Square	10.792
df	3
Asymp. Sig.	.013
a. Friedman Test	

The Friedman test results for the S24 indicate that there is a statistically significant difference in the attitude to communication scores of the participants over the four time points. *n*=8, *p=.013* χ^2 (3, *n*=8) = 10.792

Wilcoxon Signed Ranks

Wilcoxon Signed Ranks S24 were obtained for three sets of data; results for pre-therapy and post-therapy; S24 results for pre-therapy and one year later follow up; S24 results for pre-therapy to two/three year follow up.

Statistical significance has been identified among the three to four time points on the S24 for the participants. Post hoc testing was carried out to compare the results between the time points, using the Wilcoxon signed ranks test.

5.5.1 S24 Results for pre-FTS and post-FTS

Analysis indicated a statistically significant change in scores between the initial pre Therapy assessment and the post therapy assessment. *n*=11 and *p*=.008 z= -2.655 (Appendix K, table 4). Effect size was calculated as .566, a moderate effect size.

5.5.2 S24 Results for pre therapy and one year follow up

There was a statistically significant difference between the S24 scores and the scores one year later. N=11 and *p=.010*, *z*= -2.582 (Appendix K, Table 5). Effect size was calculated for pre FTS and the results on year later. The results give a moderate effect size of .55.

Following this a comparison was made between the pre therapy tests and the two /three year test. There was a reduction in sample size for the analysis due the exclusion of missing data by SPSS.

5.5.3 S24 results for pre therapy to two/three year follow up

The Wilcoxon Signed Ranks test indicates that there is statistically significant difference between the pre therapy tests and the two/three year results. n=11 initially and then n=8 $p=.017$ z=-2.383 (Appendix K, Table 6).

The Effect size again was calculated using the formula r=z divided by the square root of N. The Effect size of .5467 was moderate when compared to Cohen's d.

5.6 Overview of the results from Statistical analyses

In order to answer the research questions set out at the beginning of this chapter the assessment data from four time points (pre- therapy, post-therapy, one year post-therapy and a final assessment date two/three years post therapy) for all eleven research participants was statistically analysed. The data was checked for assumptions of normality and were found to be skewed. As a consequence of this, I made a decision to apply non-parametric tests. Friedman's test was chosen because it is the non-parametric equivalent of an ANOVA (a one-way analysis of variance), where the same sample of participants was measured at three or more points in time or under three different conditions.

The results of the Friedman tests indicated a statistically significant difference in the assessment results across four time points for all subtests of the OASES, the S24 and four out of the five WASSP subtests. However, for one subtest (the stuttering behaviours subtest on the WASSP) the results were not significant and the null hypothesis could not be rejected. As such the null hypothesis was rejected for the OASES, S24 and four out of five the WASSP subtests. This means that positive changes were evident in thoughts, feelings and attitudes to communication following the Narrative Therapy process in the *Free to Stutter Free to Speak* programme. These positive changes were maintained without relapse to pre *Free to Stutter Free to Speak* levels over a three-year period.

The Wilcoxon Signed Ranks tests were administered to control for type one error. The total impact score of the OASES was taken and analysed over the four time frames. The difference between the pre-FTS score and the final score was statistically significant. The S24 results were also explored across four time points with the Wilcoxon Signed Ranks test. Again, significant results were obtained. The Wilcoxon Signed Ranks tests were not applied to the results of the WASSP, as this assessment does not provide a total impact score but rather separate subtest results. The difference again, between the pre-FTS and the final test scores was statistically significant. Moderate effect sizes were evident for the OASES and the S24.

The results from the statistical analysis of the three standardised assessments (OASES, WASSP and S24) clearly show positive measurable changes from the Narrative Therapy programme *Free to Stutter...Free to Speak* in terms of stuttering behaviours and attitudes. However, the question remains as to whether those outcomes are meaningful to the participants. In the next chapter, the focus shifts to the experiences of the participants, to explore their experiences of change and the outcomes that they foreground as meaningful.

Chapter 6 Introduction

Themes from the early stages in Narrative Therapy

This chapter presents the findings from the Interpretative Phenomenological Analysis describing the experience of being a person who stutters at different stages in the process of Narrative Therapy.

The process of Interpretative Phenomenological Analysis involved the immersion in the transcribed narrative therapy sessions with detailed coding of themes for each therapy session as detailed in chapter four. Interpretative Phenomenological Analysis of the narrative therapy sessions from the three participants revealed five superordinate themes, each further subdivided into subordinate themes. Each superordinate theme is illustrated by a visual map in keeping with White's (2007) description of *Maps of Narrative* practice. The five superordinate themes that emerged from the data were: (a) the impact of stuttering, (b) hope as a transformative force, (c) identity as a person who stutters at the beginning of therapy and following therapy; (d) will; and a final theme linked to (e) unique outcomes from the externalisation conversation. Table 6.1 outlines the five superordinate themes and their subthemes. The focus of Chapter 6 is on the first two themes as they emerged in the Narrative Therapy sessions: Impact of stuttering and Identity. Chapter 7 details the themes as they arise in the latter stages of Narrative Therapy, in particular Identity under transformation, Hope as a transformative force, Will and the theme describing the unique outcomes of each participant.

This next section focuses on the conventions used within chapters 6 and 7. Each theme is illustrated by verbatim quotes from the participants' Narrative Therapy sessions (Appendices C, D and E). The line numbers for each quote is provided along with page numbers of those included in the appendices. The progression in the themes from initiation to completion of therapy is noted. The quotes taken from the participants' letters following therapy and review days (Appendix F) are indicated as correspondence (C) and those from participant responses to the triangulation letter (Appendix L and L2) are identified as such. The line numbers for each quote is provided. Pauses are indicated by the use of brackets () with the length of time given within.

Other voices from the definitional ceremonies are identified as outsider witnesses and by pseudonym. Edits intended to clarify quotations appear in brackets for example (*laughs*). Repeated words and fillers for example *erm, em, like you know*, have not been removed from the text, as they are testimonial to the dysfluency experienced by the speakers. Omitted text is indicated by …. All information that could potentially identify the participants, for example, name, specific locations and personal identifiers have been altered. Reflexive commentary is included at different points. This commentary is taken from notes kept by the researcher during the process of Interpretative Phenomenological Analysis.

Figure 6.1 Map 1 Superordinate Themes from the Narrative Therapy sessions of People who Stutter

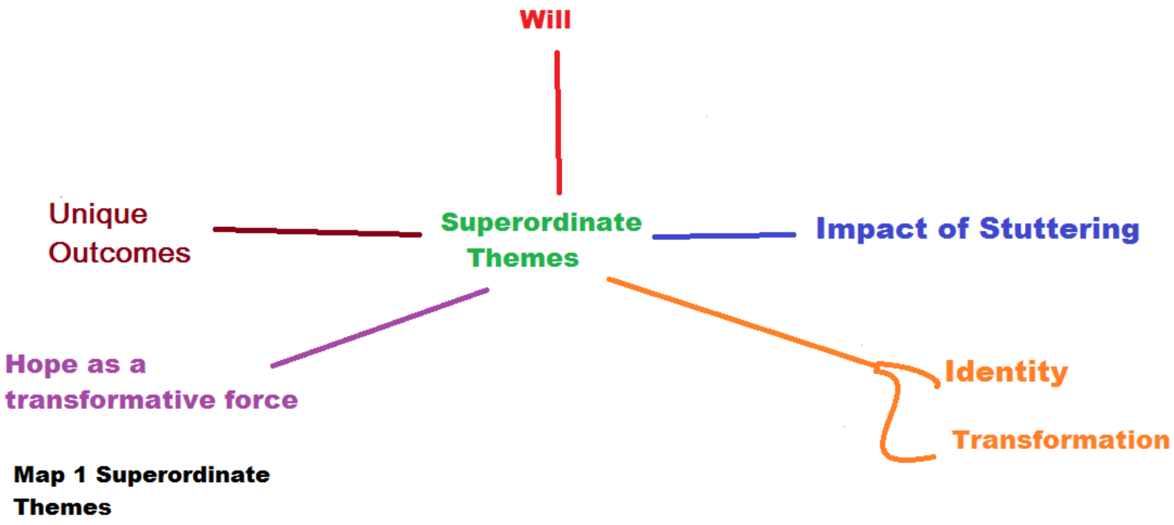


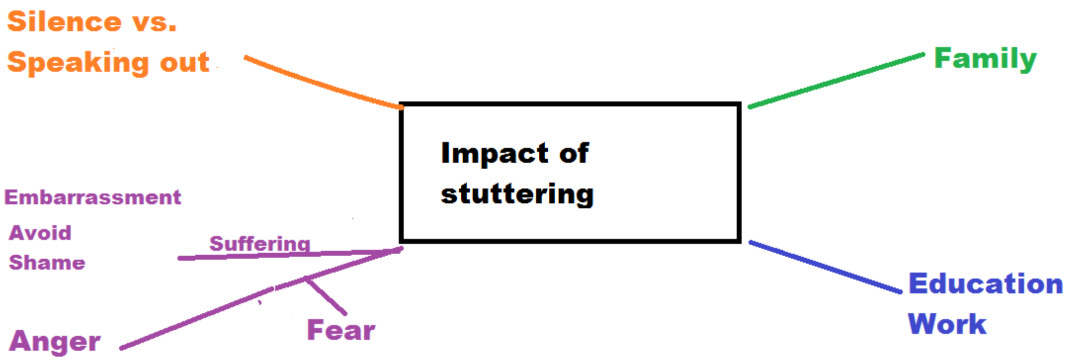
Table 6.1 Superordinate Themes, codes and subthemes

Subtheme	Theme 1 Impact of stuttering	Theme 2 Identity	Theme 3 Hope as a transformative force	Theme 4 Unique Outcome	Theme 5 Will
1	Family	Sense of being other/outside	Hope Humour	Without words	Identifying own resources
2	Education Work	Values Ideas and expression Success Contribution Commitment to others	Pride	Persistence	Determination Preparation
3	Suffering Anger Fear Avoid/ Embarrassment/ Shame	Transformation Speaking out Self determination Acceptance	Fulfilment	Speaking/acting out	Linking in with others (living a more peopled life)
4	Power /powerless Silence vs. speaking out		Moments of Transition: hope in action		Moving on Action

6.1 Theme one: Impact of stuttering

The superordinate theme of “the impact of stuttering” refers to the impact of stuttering across varied domains of life as described by the people who took part in the study. This theme emerged strongly to the researcher in the initial narrative therapy sessions when the problem story was richly described. Minimal prompting from the therapists resulted in references to a variety of past experiences describing the impact of stuttering on education, work and family life. While it might initially appear that the impact of stuttering is predominantly negative, as the Narrative Therapy progressed a more complex picture emerged. Initial reporting of experiences of bullying and isolation was overtaken by stories of people engaging in meaningful and supportive relationships and succeeding professionally in chosen careers. The subthemes of *Impact of Stuttering* are impact on family, and of family; education and work; suffering and feelings. A fourth subtheme of silence versus speaking out and power versus powerless emerged for some participants but did not appear as evident to the researcher as the first three subthemes.

Figure 6.2 Map 2: Theme 1 Impact of stuttering



6.1.1 The impact of stuttering was notable particularly in relation to family.

Subtheme 1.The family: We are not really a *talking kind of family anyway*.

> **SLT: What about your family? Is there a family history of stuttering?**
>
> **RT: no, my uncle (waves hand), he blinks a lot. Kind of rambles, so maybe he has one, he's covert (waves his hand) … No wouldn't talk about it.** (Appendix C, p26, 106-108)

This example highlights the impact of stuttering on families. RT's description of a family who does not talk about stuttering even if other members of the family stutter, is echoed by other participants. While stuttering and the impact of stuttering were not directly talked about at home, correction was offered.

> **RT: They'd always kind of correct... telling me like to to 'slow down'** (Appendix C, p27, line 114-118)

A culture of silence and denial of the impact of stuttering was reported by RT and Mac. Both of them reported a family member possibly having experienced stuttering without their ever having had a conversation about stuttering with that person. This lack of sharing experiences suggests a culture of isolation within an already marginalised group. Mac described how the culture of not sharing her feelings about her stutter within her family has made it difficult to discuss the other issues that are impacting on her.

> **Mac: not at all, no. We are not really a talking kind of family anyway. She wouldn't really talk to me about anything. It's not really easy to bring up other**

> **anxiety issue, that's been going on a lot longer, then. Yeah, I do think she does have a slight stammer**... (Appendix D, p78, line 238-242)

For Mac, the impact has been on communication within the family.

> **Mac: Em, family life. I will start with that, when I'm having bad days, there is a complete lack of communication** (Appendix D, p91, line 356)

When Adam discussed his family, he emphasized his new created family (wife and children) and did not refer to his family of origin. Externalising the problem from his own self he referred to himself in the third person and he said that the stutter (Stuts) is blocked from meeting his (Adam's) family and friends. This results in avoidance of situations and stuttering resulting in frustration and anger. When speaking in 'Stuts' voice his language changed, using colloquial verbs.

> **Adam (as Stuts): I'm usually around most of the time, but <u>he (Adam)</u> <u>don't let</u> me meet his family or friends** (Appendix E, p96, line 4)

However, in one of the final Narrative Therapy sessions he described how it is important to share with family. Openness about stuttering and emotions is encouraged by his wife.

> **Adam: Basically very fulfilled and purpose love, sharing… Sharing, good and bad** (Appendix E, p135, lines 302)

He has made choices about how he spends time with his family. He chooses to be actively involved and not leave them to passively watch TV. He values his role within his family and recognises the importance of being there for them.

> **Adam: Wife was working five days a week, new role change that round, become a parent. I didn't just want to mind them, turn on the TV half nine in the morning go away inside**. (Appendix E, p114, lines 139-140)

Overall within this theme, the impact of stuttering on the family and how families communicate was reported by the participants; in particular, they spoke about choosing not to talk about things that directly affect them or have affected them in the past for example stuttering. Experiences of being a person who stutters were not shared within families. This impact of stuttering with the family extended beyond the family, to other formative experiences particularly in school.

6.1.2 Subtheme 2.1 Impact on Education: *the burning urge*

Childhood and young adult experiences of education were challenging for all three participants. Each participant described the impact of stuttering on education. For example, referring to himself in the third person as part of his externalising narrative, RT described how stuttering had taken control

> **RT: He left school as I (stutter) had taken control he (RT) couldn't concentrate** (Appendix C, p13, line 9)

Later on RT described how moving school did not help but rather exacerbated the difficulties he was having. A common experience for RT and other participants was one of not being believed about speaking difficulties and the *fear* of not being believed. RT elected to be in a bottom class, which he believed would place less demands on him orally. Unlike the other two participants, he experienced bullying in school from pupils and negative reactions from teachers.

> **RT: Yeh got kicked out. No good …Yeh moved into a new school, was put down into the bottom class, because I thought it would be easier sort of got, was bullied. ..** (Appendix C, p15, line 24-33)

> **Remember, when the teacher when he was mad and asked me question. I didn't hear, cos like he rants aha ahah. 'What? I said to him what did you say? He said well he said like are you deaf as well as dumb? That was, remember that. Remember too like the headmaster he asked me too was my stammer real. He thought it was a spoof, putting it on.** (Appendix C, p23, lines 80-83)

RT's experiences of bullying were not shared by Mac or Adam. However, they had have experiences of education that had left significant and lasting memories. For Mac, stuttering has resulted in a fear of speaking out. Despite "a burning urge" to share her ideas and opinions reportedly the fear of being judged was too great. She expressed a fear of being thought stupid or unprepared but the fear of stuttering was greater than that of being thought stupid, resulting in frustration. She dropped out of college.

> **MAC: I just same word same primary, secondary, sometimes when a teacher would say, does anyone have a response to that or whatever I had a *burning urge* to say because I feel like it's a really good response.**

> **I'd like to share, and most of the time I would feel so anxious and so worried that I would stammer or you know people would be judging how I do a lot of…do a lot of pausing.** (Appendix D, p64-65, lines 61-62)
>
> **Yeah when it comes to say when I was in college if it came to speaking out or being asked questions which I wouldn't be brave enough to answer. Em I'd have a burning desire to answer I'd be so afraid of it, and people's reactions that I wouldn't answer and then I'd feel that I would give off the impression that I just didn't know the answer and feel kind of stupid or that the lecturer thought I didn't do my work or, very frustrating.** (Appendix D, p93, lines 366-367)

Adam persevered to attend and complete at university level. This was not without its challenges. At moments when he described the impact of stuttering on significant events, his sentences became compacted and were articulated with flat expression without elaborating further. The short flat utterances were perhaps indicative of the effort and toll stuttering has taken and continues to take on him. There appears perhaps a hint of suppressed anger in the clipped sentences.

> **Adam: Have made many appearances at important stages in his (Adam's) life...There was em my final part three exam in University. It was an interview. Went bad** (Appendix E, p96; line 4; p114, line 132-134)

For some participants, there is a sense of underachieved potential due to stuttering emerged and for others, a sense of struggling through. Early educational experiences as a child and young adult who stutters create challenges for the young adult in the work place.

6.1.3 Subtheme 2.2 Impact on Work: *leaving my work speak for itself*

Opportunities for careers of choice are limited in a recession. The data for this research was collected at the height of the deepest recession Ireland has experienced since the 1950s. Opportunities for people who stutter to advance professionally in a chosen career were found to be even more restricted. All three participants described how the impact of stuttering on education further led to challenges professionally and with occupational choices. RT described the impact of stuttering on career choice. There is a strong sense of restricted choices due to stuttering. His use of the past tense suggests that this is in the past and maybe therefore not what he will tolerate now.

> **RT: Stopped him from getting jobs he wanted, ended up working in jobs bad (sic) paid, working for people who treat him badly** (Appendix C, p13, line 11)

For Mac, stuttering impacted on performance and self worth within the work sector. Mac has not had consistent paid employment since she left college. She volunteers for animal charities and takes part in animal rights demonstrations. Even when volunteering, stuttering has an impact.

> **Mac: yeah it is because sometimes I feel I'm not doing anything by just standing there em, with the poster or whatever, em sometimes I feel like there is not much point in being there if I can't speak about it.** (Appendix D, p63, line 49)

Adam described how stuttering shows up at all the important times. It impacted throughout college and has left him with a sense of anxiety about speaking situations in work.

> **Adam: Like making speeches at graduation, college presentations, interviews and all the big stuff** (Appendix E, p96, line 5)

Avoidance of words and situations form part of the profile for many people who stutter. Working in a creative field Adam described how the work can stand on its own without any verbal input from him.

> **Adam: Sometimes I leave my work speak for itself you know** (Appendix E, p100, line 40)

The earlier impact of stuttering on education has followed Adam, Mac and RT into career choices and work situations. Adam has previously defined himself and his role in life by his profession and now he is only partially employed due to work cutbacks in the recession. Mac indicted she feels that there is not much point in persevering if she cannot speak and RT expressed anger about the work choices he has made due to stuttering.

6.1.4 Subtheme 3. Suffering: *no way out of the darkness*

Distress, pain and hardship are evident in the participants' accounts of living with stuttering. Participants described how the impact of stuttering moved beyond the occupational and educational and impacted in very real and meaningful ways across all their domains of daily living. The initial Narrative Therapy sessions focused on developing a 'thick description' of how the problem emerges across the different domains. A rich seam of suffering emerged, that crosses boundaries of age, time and gender.

> **SLT: and do you think your stutter was responsible for the friends, the bullying in school? It had that kind of effect on you?**
>
> **RT: Had to (3) like (3) stood out** (Appendix C, p22, lines 73-76)

RT described how, in order to survive the bullying, he befriended the bullies.

> **RT: Yeh, made friends with the bullies, yes cos then was always then was always was always kind of protected. ..Kind of like survival** (Appendix C, p17, lines 42-48)

Stuttering has affected all aspects of his life. He also recognises that some of his lifestyle choices have impacted on his life. Reflecting back to RT on his description of the impact of the stutter on his life, the Speech and Language Therapist questioned this and wondered aloud if this an accurate statement. In Narrative Therapy, checking in with the participant is recognised as key to the reauthoring process.

> **SLT: The stammer has affected everything? Is that too broad a statement?**
>
> **RT**: **I think part of it yeh. My lifestyle wasn't too healthy I think** (Appendix C, p28, lines 121-123)

For Mac, suffering became the backdrop to daily life.

> **Mac: I've been through a lot and I never complain that much ah. I don't have a desire to complain just try and get on with things as best I can even though I have days where I just feel so low or so fed up that things are very difficult.** (Appendix D, p67, lines 79-80)

Stuttering has resulted in withdrawal, physically by choosing not to talk and emotionally by not speaking and expressing her feelings. She described the dark emotions linked with her stuttering and the impact that it has had. Mac feels that her stuttering is linked with her diagnosis of social anxiety and the combined impact has lead to isolation. She identified the lack of openness about stuttering as contributing to her sense of loneliness and isolation. In what is a detailed description of emotional turmoil, Mac reflected on her own use of language. Brevity seems to reflect her state of mind.

> **Mac: I don't speak some days, em I may give the impression I'm having a moody day or something because I have really short answers like, I just don't want to elaborate, em.** (Appendix D, line 380)

Her interactions with others are curtailed as she withdraws into herself. The description of being "lost in myself" is linked with her later story of being physically lost (see Unique Outcomes). Mac uses words such as "light" and "dark" to represent her state of mind. There are phrases such as "dark emotions", a "dark room" and "being in the dark", "with no way out of the darkness".

> **The way I act like in my behaviour, more so or if, say, after a situation like that, I'd be interacting or talking to someone who I would know a lot better or feel more comfortable with em I wouldn't, you could just tell by looking at me. I wouldn't pay much attention I be so lost in myself. So kind of dark emotions or whatever …** (Appendix D, line 392)

> **In the dark room, it just felt, well I was thinking as regards to my own life was looking back at times when I was so low that I thought that this was it basically I didn't want to continue when I was younger because no one explained things to me, em when I was really ill as well with my social anxiety. God I was in a very bad place a lot of times, being in the dark, I always felt I was in the dark and because kids when kids are young no one explains that side of life, no one explains things the way they probably should em I felt like I was the little young girl in the dark who was so confused em felt there was no way out of the darkness.** (Appendix D, lines 505-506)

For Adam, there is a conflict inside between speaking and not speaking, between stuttering openly and avoiding speaking. The resulting "battle" impacts on his sense of self and self worth.

> **Adam: Inside there will be all those inner battles…low self-esteem** (Appendix E, p107, line 89)

Suffering is fed by strong feelings about stuttering and the situations the participants find themselves in as a result of stuttering. Anger, fear, avoidance, shame and embarrassment emerge from their stories.

RT described his anger at a therapist questioning his motivation to take part in a programme due his late arrival. He had travelled many hours across country to attend and felt his effort was unacknowledged.

> **RT: They said I'd got no eh got no interest in fluency, I just lit up.** (Appendix C, p32, line 150)

He described the anger he feels about speaking situations and the way his life was progressing at that time. This anger resulted in him moving job, home or country at different times.

> **RT: Because I got angry, kind of anger, frustration that's kind of doing something, I'll just, could be just move.** (Appendix C, p55, lines 165-167)

For Mac the anger was fuelled by a sense of her own entitlement to speak out and the distress her failure to do so caused. She identified strongly that she has the right to speak out but her failure to do so resulted in anger towards herself.

> **Mac: Would make me quite angry that I, I have a right just like anybody else.** (Appendix D, p65, line 67)

In contrast to her anger, her recognition of her rights, there was fear. This is fear of change, fear of staying the same. As Mac stated her goal is;

> **Mac: Not to be afraid of change.** (Appendix D, p70, line 158)

She also spoke of fear also of regressing and fear of the judgement of others.

> **Mac: Fear… backwards… mainly would be fear of being judged, by people, listening hearing their reactions to speech.** (Appendix D, p71-72, line 175-179)

As therapy progressed, Mac's use of language suggests that she recognised that fear is double edged, that it could motivate her to change and to continue to change.

> **Mac: I'm here to not be afraid really not be afraid of any judgements that I have perceived people may have or people do have. That would have been the principal reason why I avoided** (Appendix D, p91, lines 349-350)

She identified what may sabotage her progress.

> **Mac: Mainly fear and frustration, feeling low, stress (writes embarrassments, Judge).** (Appendix D, p85, line 308)

Adam also recognised the importance of identifying the fear as he came towards the end of the intensive week programme *Free to Stutter...Free to Speak*. This progression was significant for both Mac and Adam in recognising the impact of emotions on their speech and on their ability to progress in therapy.

> **Adam: I'd like to know a little more the different things … about the fear and the embarrassment** (Appendix E, p106, line 83)

Surviving in spite of suffering was common for RT, Mac and Adam. The acknowledgment and exploration of the feelings associated with this suffering in the initial externalisation conversations appear to be a significant point in the therapy process.

6.1.5 Subtheme 3: 2 Power/Powerless

The absence of power and feelings of powerlessness predominated in the early Narrative Therapy sessions for all participants. Stuttering by its nature is unpredictable. The variability that is a core constituent of stuttering may exacerbates these feelings of powerlessness. People who stutter recognise that there are things beyond their control, for example when and where they might stutter. The discourse extracts above suggest that this sense of powerlessness has spread to other aspects of the daily lives of the three participants. Feeling powerless has resulted in RT going along with the bullies, drifting out of school, leaving employment. However, in the final Narrative Therapy sessions, the language used points to a clear sense of taking back control and reclaiming power.

Initially, as RT described his life from the point of view of the stutter (his externalisation conversation), he talked of the lack of control and how this was set to change.

> **RT: He left school as I had taken control he couldn't concentrate.**
>
> **He used to think I will always be in control but now he is taking control and sees himself as master of his mind body and soul.** (Appendix C, p13, line 9-10)

In response to comments in his definitional ceremony in the final Narrative Therapy session whereby his outsider witness described him as a 'fighter' RT said:

> **RT: Its nice, yeh. It is good. Means that probably what's the word tougher, in control** (Appendix C, line 443-445)

For Mac, there was awareness early on in the River exercise (Appendix M) that her lack of agency and power may be what was affecting her ability to implement change.

> **Mac: That I can be quite persistent but at the same time weak** (Appendix D, p73, line 194)

As Adam progressed through therapy, he seemed to realise that the key was not to have power over the stutter or to feel powerless in the face of it but to choose another path. In a continuation of his earlier battle metaphor, he decided not to be "ruled" by his stutter and not to engage in this struggle between stuttering and fluent speech. This was a significant departure from his earlier goal of enhanced fluency.

> **Adam: Not being ruled by it, I suppose before I would let's not be ruled by it lets try and overcome it and become more fluent and whatever, but that's not, that's not the way** (Appendix E, p103, line 60)

Feeling powerless in the face of stuttering is a shared experience for these three participants. Reclaiming power, however, means different things for each person: for RT it is about being in control; Mac recognises that she lacks agency; and Adam sees a different path wherein he removes himself from the struggle for mastery over his speech.

6.1.6 Subtheme 4 Silence /Speaking out: *Without words of course*

There are risks inherent in speaking out. Speaking out can identify someone as a person who stammers and leave them exposed to ridicule, shame and embarrassment. Conversely, failure to speak out may result in isolation, loneliness and feeling that one has cheated oneself by failing to achieve one's potential. RT identified early on how frustrated and upset he was that his efforts to attend a speech programme in England were not acknowledged. He chose to not defend himself and his actions but to drop out of the programme instead.

> **RT: I didn't say anything. After kind of driving over from the west of Ireland to Dublin, getting the boat over staying the night** (Appendix C, p32, line 151)

In a humorous description of how he tried to avoid Irish dancing classes he described his performance at a Feis. A Feis Cheoil is an opportunity for people involved in either traditional Irish dancing or music to compete against others in front of an audience and a panel of judges. A Feis may be a locally organised event or a national competition. The smaller events provide an opportunity and exposure for the participants but are none the less extremely competitive. The city in which this story takes place is noted for its large Irish immigrant population and this would have been a significant event perhaps leading to a national competition. This story was enacted to an audience of people who stutter and involved actions and reading of a pre-prepared piece. There is an uninterrupted flow to this story that is not present in his other transcripts. That is not to say there is no stuttering in the retelling of this story but almost a rhythm of a story he has thought about or told before.

> **RT: With the loudest sound of a motorcycle I could roar I stood there going going nowhere but sounding like a motorcycle being ridden at great speed. The audience loved it. I turned left and exited the stage.**
>
> **My dancing teacher grabbed me in full voice and told me I would never dance for her again.** (Appendix C, p35, lines 10-13)

Mac described a personal cost to not speaking, she feels that without voicing her opinions there was no point in her presence.

> **Mac: Sometimes I feel like there is not much point in being there if I can't speak about it.** (Appendix D, p63, line 49)

Even if the words are stuttered, and people react in a negative way it is the content that seemed to count for Mac. This desire to speak out and be heard is a recurring theme throughout her Narrative Therapy sessions and appears to be a motivating force in her engagement with therapy.

> **Mac: that even though I did experience em hurt by actually speaking out and sharing my ideas whatever em I can build up the courage to do it and that I have learned, that I have a right to…**(Appendix D, p65, line 65)
>
> **I do try, even though I might mess my words up a little.** (Appendix D, p63, line 53)

Adam has found expression through work and art. He has used this as an opener, to engage in a conversation that goes beyond the spoken word. There is joy for Adam in the sharing of ideas with another professional as an equal. As he described it, the risks inherent in speaking out for Adam are balanced by the positive outcome.

> **Adam: through all of my books, drawings, I was able to convey all of my projects to someone I had not met, to discuss to chat about all of this with him. It was one of the most pleasant chats I've had. I was delighted to be able to communicate some of my ideas to a stranger.** (Appendix E, p111, lines 110-111)

Within the IPA process reflective logs were an integral component in the development of the themes.

Reflexive Commentary

Reflections on the initial coding of data for RT:

I found that on initial viewing of the DVD from RT's sessions I was caught by the client therapist interaction. I began to think of questions I could have asked, things I could have should have probed further, critiquing my use of narrative therapy. Instead of focusing on the narrative as it evolved, I focused on the therapist. In order to separate out the therapist from the interpretative listener after my first initial listen through I elected to fast forward through some of the therapist questions and focus on the story on the first run through. In the future it may be beneficial to analyse the client /therapist relationship as an independent research project. At this stage I needed to focus on the story rather than focus on my own personal response to my role as a therapist and the outcomes I was hoping to elicit at that time. The therapist has a role with the client in the building of an illness narrative that allows the people who stutter to make sense of and give value to their experience but this research is not to explore that.

Listening to RT I recalled the writing of Kleinman (Kleinman, 1988) *when he spoke of the chronically ill living at the margins. My response was one of immense sadness when I listened to RT talk of the impact of stuttering on his childhood. He was marginalised by his stuttering and became an observer, a recipient and a person who tagged along and only now is taking ownership of his life. The impact of stuttering for RT is only understood in the context of his life and this included the family culture of being Irish and abroad; a culture of silence and not discussing problems, a culture of running away and alternatively moving forward. Hope is a word that emerges strongly for me listening to his narrative. Hoping for better does not mean that he does not* *accept that he is a person who stutters. There is also a strong sense of suffering, and of voices silenced.*

I also note that there is something emerging about the mind as separate to the body, escaping from the mind escaping into the mind, withdrawing into addictive behaviours? I am reflecting on the importance of identity for RT. Identity as a son, a friend and now a father, many identities that he is trying to make sense of. I am reading further about the narratives of illness. RT's stories link with that of Hunt (Hunt, 2000). I wonder if my sense of impact and isolation due to stuttering will be reflected in the other participant's stories.

Reflections of initial coding of data for Mac:

Impact of stuttering is a standout theme for me initially as I transcribe the sessions. It is certainly easier to transcribe with the increased fluency she demonstrates, though I am noting all the subtle avoidances and tricks that she uses to hide her stuttering. I responded particularly to Mac's story of being lost and alone. I am almost overwhelmed by the loneliness in her story. There is a very strong sense of suffering which is hard to listen to again even though I was her Narrative Therapist and heard this story for the first time in 2010. Her eloquence surprised me all over again as did her openness about her experiences. I feel that she is judging herself very harshly for not speaking out, that her internal dialogue is one of criticism and negative judgement. I recognise that sense of judgment because as I watched and listened to her tape, I started listening to myself as a therapist asking the questions. I felt that the sessions might have taken a different route and been developed further if I had explored some of the alternative stories she had from that time. I need to remind myself to take the viewpoint of researcher not therapist evaluating the session. I note that she is not diminished by her experiences but is hopeful for the future.

Peer support with my co therapist at the time allowed me to step back and it is a timely reminder for me now when immersing myself in the transcriptions to bring my responses to the transcriptions to my Narrative Therapy study group.

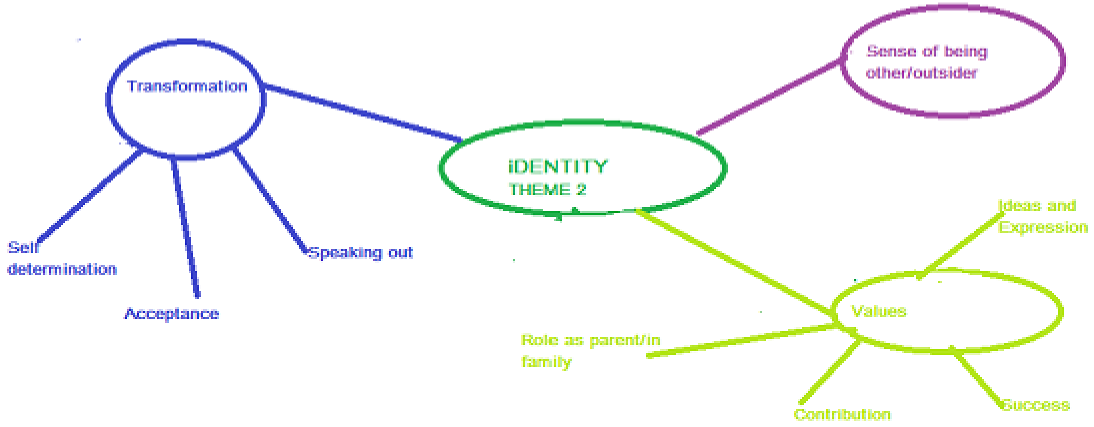
Reflections on IPA

The detailed transcription required for IPA is proving problematic from the very start with RT's tapes. The severity of stuttering in the initial Narrative Therapy sessions' means the transcription is taking three times as long as anticipated. It involves continuous repeat listening. I took this back to my fellow researchers and on their suggestions I downloaded Dragon technology. Initially very frustrating to set up, it is allowing me to repeat what he says and it automatically types. The quality of one of the tapes is extremely poor and I have decided on discussion with my supervisor to use what I have and omit this tape which was recorded a year after his attendance at the programme. Despite these setbacks I feel immersed in his narrative and words that he uses are resonating strongly. I am noting them on his transcripts and underlining the elements that appear to be particularly salient.

6.2 Theme 2: Identity

The superordinate theme of Identity emerged as demonstrated in the map below. The starting point in Narrative Therapy is an identity of 'other', of being on the fringes, an identity of difference linked strongly to a problem-based narrative. In the externalisation conversation the values that each participant holds, are elicited and these start to move away from the initial sense of being an outsider. Values, or the hopes that a person gives value to, differed for each individual participant but subthemes did emerge. Subthemes included the importance of ideas and expression; success; contribution and commitment to others through role as parent or within family. The third subtheme of transformation, which emerged in final sessions of the intensive week and the follow up sessions, is reported in chapter eight as it marks the endpoint or beginning of the endpoint and perhaps an initial outcome of the therapy.

Figure 6.3 Map 3 Theme 2 Identity



6.2.1 Subtheme 1. A sense of being ‘other’: *Only mad people would walk there in the dark*.

RT described childhood experiences of being ‘outside’ the strongly Irish community that he grew up in. Irish culture is ‘thrust’ upon him. (P8 195-197)

> **RT: I was brought up in a strong Irish community in Birmingham.**
>
> **Irish culture was thrust upon us at an early age.**
>
> **Irish dancing was a favourite among the Irish mothers and mine was no different. I hated it.** (Appendix C, p33, lines 1-3)

He described how, aged seven or eight, he escaped from Irish dancing with behaviour that ensured his expulsion from dancing lessons. In later childhood he was suspended from school for an act of rebellion that he accredited to his sense of being different. He was punished by being sent to work on the bog for a week. Despite hating the bog, he feels the act of rebellion was worth it.

> **RT: I put a condom on the aerial of the principal’s car. I dunno why. I just got this notion**
>
> **SLT: what were the consequences of that?**
>
> **RT: I got er suspended. I went home. Told my dad I just got suspended.**
>
> **I put a balloon on the car. He thought that’s a bit harsh so he (mimes phoning) phoned up the principal and came back to me.**
>
> **He laughed was like what have you done. So in the bog for a week that was my punishment.** (Appendix C, p40, lines 50-72)

He described that he can be eccentric. This sense of being different is valued by him and he reported that this difference is recognised by his sister.

> **RT: She thinks I don’t do the obvious the obvious like get a job**
>
> **SLT: is that something you value, not doing the obvious?**
>
> **RT: yeh** (Appendix C, p46, lines 99-101)

For Mac there was also early awareness of being different although she is expressed uncertainty as to why this is or how she knows it.

> **Mac: At this time in my life, I knew I was different in a way, but couldn’t put my finger on it.** (Appendix D, p57, line 3)

For her this sense of being an outsider is not a positive thing. She called her judgement and decision making into question. Her friends also recognised this difference in her.

> **Mac: Only mad people would walk there in the dark. ..** (Appendix D, p58, line 11)
>
> **My friends might have said it just saying how mad I am** (Appendix D, p66, line 73)

In contrast to Mac and RT, Adam relates to those who share his profession, he enjoys the insider status that comes from sharing his work with other professionals; through his work he has made connections. He has a close bond with family, spending time with wife and children. He identifies the commonalities he has with his professional colleagues. Despite this shared professional identity with colleagues, there is a sense of being an outsider with shame and embarrassment linked to being a person who stutters. There is sadness and a sense of otherness linked with being an outsider when he said:

> **Adam: I'm going to spend my life as a stutterer. That's me.** (Appendix E, p103, lines 58-59)

The analysis suggests that outsider status as a person who stutters is not a positive experience for Mac or Adam. RT identifies strongly with an identity of difference an eccentricity.

6.2.2 Subtheme 2. Values: *Inside like, I'm laughing*

The purpose of particular Narrative Therapy sessions is to elicit the values that an individual is trying to honour and hold to in resisting the effects of the problem (in this situation, stuttering) that has brought them to therapy. RT, Mac and Adam valued ideas, expression and knowing their own mind.

> **RT: eccentric kind of...**
>
> **RT: it is complicated kind of notions**
>
> **SLT: ok eccentric. Do you value that in yourself its sort of unpredictable?**
>
> **RT: I do** (Appendix C, line 38**,** line 36)
>
> **SLT: you do, you value that**
>
> **RT: my mind the way I think inside like, I'm laughing... My mind, I am always able to look at new things. .. I can, if I get stuck kind of one way I can see which step I do next** (Appendix C,p41, line 56-59)

RT used short emphatic sentences produced almost in a staccato pattern to underline the importance of these values and their impact on him. He affirmed his position, emphasizing this particular value and his realisation of the value he places on his mind. The repetition of the words ‘my mind’ gives an almost poetic cadence to the sentences. This is underscored in the appendix to highlight the rhythmic quality of his words. He values his voice, the way it is and links this with his identity. The emphasis he places on the pronoun “my” reflects this new awareness. This contrasts with his earlier sense of being an outsider whose speech resulted in suffering for him.

> **RT: My speech. My wellbeing, happiness, my future…my mind because. Voice, kind of me** (Appendix C, p50, lines 125-126)

Adam described how there are parts of him he can be proud of, the parts that celebrate his mind, his individuality and his professional life.

> **Adam: There are kind of other aspects of me that I would be proud of**
>
> **There is swings and roundabouts so ok with speaking, my presentation isn’t as clear and sharp as it should be, but I’ve got a and fantastic bubbly personality or my whatever and in my professional life.**(Appendix E, p100, lines 38-39)

Mac placed value in having views and expressing them.

> **Mac: you would say your views about animal rights and that**
>
> **Therapist: it is important to say your views.**
>
> **Mac: yeah it is...** Appendix D, p62-63, line 47-49)

She emphasized the importance of knowing her own mind and how it keeps her focused.

> **Mac: My mind just keeps me focused.** (Appendix D, p83, line 286)

Knowing her own mind is about knowing who she is as a person and valuing this knowledge.

6.2.3 Subtheme 2.1 Success: *to be a better person is to stutter more freely, to stutter better* (Appendix C, line 413)

Success is defined differently by all three participants. For Adam, to succeed is crucial to his sense of who he is.

> **Therapist: and it was important to you to?**
>
> **Adam: to succeed.**
>
> **Therapist: so succeeding would be, in terms of identity, important?**
>
> **Adam: very important** (Appendix E, p112-113, lines 122-124)

In the initial stages of therapy Adam recognised that his goal was to become fluent.

> **Adam: I suppose before I would let's not be ruled by it. Let's try and overcome it and become more fluent** (Appendix E, p103, line 60)

In the Narrative Therapy process his goals changed. In the final sessions, Adam's identified value is to "become comfortable" with his stammer, he described how he wanted to become desensitized to stuttering.

> **Adam: to desensitise myself, to different situations everyday, talking to people just trying to bring it (stuttering) in.** (Appendix E, p107, line 85)

RT's idea of success is not career- or particularly speech-driven; it is about freedom to live as he chooses. He has walked away from school, from work, from speech and language therapy programmes in the past. Success is stuttering freely and saying what he wants to say. There is chorus-like cadence to "I just wanted to". The emphasis on "I" as noted in Appendix D, suggests a growing sense of agency emerging in the Narrative Therapy process.

> **RT: Back in 2000, I was working in England and I had a job. Living with my sister. Put me up with work she had, one day I just left. I, just back to Ireland, I wanted to to take photographs of Ireland I just wanted to, that was it.** (Appendix C, p47, lines 105-108)

In RT's definitional ceremony his outsider witness described RT's drive to succeed. The repeated use of the word stuttering serves to emphasise the transition RT is making. The idea that the aim is to "stutter better" and not avoid and not become fluent is a transition in itself.

> **Outsider Witness: Wants to improve as a person for him to improve as a person to be a better person is to stutter more freely, to stutter better** (Appendix C, line 413)

Mac's understanding of success is not career-related at this time. Success is being heard, speaking out and expressing her own views. Repetition of words and part words is a feature for many people who stutter. Mac does not normally repeat words, and she avoids repetition as she does other overt stuttering behaviours, substituting words instead or remaining silent. Therefore, her use of phrase repetition (I have a right) is particularly significant serving to emphasise the point she is making.

> **Mac: I can build up the courage to do it and that I have learned that I have a right to, I have a right.** (Appendix D, p65, line 65)

Mac described that she will be happy to make it to the far side of the river, to have completed her journey.

> **Mac: To be happy, just to get there.** (Appendix D, p86, line 313)

Reduction in fear of speaking situations, stuttering easily without fear and tension appear more important than fluent speech.

6.2.4 Subtheme 2.2 .Contribution: *important to give something back*

To value and be valued involves making a contribution to something other than oneself. It appears that early on in Narrative Therapy each participant recognises that there is a need to be involved and engage with something wider than oneself. There is a strong need to contribute at a societal and familial level. Mac supports animal rights and is an activist despite the difficulties she encounters at protests and information stands.

> **Mac: I had a *burning urge* to say because I feel like it's a really good response. I'd like to share…**
>
> **Talking in terms of being determined, sometimes the weather is bad.**
>
> **I'd still go sometimes a lot of people don't turn up and like a lack of human power or people power means just get washed out, nobody really wants to listen to you** (Appendix D, p63-64, lines 61-62, lines 51-52)

RT wants to be able to help others, to listen and support them if they are in trouble.

> **RT: I like to help people. If I can** (Appendix C, p52, lines 139-140)

After the programme Adam started volunteering with teenagers in a school programme sharing his skills, and has taken on the opportunities presented by redundancy to spend more time with his children.

> **Adam**: **Important to give something back… because I got something back when I was growing up.** (Appendix E, p116, line 147, line 151)

This step appears to be a significant one for him; it links with the values that he identified in the early Narrative Therapy sessions.

6.2.5 Subtheme 2.3. Commitment to others (as Parent or in relationships): *it's a gift.*

A 're-membering' conversation allows each participant to identify and acknowledge not just the contribution of others to their lives but their own contributions to the lives of significant others. Two of the research participants were parents and actively involved in their children's lives. RT described the importance of being able to read bedtime stories to his daughter even if he stuttered. Adam described the positive side of sudden unemployment as a "gift" of spending time with his children.

> **Adam: It's a gift. Being able to spend so much time with them** (Appendix E, p115, lines 144-145)

RT described the role of father as being there to listen and not necessarily to speak.

> **RT: Listens, be there, to be there…I suppose because listen, they tell you things. Be there you can see things. If she has like she has worries em it is my job to help her through like or if she is or if she is scared?** (Appendix C, p50, 51, lines 130-134)

Relationships with significant others underpin the efforts made to keep going in the face of stuttering. Adam described the impact of stuttering on his relationship with his wife.

> **Adam: She has given it a purpose, self-fulfilment as a person, partnership** (Appendix E, p133, lines 283)

Mac described how her partner Eoin sees the potential she has.

> **Mac: in terms of seeing me as determined and courageous, would definitely be my partner, Eoin. He knows the best.** (Appendix D, p66, lines 73-74)

The relationships are a two way street of loyalty, support and recognition. For RT, it is his sister who recognises his potential and offers support and loyalty.

> **SLT: who would have said you were capable of these things?**
>
> **RT: my sister. She is the same age. She knows me**
>
> **SLT: what would she say about you what words would she use to describe you**

> **RT: em dunno I can't think of any**
>
> **SLT: what does she see in you? She sees something in you that she thinks (3)?**
>
> **RT: it's a word that (gestures around head) eh (4) can't think of it what's the word em kind of like clever (3) She thinks I'm a good Dad. I'm good with kids.** (Appendix C, p45, lines 87-93)

This commitment to others is linked to one particular person for each participant. A small close social network appears to be a common factor for all three participants. In Mac's Narrative Therapy session entitled 'the team of life', roles were assigned to significant people who will support her on her return home. She identified that the therapists will be her coaches, cheering her from the sidelines; Eoin will be in defence, a forward and her goalie. The other course participants may provide some support but no other family or friend is enlisted by her in her team. In the River exercise (appendix N), Mac described how Eoin is in the "baggage", in charge of the life rafts and her phone contact.

Reflexive commentary

Identity stands out for me. It is evident that identity in transition is relevant for all participants. It seems that accepting who you are is significant in therapy even though it can be difficult. Is acceptance too patronising a term? It may be overused in therapy for stuttering and I am not quite comfortable with it. Perhaps knowing who you are allows you to make changes that are necessary. I am curious about how identity develops. I have decided to read more about the development of personal identity. Michael White writes that identity is a storied affair and I feel that I have only one story to tell about it, mainly from a narrative perspective and I need to develop this further.

Adam:

Adam struggles with the notion of his identity as being that as a person who stutters. He acknowledges anger and resentment but then a shift emerges; he wants to accept it but on his terms. He can be wryly humorous about it but finds it difficult;

'So tonight I had a chat about acceptance and he mentioned he would try and love me, or at least learn to love me and he gave me a big hug'.

Is this the development of realism about the challenges of acceptance? Starting point in therapy one of anger and denial less hopeful but more kind to him, he will make it his friend; it has given him drive and ambition. If he works hard enough he can prevail.

Adam's metaphor is one of a battle but he is arming himself with hope, persistence and flexibility. He talks of the struggle to acceptance. He wants to accept his identity as a person who stutters but who can change. He uses humour and irony to deflect when he feels he has got too close to the hope he has, it is arming himself for further failure. He also talks of letting his work speak for himself, again silence and letting something else represent you as RT did with photography and Mac does with animals. Once he finds an entry point into his new narrative, that of determination and flexibility he elaborates this role for himself. In this new story he also recognises the need for support from others (the group and the support group at home).

I have found it harder to immerse myself in Adam's data. It has been the easiest to transcribe without significant overt stuttering behaviours which beset the transcription of RT's tapes. It lacks the explicit and intense suffering described by Mac. He appears so careful and watchful in each interaction. Almost like a child watching and waiting for approval. He jokes and uses humour and there is much eye rolling and grins but every word is measured and of huge meaning to him.

MAC: *Of significance was the emergence of the sense of being 'other', of being different and on the fringes. She is an outsider with her peer group, her classmates, and her family. She is even an outsider in stuttering, a silent minority of women who stutter. She is reliant on one person. This sense of outsider links with the emergence of identity as a theme for RT. I wondered initially whether her sense of otherness was emerging from her social anxiety or her stuttering but the examples she gives relate to both. She also describes the isolation within family and within herself that comes from not speaking about stuttering openly. She describes the sense of rejection when she shares her experiences with her cousin only for it not to be discussed again. Perhaps a starting point for therapy is the move from isolation and the need to be open. An initial outcome therefore would be increased openness not just about stuttering but about her identity and who she is as a person. Is acceptance of self or 'knowing who you are' as a person who stutters then a significant part or the first stage in therapy? Reading on identity: What has struck me from the reading is the lifetime nature of identity work. Integrating different aspects of ourselves to become whole is a key aspect for the development of identity and this identity is a 'storied' one. The challenges that RT has faced have been opportunities for growth and development. Mac has challenges to her core identity, to who she is as a person, she is an outsider, what would it be like for her to be an insider?*

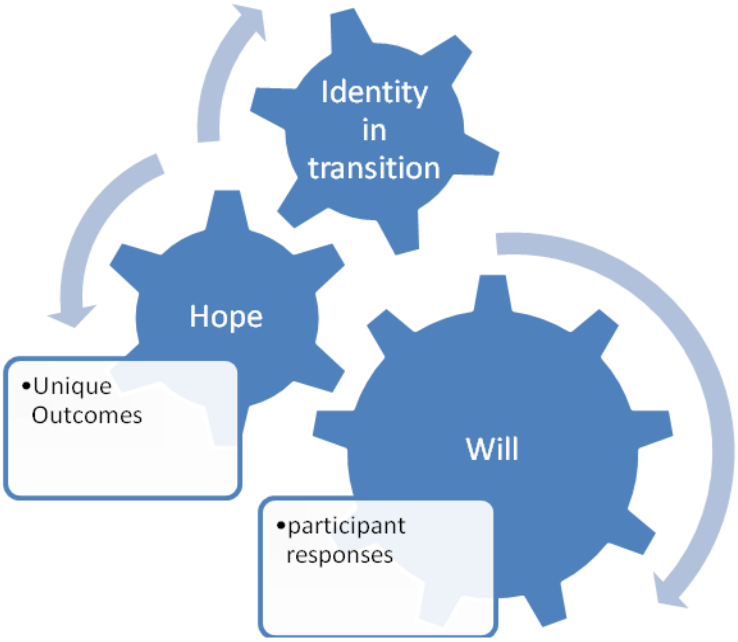
People: a common sense of aloneness pervades. Why do they all seem so alone? Reading and rereading serves to emphasize this sense of being alone and being outside from others.

Chapter Seven:

THE FINAL STAGES IN NARRATIVE THERAPY

Chapter 7 further describes the themes that emerged from the Interpretative Phenomenological Analysis as the Narrative Therapy sessions progressed. The theme of Identity becomes one of transition and transformation. Hope appears to play a part in this transformation. Examples are given of this process in action. The unique outcomes for each participant are described. The final theme of Will is elaborated upon and outcomes in action are illustrated by quotes from participant correspondence after the *Free to Stutter* programme. The final section of this chapter includes participant responses to the researcher's letter detailing the emerging themes and describing their own outcomes.

Figure 7.1 Overview of Chapter 7



7.1 Identity: *The road to being absolute*

Throughout the Narrative Therapy process, aspects of the narratives changed. The second major theme of Identity became one of identity in flux as distinct from the first theme (ideas and expression, success, contributions and commitment to others). This theme of Identity in transformation reflects the individual's process as one of transition and transformation. In the closing phase of the Narrative Therapy sessions the theme of Identity became one of transformation incorporating subthemes of speaking out, self-determination and acceptance.

7.1.1 Subtheme 3: Identity in Transformation: *is it too profound to call it an awakening?*

The analysis suggests that there is transformation as the Narrative Therapy sessions progressed. The data indicate a change in goals, a change in how the self is viewed. For the participants, the importance of knowing who you are as a person and satisfaction with that knowledge became apparent. For RT and Mac, this change emerged over the sessions without specifically identifying a moment of transformation. RT described how his view of himself and the options available to him, have changed:

> **RT: I can work on what I've heard, what I've been told, to be kind of less kind of less kind of judgmental of myself. And I've learnt that things are good. There is a path, kind of steps I can take, to to to improve my speech and like. I won't say fluent because that's a pipe dream**
>
> **SLT: to be happy**
>
> **RT: Yeh**
>
> **SLT: What skills do you have to help you do this? What resources do you have to help you do this?**
>
> **RT: I was able to go outside and find judge, fear of people, you know just kind of to be aware of what's happening** (Appendix C, lines 378-387)

For Mac, this transformation came as she realised her strength, that the hopes and aspirations of her younger self were still there, still attainable.

> **Mac: Just I am a strong person, if I wasn't strong person; I wouldn't even be here today kind of a thing, I have to say so. I did have these hopes and aspirations inside when I was a lot younger, but I wouldn't really have developed as a person yet… I'm in a much more relaxed place em** (Appendix D, p88, lines 338-339, line 371)

Adam pinpointed the moment of transformation for him, though he recognised it as a difficult one that he was challenged by and fought initially. This moment involved observing a DVD about stuttering, wherein a person who stutters described how his stutter has been 'a gift' though not an easy one.

> **Adam**: **I mean, in 10 years time, remember this day as being an epiphany…Is it too profound to call it an awakening?** (Appendix E, p118, line 168, 164)
>
> **There was kind of a catalyst or something like that, I heard something, I felt something I saw something on the DVD, I didn't agree with it. I thought, okay, let's just… (Voice trails off)** (Appendix E, p119, line 170)

Adam could identify a specific moment of transformation; Mac recognised her own resources and RT identified that choices were available to him. While moments of transformation appeared to arrive suddenly when pertinent words spoken by others had an impact, they could often have arrived gradually.

7.1. Subtheme 3.1 Speaking out: *I just, I spoke out*

Key to the transformation for all participants was a defined moment where they spoke out about something they felt strongly about. This theme was mentioned at the beginnings of the Narrative Therapy sessions but was revisited by all as the significance of the stories are recognised by the participants in the later sessions.

> **Mac: On occasion, I have spoken out, even though it's difficult and I got through it** (Appendix D, p65, line 63)

Mac reframed speaking out and judging herself for how she spoke and felt about it afterwards, to recognising that she "got through it". Adam spoke out and the reactions were not negative, he expressed strong feelings and was listened to. In response to being listened to, he was able to listen to others' viewpoints.

> **Adam: I just, I spoke out… I expressed an opinion. Normally I would be a lot…It brought out into the open, and the others said it could be this could be that.** (Appendix E, p119, lines 172-174)

For RT, his actions spoke out for him, through his rejection of Irish dancing, his rejection of a particular programme for stuttering, through his suspension from school. Towards the end of therapy he connected these actions reframing them and recognising how they linked with his values. In November 2011, one year after he attended the programme, following a review day RT wrote of the impact that his thoughts had on the process of therapy. There was a sense of agency and action; he was not a passive recipient of therapy. Echoing his previous words of a year ago he placed emphasis on the work his own mind was doing.

> **RT**: **The idea that it was my own mind doing the work is a breakthrough.** (Appendix F, p147, line 8)

7.1.3 Subtheme 3.2. Self-determination: *the spark is me, the significance of self-belief*

Mac, RT and Adam identified the importance of self-belief in their final sessions. This self-belief went beyond goal setting into the self-determination to make changes. This self-determination described 'the want' to change.

> **RT: There is a path, kind of steps I can take, to to to improve my speech and like** (Appendix C, line 380)

Two years later following a review day, RT was emailed by the researcher/therapist to follow up on his definitional ceremony that had taken place. RT was asked (Appendix L) to describe “the spark” he had identified. He replied:

> **RT: The spark is me I have realised. I thought it was a light or some kind of spiritual guide that helped me through the tough times. It is actually my inner belief that I never knew I had, I thought I had none or that it was lost long ago. I think as a result of going to W... (FTS programme) that time 2 years ago, I reconnected with myself as a teenager.** (Appendix F, p 146, line 2-5)

He described a “re-connection” with the hopes and dreams of his younger self that suggests Self-belief allowed him to plan for the future; he was looking at further study and was realistic about what is attainable for him.

> **RT: I aim to go on to further study after this year, social studies appeals to me. Speech and Language Therapy enters my head often, although I doubt I would be capable of that level of study.** (Appendix F, p 148, line 14-15

Mac described what was necessary for her to progress with her communication. She emphasized the characteristics that will carry her forward. The repetition again of ‘I want to’ suggested intrinsic motivation.

> **Mac: because to be able to communicate well, I want to progress with the speech… positive attitude, to wanting to change things. ..** (Appendix D, p69, lines 147-150)

> **Positive attitude, perseverance, determination, commitment, willingness to..., and em, just the want to** (Appendix D, p87, line 322)

For Adam, this belief was about persistence, that he could stay the course and stay with what he has learned. The pronouns (I) are used with emphasis, potentially reflecting his commitment and values.

> **Adam: I do have that, persistent nature. I will stay with something** (Appendix E, p125, line 221-223)

Self-determination is the freedom to live as one chooses and to act or make decisions based on this knowledge. This self-determination was recognised by all three participants as important for making progress with their own individual goals. RT also switched from not using pronouns earlier in a Narrative Therapy session on day 2, to the direct use of "I".

> **Decided that education wasn't my thing just kind of leave like...** (Appendix C, p44, line 85)

This contrasts with his increased self-determination and the direct use of 'I'.

> **I just back to Ireland. I wanted to to take photographs of Ireland I just wanted to, that was it.** (Appendix C, p47, line 108)

7.1.4 Subtheme 3.3 Acceptance: *because it is me, it's who I am. The value of knowing who you are*

Acceptance of stuttering as a facet of who they are is a thread common to all the narratives. This acceptance was a challenge that Adam found particularly difficult and he responded angrily to a DVD shown on the first night of the programme wherein a speaker at Stuttering Foundation of America spoke of his lifelong journey to acceptance, describing his stutter as "a gift". Following his initial outburst, Adam reflected using his journal and in his Narrative Therapy session the morning afterwards described the process towards acceptance for him.

> **Adam: I am stuts, Adam's stutter, tonight for the first time, Adam put his arm around me and greeted me he said wasn't sure that he could call me a gift yet more fundamentally, he said that we should be friends…**
>
> **So tonight I had a chat about acceptance and he mentioned he would try and love me, or at least learn to love me and he gave me a big hug.** (Appendix E, p95, line 1, line 8)

In the final Narrative Therapy session, Adam referred to the words of another person who stutters attending the programme.

> **Adam: It has led to realising that I can't, like Jack said, come to the realisation that I'm going to spend my life as a stutterer. That's me. Not being ruled by it, I suppose before I would let's not be ruled by it lets try and overcome it and**

> **become more fluent and whatever, but that's not, that's not the way, it's probably since, the mirror that I put up to myself, the sense I have to embrace it. I have to, I have to become its ...**
>
> **Well, I would rather see myself as a stutterer and continue to change it, but I will still be the stutterer.**
>
> **… Because it is me, it's who I am.** (Appendix E, p103, lines 58-64; p106, line 78)

The data suggested an alternative self, one he can see in a mirror, if he could just reach though and get there; but this was not an easy task. There is a sense of compulsion in his repeated use of "I have to" and his failure to finish this sentence seems emblematic of the challenge he felt in accepting of stuttering and himself as a person who stutters. Acceptance of stuttering can entail recognition that total fluency of speech is not an attainable goal for many people. For RT this recognition, this acceptance, did not mean that he will not progress further in therapy but that he would be more 'able'.

> **RT: Just to be more able. To kind of not let people stop me from being and just be happier** (Appendix C, line 381-382)

In the Narrative Therapy session entitled the River (appendix N); Mac described how in attempting to cross to the other riverbank she could become more comfortable with herself. She discussed an experience she had during the programme where ordering lunch in the presence of Speech and Language therapy students, she stuttered. Mac had spent many years avoiding stuttering openly, using tricks and strategies such as word substitutions, gesture and situation avoidance. The experience with the students was a turning point. Mac wanted to say what she wanted to say, without avoidance, even if this meant she stuttered openly. At the end of this session she wrote the title of her story.

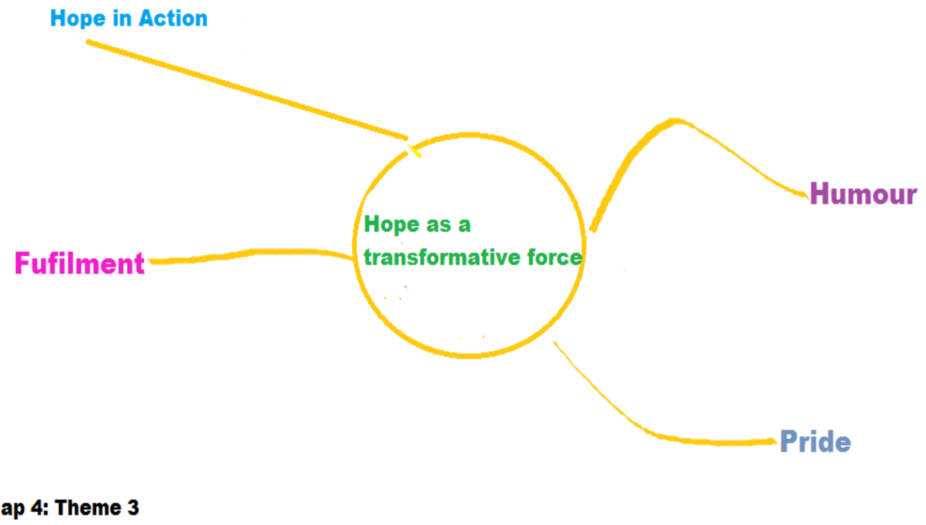
> **Mac: At first I was sort of embarrassed, shook up, because that was the first time in a very long time that I stuck on a word, but then after, I was kind of like if I can do that, maybe I can improve and be more comfortable, more.** (Appendix D, lines 105-106)
>
> **Therapist: and how could your relationship with yourself change in the crossing?**

> **Mac: acceptance (4) and seeing myself as not necessarily a better person, but in my eyes being more comfortable, and a happier person...**
>
> **By accepting and working with challenges and seeing, noticing the changes, positive aspects.** (Appendix D, p74, lines 198-203)
>
> **That it's not as much as a challenge, as daunting as it seems, starting out on your journey em to accepting your stammer…** (Appendix D, line 458-459)

The title she gave her story highlights that it was a process, a journey with many permutations, and an infinite variety of outcomes.

Story Title: **The journey to being absolute** (Appendix D, line 341)

Figure 7.2: Map 4 Theme 3 Hope as a Transformative Force



7.2 Theme 3: Hope as a transformative force

7.2.1 Theme 3: Hope as a transformative force

Hope is the key to the transformation, allowing freedom of choice for the participants. Hope is the recognition that for each negative experience the participants have had in the past or may have in the future, the participants can choose how they construe these narratives. They can choose to take action or not to act. There are also choices to be made in terms of goals and future actions. Hope was expressed with a dual nature: firstly hope as recognition of an internal resource and secondly, hope as forward action. Hope was explicitly stated in each narrative, emerging in the initial Narrative Therapy sessions and then as a thread throughout the later sessions as the participants elaborated on their hopes for the future. The participants identified the practices of hope. Hope was the key to the actions they planned to undertake. RT's actions of changing school, moving country, returning to Ireland to pursue photography, were the actions of hope.

> **SLT: …maybe that says something that you, about what you are capable of doing when you decide to do something**
>
> **RT: yeh hope so** (Appendix C, line 348-349)

Two years after RT completed the Free to Stutter intensive week, RT described how hope, linked to the actions he has taken and continues to take, was still present in his life.

> **RT: If it goes bad, I don't lose hope like I would have done.** (Appendix F, p140, line 32)

In "The River", the therapist (appendix N) took a particular role, that of listening and reflecting back to the client while moving forward through the questions. Mac's language expressed hope for the future; she recognised that hope has always been there.

> **Mac: no fear, things are going to be better.**
>
> **Therapist: any hopes and dreams for the other bank?**
>
> **Mac: that I won't be afraid again.**
>
> **Therapist: how long have you had this hope inside?**
>
> **Mac: if you are talking from when I actually knew that I had all this difficulty, since I was 16, 17, five years…**
>
> **Therapist: ...how did you do that for five years?**
>
> **Mac: Just I am a strong person, if I wasn't strong person; I wouldn't even be here today kind of a thing, I have to say so. I did have these hopes and aspirations inside when I was a lot younger, but I wouldn't really have developed as a person yet...** (Appendix D, p88-89, lines 335-339)
>
> **There is hope and you will learn and you will grow.** (Appendix D, line 505)

Adam expressed hope that openness could lead to self-fulfilment. In Narrative Therapy Adam was asked what his hopes for the future were. He identified hopes for adapting and moving forward that did not tie him down to a particular pathway.

> **Adam: take on board what I heard this week adapt what I need to do to take on the challenges to practice to see how it goes.** (Appendix E, p125, line 227)

Hope at the beginning of Narrative Therapy is the hope of people starting on another new programme, hopeful for fluency, hopeful for change but as yet uncertain of what that change might look like. Hope has kept the three participants involved with the therapy process after the programme has completed.

7.2.2 Subtheme 1. Humour: *And lotto win :)*

Humour as a subtheme was slow to emerge. Initially, it was the shared experiences of the participants that are greeted with wry and self-mocking humour. These stories, none of which are particularly funny on first reporting, contained pain, suffering and loss. Sharing the experiences with others seemed to create a bond of common misfortune that was transformed and reframed by the participants themselves, over time to experiences of community and humour. Humour was recognised as an internal resource by the participants, a means to acknowledge significant events and reframe them. The stories RT told in his externalisation conversation about school and his unique outcome story about Irish dancing were told with wry humour, though the experiences were at times humiliating and painful. RT had experienced many different programmes to address his severe and overt stuttering behaviour. As therapy has progressed he reviewed some of the stories with humour:

> **RT: Well, no, possibly if the door doesn’t open (laughs), you got to try (mimes pushing)…** (Appendix C, line 364-365)

His move towards humour was reflected in the outsider witness comments in the definitional ceremony.

> **Outsider Witness: He’s very very quiet like where as the week has gone on he is after opening out, he is expressing his feelings more, he is, you see him there laughing** (Appendix C, line 408)

RT verbalised his intention to move forward with humour. In this way, RT recognised that humour is part of his future actions. Humour itself was a goal for RT, a desired outcome.

> **RT: It's to move, I think to move forward, just kind of enjoy myself, laugh** (Appendix C, line 406)

In an email two years after the programme RT closed with a list of goals and humour:

> **RT: More self-belief is needed too. And lotto win :).** (Appendix F, p140, line 36)

The theme of humour was evident in Mac's response to feedback from other participants (Martin) in her definitional ceremony is humour. Martin had taken the position of outsider witness and had been asked to respond along four particular lines of enquiry (Leahy, et al., 2012). Mac adopted an accent and played with it in the style of a chat show, Martin took this up and identified that she was like a self-promoting wrestling federation competitor:

> **Mac: I am just so awesome.**
> **Martin (interjects): you like a fella wrestling**
> **Mac: I love wrestling! (Laughter)**
> **Martin: like a fella 'I am awesome'**
> **Mac: I am awesome.** (Appendix D, lines 117-121)

The use of the wrestling analogy was quite unexpected. A wrestler performs in a ring: with suspense, drama and bravado leaving the audience guessing what is real and what is put on for the show. As with narratives, there are tricks and surprises. Martin appeared to have intuitively reflected the performance that Mac herself identified as part of her daily life. She reached a position where she can identify her own tricks and within the context of the group, laugh at them.

> **Mac: I was, I got stuck on the first word and I just let it go. And then I did a trick,**
> **(Laugh) I would have been stuck on it for God knows how long.** (Appendix D, lines 103-104)

Similarly, Adam's externalisation conversation was deliberately told humorously, using colloquial language in the third person voice, disassociating himself from both Stuts (his stutter) and the experiences he has described.

> **Adam: I am a bit confused because I have been a langer for years and now he's only going to accept me. Geez. Stuts** (Appendix E, p96-97, line 9)

This deliberate humour (Appendix E, line 9 above) was replaced with a dry humour, a wryness and self-deprecation that reflect a change from the angry outburst that followed the DVD on the first night (Appendix E, line 160 below). Adam chose with careful deliberation to use the words ‘the gift’, that so upset him in the DVD. There was a pause, a knowing smile and a flash of eyes.

> **Adam: I don’t know (smiles), the gift or whatever...**
>
> **To have as good a time as possible (Laughs)** Appendix E, p117, line 160; p127, line 244)

Humour was acknowledged in the emails and letters from other participants: a year after her intensive course, Kate has returned to college and reported that humour was significant for her. She linked hope with her future actions and moving forwards. Kate identified strongly that humour for her is both a resource and a forward action.

> **Ya I feel that seeing the funny side has helped me a lot to learn to accept “overcome” (I say overcome in a sense that I feel I have even though I am not fluent) my speech, as I spent many years been depressed basically and thinking I could do nothing because of my speech. I don’t know if I told you about the joke I said to my classmates about the presentation I had to make saying I was going to stammer for the whole thing, I think that was good because it helped me show my fellow classmates that it wasn’t something major in my life any more and I can joke about it. Like I say if you can’t have fun then what can you have. :) I do feel that humor (sic) has a part to play in the determination factor of my journey as I don’t wanna look backwards where there wasn’t very much humor in my life and I hope in time humor can help me go forward and not look back at the negative stuff from when I was younger.** (Appendix F, line 4-7)

7.2.3 Subtheme 2. Pride: *that was me*

Pride in action both past and present is a subtheme of hope as a transformative force. Pride in self, is in marked contrast with the theme of impact of stuttering. Pride does not emerge in the early stages of the Narrative Therapy sessions but towards the final closing sessions or in the definitional ceremonies when the same stories are reviewed but the retelling to a select audience has allowed them to be reframed. RT was now in a position to acknowledge that of the different programmes he has attended, some were at his own instigation and arose from his own motivation to change.

> **RT: That was me** (Appendix C, p49, line 121)

He can also acknowledge the feedback from his outsider witness with pride and achievement.

> **RT: It is good. Means that probably what's the word tougher (gestures as fists), in control** (Appendix, line 445)

For Mac, pride emerged as she reviewed past actions, she had triumphed through adversity.

> **Mac: I didn't make a wrong turn. Everyone had been looking frantically for me around the town and my boyfriend had been so worried. I was really proud of myself.** (Appendix D, p60, line 21-22)

In her definitional ceremony the outsider witness reflected on what he had heard and the changes Mac was making.

> **Martin: I kind of, I kind of felt sorry for her.**
>
> **Therapist: okay, so you felt sorry.**
>
> **Martin: yeah**
>
> **Therapist: you felt sorry for her when she was?**
>
> **Martin: yeah**
>
> **Therapist: okay, now that you've heard what she's doing about that, how do you feel about it now?**
>
> **Martin: I feel like eh, proud, proud of her.** (Appendix D, line 405-411)

Adam described his pride was in himself and his identity as a person who stutters who can chose how he stutters and how he uses his stutter.

> **Adam: Yeah PWS, that's just up to me then. Yeah. What way I use my stutter** (Appendix E, p104, lines 68-69)

Pride is fuelled by the participants' recognition of the importance of past actions. It provides an alternative story to that of suffering and impact of stuttering.

7.2.4 Subtheme 3.Fulfilment: I feel that I've achieved what I wanted to

Fulfilment or recognition of fulfilment of goals that are not necessarily speech related seemed significant for Adam and RT. RT recognised that the small successes could lead to increased awareness and appropriate planning for the future. A fulfilled person is a hopeful one, open to possibilities and potential. RT linked this growing sense of fulfilment with being in tune with his own sense of self and feelings. This sense of fulfilment is reflected in the use of the pronoun ‘I’. The initial sentence contains the repetitions that were characteristic of his stuttering behaviour. RT appears confident in what he will undertake next and this is underscored by his use of ‘I’.

> **RT: I’m in a I’m in a I’m in a just at the beginning of Free to stutter dot dot dot dot, four dots! And I feel good. I feel that I’ve achieved what I wanted to**
>
> **SLT: what did you want to achieve?**
>
> **RT: Just get back in tune with my fears? Emotions**
>
> **SLT: You got in tune with your fears, emotions.**
>
> **RT: So am yeh**
>
> **SLT: Where are you going from here?**
>
> **RT: I can work on what I’ve heard, what I’ve been told, to be kind of less kind of less kind of judgmental of myself** (Appendix C, lines 369-372)

Adam described how his sense of fulfilment arises from family and how he has turned a frustrating situation into a positive one. His work was fulfilling but he came to recognise there are other sources of fulfilment. He recognised that reframing his experiences (losing a job, stay at home father, stuttering) in this way is a choice. Having a choice to reframe it is also part of the “gift”. Adam’s careful use of words and measured tone throughout the sessions accentuates the significance of this description as a “gift”. Adam appeared to be conscious of the import and impact of the words he chose to describe his experiences, thoughts and feelings.

> **Adam: I actually only said that word, just wanted it to be a catalyst to push me to stand out, to want to embrace it**. (Appendix E, p121, line 187)

.As he spoke, it is evident with his careful precise manner that each word he used to describe his experience was selected for its close representation of his experiences.

> **Adam: (nods) brought me trying to think of the word, satisfaction, no satisfaction is not the word** (Appendix E, p124, line 215)

He chose the word ‘gift’, a word that he rejected in the first instance as unbelievable and at variance with his own experiences.

> **Adam: It is a balance in that, frustrated in being at home, frustrated that I spent so long in College that I chose this. It's a gift. Being able to spend so much time with them** (Appendix E, p115, line 142)

Mac's sense of fulfilment appeared to be linked with her commitment to her animal welfare causes though she struggled to participate she has persevered. As the youngest of the three participants she was not yet sure where she is headed or what it will look like when she gets there, but she expressed a desire to be comfortable in herself and how she views herself.

> **Mac: but in my eyes being more comfortable, and a happier person** (Appendix D, p74, line 199)

Reflective commentary:

Humour bubbles away under some of the stories. Some stories are genuinely funny but I don't want to trivialise them. Some of the asides from the outsider witnesses are witty because they have shared the same experiences and it is this sharing that I think is important.

Mac is seeking something. She hasn't yet found what it is she wants to do or who she wants to be. The sense of fulfilment is not as tangible as it is for the others. Following from my reading on the development of identity I believe this perhaps is linked to her age and stage in the development of her identity.

7.2.4 Subtheme 4. Moments of transition: Hope in action

Moments of transition were evident for the participants. Such moments are characterised by a story of trouble and difficult experiences that are acknowledged by a listener in such a way that progression and forward movement in the story are possible. Such a moment occurred in Mac's definitional ceremony when an undergraduate student is invited to respond in the role of outsider witness[4]. As Mac was of a similar age to the student, it was felt that the reflections might be pertinent. The therapist invited her to respond in the particular format required of the definitional ceremony, to the expressions she was drawn to in Mac's story and then to comment on any image that came to mind when listening to Mac's story and finally to transport;

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[4] Students may be invited to take part in definitional ceremonies if they have been present for the person who stutters Narrative Therapy sessions from the beginning and if the person who stutters is interested in their reflections. As Mac is of a similar age to the student, it was felt that the reflections might be pertinent and she welcomed the student as one of her outsider witnesses.

the recognition of possibilities for her own (outsider witnesses) life. The ceremony reflected a moment of synchrony and understanding that acknowledged Mac's position and values, while reflecting her hopes for the future.

> **Therapist: when you listened to Mac what expression were you drawn to?**
>
> **Student: respect for herself and acceptance of herself. I think. It's probably one of the most difficult things that anyone can do. Something about your opinions and your judgement, as opposed to external opinions and judgement, and just about you're (unclear), and even though it has been extremely difficult, it is easier than having to face the judgement, em. ..** (Appendix D, line 478)
>
> **Student: about it's about yourself** (Appendix D, line 485)
>
> **Therapist: And going forward (transport)?**
>
> **Student: it is about judgements, not being good enough.**
>
> **Mac: yeah everyone is better than you (smile)**
>
> **Student: it's about feeling stupid, that judgement thing again; maybe other people think it's not good enough.**
>
> **Mac: that's exactly it.**
>
> **Student: about not being good enough.**
>
> **Mac: everyone else is better than you.**
>
> **Student: yeah, and the whole thing like being struck with the dark room. You might have the same; people might give you all the compliments in the world, because you didn't say them yourself. So the darkness will always be there unless you give them to yourself, the gift of acceptance. I think you started to give yourself the gift of accepting yourself and to ignore some of the judgements...** (Appendix D, line 486-496)
>
> **Mac: Wasn't expecting that well I wasn't expecting much of response from anybody. So, em really, I got emotional at the end. It's not very often that you hear someone saying what you do had an impact on them in a positive way that really feels amazing.** (Appendix D, line 501-502)

Adam's transitional moment occurred when the therapist challenged him on his use of the word 'stutterer' and in doing so she moved the conversation from the line of identity to the line of action in White's map of the reauthoring conversation (Appendix G). This movement from the thought process into actions was momentous for Adam.

As a person who appeared to measure words with the careful precision of a wordsmith who recognised the value and significant consequences of the correctly chosen turn, it was a significant moment. He had spent his life rejecting the role of “stutterer” and now he was electing to use that word instead of the term “person who stutters” or “PWS” that the therapist used. The repeated use of “see myself”, “see me”, and “who I am” served to emphasize the transformation that was taking place. They provide a rhythm to the transcript suggesting that with each repetition a new sense of self was emerging.

> **Therapist: that’s a big shift in your identity as somebody who stutters, that is how you see yourself as somebody who stutters and that is how it is. Whereas before it is somebody who stutters and I have to change it. That is a big shift in how you see yourself.**
>
> **Adam: well, I would rather see myself as a stutterer and continue to change it, but I will still be the stutterer.**
>
> **Therapist: PWS person who stutters.**
>
> **Adam: that’s it.**
>
> **Therapist: person who stutters.**
>
> **Adam: yeah PWS, that’s just up to me then. Yeah. What way I use my stutter.**
>
> **Therapist: can you think of any positive ways you can use your stutter? That it could have a positive effect on your life.**
>
> **Adam: Em. It’s not just me, its part of who I am.**
>
> **Therapist: it’s part of your uniqueness.**
>
> **Adam: yeah, though I’ve always hated the whole idea, you know, I was often asked before in therapy, how do people view you and it always seen as a negative, well I always saw it as a negative, write down a list of how people would see me, see me as a stammerer (makes face, gestures) . Its, people see me as a stammerer.**
>
> **Therapist: you are changing that actually you are changing that.**
>
> **Adam: I am I have to change that.**
>
> **Therapist: why, why do you have to change that?**
>
> **Adam: because it is me, it’s who I am.**

> **Therapist: so you… define sense of identity. What do you think that would mean to him. What's the next step?**
>
> **Adam: the next step is to to work on some techniques like, avoidance eh, what was going to say, like voluntary stammering.** (Appendix E, p103-105, lines 61-82)

Moments of transition are further developed by the process involved in a Definitional ceremony. Definitional ceremonies can provide opportunities for reflection and acknowledgment that are a core aspect of healing dramas. When invited to reflect on image and the images that RT's story have brought to mind, RT's outsider witness reflected on the changes taking place for RT and himself, recognising the development of his own awareness and personal growth intrinsic to his personal story.

> **Outsider Witness: Well he kept saying like he doesn't want to go backwards, he wants to go forwards maybe like like he can improve, that he has gained, he won't go backwards, he has gained, he has made sufficient ground this week, he doesn't want to go backwards because maybe at the back of his mind he might be a bit worried that he might go backwards , but he has the support and the image is that he is a fighter like he is saying its now or never like and he want to like you day next week he is gone , he has become a lot he has opened up a lot like , you know like even jokes and stuff .You see I remember when I first met him in the bar that night , he is expressing himself a lot better, with eye contact and he is eh like once he keeps up with the work like, does what he says like and puts on his goals , like his hierarchy and stuff he is eh**
>
> **SLT: the image of him moving forward, the image of moving forward is very strong?**
>
> **Outsider Witness: Definitely yeh, yeh he has the structure in place now to do that, cos he is not on his own any more like regards being a person with a stammer like, he has contacts.** (Appendix C lines 420-423)

RT was surprised and struck by this response; it was movement towards agency. He was not a passive recipient; he is a fighter. In this moment he was challenged to reflect on his own perception of himself.

> **SLT: Ok RT, did you here anything of what the outsider witness said there that struck you?**
>
> **I saw your eyes look over to him at one point in surprise?**

RT: He says I'm m a fighter

SLT: That struck you?

RT: Its kind of I don't know, I don't really think of myself a being a fighter? (Appendix C, lines 437-440)

As each narrative unfolded, difficult experiences were described. In the context of Narrative Therapy sessions these experiences led to the identification and the development of awareness and personal growth. These moments of transition challenged the previously held understandings and knowledges of the people who stutter and gave support to the development of the practices of hope.

Figure 7.3 Map 5 Theme 4: Unique Outcomes

7.3 Map 5: Theme 4 Unique Outcomes or 'Sparkling Moments'

In Narrative Therapy, unique outcomes provide an entry point into an alternative narrative and are described as "sparkling moments", times when the person acted in a way that fit with their hopes and dreams and values. The term "outcome" may appear misleading if unfamiliar with Narrative Therapy, as it does not refer to an endpoint of therapy but rather an entry point to a new story. The following describes the different unique outcomes that emerged for the three participants. In preparation for this second Narrative Therapy session, each participant was asked to journal their responses to the externalisation conversation that had taken place that day. They were also asked to think about a time or an example of when the problem-based story was not as dominant. Alternatively they could describe something they did or said that was a contradiction to the story they had told in the externalising narrative.

7.3.1 Subtheme 1. RT: Without words of course

RT's experiences of growing up in a strongly Irish community in the United Kingdom entailed features of a stereotypical Irish childhood. RT from an early age was involved with Irish dancing. He described his hatred of it and the Feis he participated in. He longed to escape. The story he told about his escape elicited much laughter from the other course participants. He appeared to enjoy telling it and in contrast with his other Narrative Therapy transcripts, there was a fluency and flow to it enhanced by his preparation and his reading of it. Words and language appeared carefully selected and he entitled it 'Lord of the Dance'.

> **RT: Irish culture was thrust upon us at an early age.** (Appendix C, p33, line 2)

RT used short emphatic sentences to emphasize strong feeling. This contrasted with general conversation wherein the presence of fillers, substitutions and severe blocking inhibits intelligibility and conversational flow. To get out of Irish dancing lessons involved planning and some spontaneous action. He was aware that ordinarily any confession of his dislike of Irish dancing to his parents would necessitate long explanations, reasoned arguments and expressing of feelings. The thought of telling his parents was a challenge in itself. As described earlier under the theme of Impact, some things were not talked about.

> **RT: Growing tired of having to do it and telling my parents** (Appendix C, p34, line 5)

The telling of this story was a performance involving actions and gesture.

> **RT: I raised my arms out in front of me and using my right leg I kick started the imaginary motorcycle I was about to leap on.**
>
> **With the loudest sound of a motorcycle I could roar I stood there going going nowhere but sounding like a motorcycle being ridden at great speed. (**Appendix C, p34-35, line 9-10)

The result for RT was success. The Irish dancing teacher refused to teach him further and his father took him to soccer matches every Saturday instead. His mother was not happy however.

> **RT: I laughed but I remember my mother's face. She was red.** (Appendix C, p35, line 14)

The key to this unique outcome was the description of his actions as taking place "without words" and yet still taking action. This story contrasted strongly with the earlier stories of going along with a crowd, befriending the bullies, drifting in and out of work and away from school. This story was one of action determined and taken by him. As an entry point to a new preferred narrative, other stories emerged of taking action with and without words.

Reflexive commentary:

After this session RT was so angry with himself the next day. He said he had slept badly because he felt he had not been true to himself. He had talked a good game but not highlighted the real pain and that perhaps we might have thought he wasn't taking it seriously. I remember this unrecorded (not DVD) discussion because he was judging himself for being open and assumed others were judging him.

7.3.2 Subtheme 2. Persistence. Mac: *I never gave up.*

Mac's story of succeeding despite misadventure was not a humorous one. Lost and alone in the dark, she berated herself for not having the courage to speak to the driver and clarify her disembarking location.

> **Mac: This adventure could have been avoided if I had had the courage to ask the driver where we were.** (Appendix D, p60, line 22)

Mac described how through perseverance she eventually reached her destination. Key to this was her pride, her determination and never giving up.

> **Mac: It was extremely dangerous walking on a dark country road. I was determined to get to my destination. I never gave up.** (Appendix D, p59, line 15-16)
>
> **I was really proud of myself** (Appendix D, line 22)

This unique outcome was developed, eliciting further examples of her determination in following through in college and speaking out at demonstrations on animal rights. There was no change in style of the language she uses in this story. As a person who stutters, she presented with significant covert features and few overt features. Her avoidance of words was subtle and there was no overt stuttering behaviour in this session recorded. However, her feelings about her stutter and her judgement of herself for each avoidance and stuttered moment are severe. It was noted in the transcripts how her repeated use of 'I do try' appears almost childlike as a refrain, as if she was trying to convince herself or the therapist that she has tried, even when it was hard to do so.

> **Mac: Even when I know I am bad and I might be… I do try to go.**
>
> **I do try, even though I might mess my words up a little.** (Appendix D, line 52-53)

In her final Narrative Therapy session "The River" (Appendix M) Mac identified that when she makes it across the river to the other bank, she will miss the challenges that she has overcome.

> **Probably miss the challenge of it all** (Appendix D, p69, line 174)

Reflexive commentary

Mac's resilience amazed me, the fact that she keeps trying with so little support. There is something quite dramatic about her telling of this story. It is a performance to an audience. There are two audiences at stake here, in the initial timeframe, the therapist, and in the now the therapist as researcher. Bracketing the emotional response to Mac's story from both viewpoints is necessary. I have been reading about breaches in the cultural borderlands that lead to healing dramas (Mattingly, 2010). Mac's story is evidence of one such breach. The therapist's role is reaching across this breach structuring questions in such a way that enables the narrative develop.

7.3.4 Subtheme 3. Speaking out: Adam's story

Leaving his "work speak for itself" was comfortable for Adam. He identified that normally he would shrug his shoulders, and was not a person who would express his opinion.

> **Adam: I just, I spoke out. I expressed an opinion. Normally I would be a lot... (Trails off)** (Appendix E, p 119, line 172-174)

Unlike the other participants, his unique outcome occurred not in the recent or distant past, but on the course itself on the very first evening. He became upset at hearing stuttering referred to as a gift and rather than say nothing he spoke out not just that night about his response to the DVD but the next morning as well having reflected on it and written in his journal.

> **Adam: that was a step. It brought out into the open, and the others said it could be this could be that. They express their own opinions and I went away that evening, thought about it, put my own twist on it or whatever. The next day I talked about it, had a chat about it.** (Appendix E, p119-120, line 176-178)

The emergence of the unique outcome, involved careful questioning and active listening on the part of the therapist. Following the line of identity and action questioning (Appendix G), the therapist probed if speaking out was his normal way. In this way the therapist was extending this new story line, embedding it in to past actions (distant past and near past) with a view to spreading it into the present and opening up the possibility of future actions. The development of the new preferred story begins with this alternative story line that emerged from the unique outcome. The therapist asked for other examples of Adam speaking out.

> **Therapist: so it was a big step to speak out, do you not normally speak out?**
>
> **Adam: Em. I was saying that in the journal, but then actually thinking about it.**
>
> **I do it to something that has to be spoken about, be it… or whatever…** (Appendix E, p120, line 180-182)
>
> **Adam: I actually only said that word, just wanted it to be a catalyst to push me to stand out, to want to embrace it. But the love isn't there at the moment** (Appendix E, p121, line 187)

Recognising the new story, Adam acknowledged his difficulties he had with accepting the stutter. He linked "speaking out" with "persistence". He needed "to stick with it" to embrace his stuttering and himself as a person who stutters.

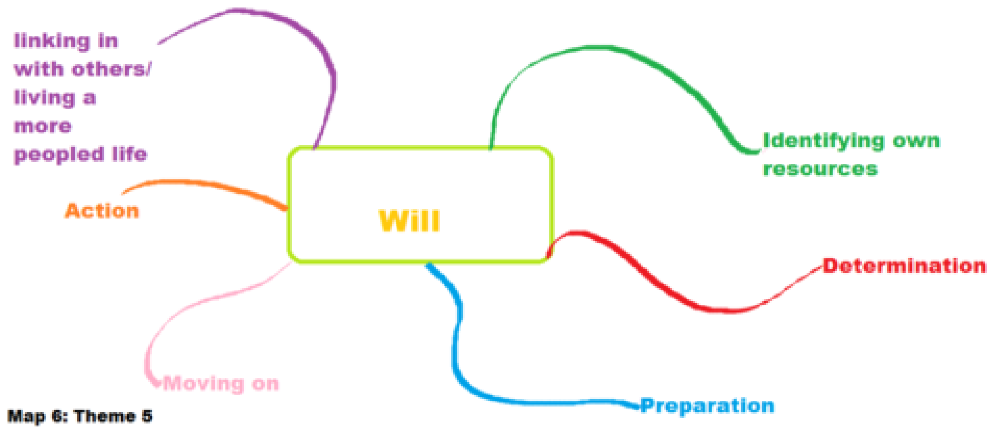
> **Therapist: it was the same when you spoke out, you stayed with it, so, there is something about staying with it.**
>
> **Adam: I do have that, persistence nature. I will stay with something,**
>
> **Therapist: so persistent is that the word?**
>
> **Adam: well, persistent in a job that has to be done, if it takes two days or two years. I just stay at it.** (Appendix E, p125, line 220-225)

Adam recognised that persistence has been there from early on, suggesting that persistence will enable him to follow through with the programme and with the changes he is intent on making, moving towards accepting stuttering.

7. 4 Theme 5: Will

“Will” is more than the desire to take action; it incorporates how this action takes place. Will links agency with action. It links the individual’s identification of their own resources with their determination and preparation for taking action. The analysis of the data suggests that the action itself is supported by linking in and making connections with others. This theme is subdivided into 6 subthemes as shown below.

Figure 7.4 Map 6 Theme 5 Will



7.4.1 Subtheme 1: Identifying own resources

Adam, Mac and RT described the resources that they have themselves, to enable them to progress in therapy. Key to this theme was agency. The identification of resources did not happen initially in the externalisation conversation but towards the close of the intensive week in definitional ceremonies or in the exercise “The River” (Appendix M).

RT identified that he can look at alternatives; he could move sideways, he could stand back and identify the options available for him. The flexibility he identified in walking away from schools, jobs and home even if it has cost him, has left him with skills.

> **RT: I am always able to look at new things. I can, if I get stuck kind of one way I can see which step I do next. With speech** (Appendix, C, p53, lines 151-152)

> **Yeh kind of up to kind of person who learns by mistakes** (line 329)

Adam realised that his suffering linked with his stammer has given him an awareness that can be useful.

> **Adam: I am capable of more. I kind of think it gave me drive** (Appendix E, p117, line 158)

In the River exercise Mac identified the skills and resources she has that can take her to the other bank and keep her there.

> **Mac: like I said before, past experience of dealing with things...**
>
> **Dealing with things I have a fair idea what works and what doesn't.** (Appendix D, p82, lines 282-284)
>
> **I have always been quite a strong person strong minded**... (Appendix D, p84, line 296)
>
> **Just the skills to try and remind myself that I can do it** (Appendix D, p85, lines 310)
>
> **Courage, to be ready for it… positive attitude, perseverance, determination, commitment, willingness** (Appendix D, p86, line 311,322)

Early on in his Narrative Therapy sessions Adam identified his drive, but it was towards the end of Mac and RT's week of sessions that their resources became apparent to them.

7.4.2: Subtheme 2. Determination: *just the want to*

Determination to follow through on the changes made in therapy took different forms for the three participants. They identified previous demonstrations of their determination and success and used these as stepping points for future action. Mac's earlier story of "never giving up" encouraged her.

> **Mac: I was determined to get to my destination…** (Appendix D, line 16)
>
> **Because to be able to communicate well, I want to progress with the speech, the challenge to myself.** (Appendix D, p69, line 147-155)
>
> **Em I don't give up easily. ..** (Appendix D, p70, line 155)
>
> **Just the want to** (Appendix D, p87, line 322)

RT's determination stemmed from previous experiences of therapy programmes where he gave up on his return home. Despite his best intentions following each programme there was a return to his previous ways though he did not clarify what these previous ways were.

> **RT: Back into Ireland adjusted back into old way** (Appendix C, line 342)

This time he expressed a determination to stick with it.

> **RT: I'm going a just start off slowly and just working everyday… I can (blocks) I can like, acknowledge what they say, just go like myself (unclear), could be (gestures high), bad (gestures low), say to myself I can leave it** (Appendix C, line 390)

Adam acknowledged that while he has started to make changes now the work needs to begin, to carryover those changes at home. Rewards are there to be gained.

> **Adam: Well I mean, all I've done is I have identified it. But now I have to put the hard work in... It's a two-way street; you have to put in the work to be rewarded.** (Appendix E, p101, line 49-50; p117, line 155)

However, he acknowledged the resources he has that will enable him to continue to take actions. The use of the word "stickability" is intriguing; it is a childlike word that reflected enthusiasm that Adam had not displayed in earlier sessions.

> **Adam: The ability to see it through, stickability and persistence** (Appendix E, p134, line 300)

Mac expressed a similar determination to see it through. She too identified her own resources that could enable her to persevere with the changes she was making in therapy**.**

> **Mac: by accepting and working with challenges and seeing, noticing the changes, positive aspects** (Appendix D, p74, line 203)

7.4.3 Subtheme 3. Preparation

Preparation for the return home following the course and preparation to implement changes preoccupied two of the participants. Adam and RT had completed therapy previously and knew that the work was only beginning as they completed the intensive week of the *Free to Stutter* programme. This was Mac's first experience of an intensive programme.

> **SLT: Where are you going from here?**
>
> **RT: I can work on what I've heard, what I've been told, to be kind of less kind of less kind of judgmental of myself. And I've learnt that things are good. There is a path, kind of steps I can take, to to to improve my speech and like** (Appendix C, line 377-380)

Adam drew on past life experiences and linked his preparation for interview and his failure to prepare at other times to his success.

> **Adam: the step I made was preparation, preparing very well.** (Appendix E, p112, line 114)

He identified that this time part of the preparation will involve the need to be flexible.

> **Adam: well, to be flexible** (Appendix E, p123, line 206)

7.4.4 Subtheme 4: Linking in with others: opening doors that were closed

The importance of a sense of community for all participants was expressed strongly by the participants. In their final sessions they emphasized the need to link in with the other course participants after the programme. RT sought feedback from others on how he is progressing. Having attended previous programmes he was aware of relapse and did not want to lose the gains he had made.

> **RT: I'll meet up with J… or F…, I might be able to get some of the feedback how I've progressed or gone backwards...**
>
> **It's good like to listen to other people, they ground you. I intend to phone people 'cos it's kind of, I don't want to go backwards again** (Appendix C, line 390)

He recognised that support is required to make the changes he wanted.

> **RT: I've always next might need to kind of go back to counselling** (Appendix C, line 158)

In his definitional ceremony, his outsider witness recognised the importance of these contacts for RT.

> **Outsider Witness: Definitely yeh, yeh he has the structure in place now to do that, cos he is not on his own any more like regards being a person with a stammer like, he has contacts (**Appendix C, line 423)

In correspondence, dated November 2011 (one year after the programme) RT described the response of others to the changes he was making.

> **RT: I think a lot of people would be happy that I am changing things, but they lost patience with me.** (Appendix F, p148, line 12)

Mac agreed her partner would need to be enlisted to support the changes she had made and was in the process of making. She had earlier on identified negative feedback she had received from sharing her experiences with friends and family.

> **Mac: I only really ask for help when I really need it so obviously I'm here for professional stuff, my partner…** (Appendix D, p84, line 296)
>
> **Therapist: who will you make contact with the other side? Are there contacts you need to make? To help you on the other side**
>
> **Mac: I need to be myself and not ignore things (draws people).**
>
> **Therapist: and contacts?**
>
> **Mac: new friends**
>
> **Therapist: and what are the practices do you want to develop?**
>
> **Mac: in relation to speech, a lot of open stuttering.**
>
> **Therapist: contacts?**
>
> **Mac: other people who are experiencing** (Appendix D, p87, line 323-332)

Mac acknowledged the difference the support of others on the programme particularly speech and language therapy students who went with her to carry out a speaking exercise.

> **Mac: I've only actually after we went out with the Speech and Language Therapy students like out on the town that really helped me like voluntary stutter in a daunting place and I actually felt confident and happy after it. Em, so that is where I am now.** (Appendix D, line 371)

In her definitional ceremony Mac responded to the outsider witness who had identified an image of Mac separated from others by a barrier.

> **Mac: especially when she was talking about the wall, that's what, I always saw it as a barrier em between me and if I could just, you know even in small steps, em. Start breaking the wall, even if it took me, no matter how long it took em that finally I would be able to not be alone on the other side am, be connected to people on the other side. That that was really powerful** (Appendix D, line 453)

As part of the *Free to Stutter...Free to Speak* programme previous participants are invited in for an evening session to talk to the current course participants about the transition following the programme. In response to a discussion with previous course participants, Mac identified the support structures she will need to put in place for her.

> **Mac: definitely, em just listening to her last night one thing she said it's very important to keep in contact with others. So if you feel like you really are really alone, start to think you are the only one in the world who stammers, because obviously we have different variety of people and their lives, so if it comes and I feel so, if I ever have a relapse and start to feel really uncomfortable it is important to keep in contact with others like what's going on and get back on track. With me, I have to be around people who are really understanding and open and respect themselves, em. I can't deal with ignorant people.** (Appendix, D, line 461)

Mac acknowledged the support of another woman who stutters, who completed the programme previously and was one of the first women of her own age she met who stutters.

> **Mac: It's always so nice when someone relates to you so well, and especially as she's *(another young female who stutters)*** (Appendix D, line 449)

Adam acknowledged the need to share his experiences with others on his return home. He identified that expectations may be different and that he would need to be open about his stuttering, his experiences on the programme and his goals.

> **Adam: For example to people outside they might expect me to come back next week with brand spanking new clear fluent Adam. But that's not going to be the way. Maybe I will be exactly the same, but actually inside there will be all those inner battles** (Appendix E, p107, line 87)

Adam used analogy contrasting the end point of therapy with the process. The “brand spanking new clear fluent Adam” is almost a medical model end and the inner battles the true process he was engaged in.

Adam planned to engage not just with friends and other course participants but with local support groups as well.

> **Adam: Talk to other members here or other members the self-help group in Cork, and just keep battling it** (Appendix E, p126, line 231)

In his re-membering conversation, he described his wife’s contribution to his life.

> **Adam: makes mountains small I can overcome obstacles gives me support to fulfil my aims.**
>
> **Therapist: she gives support for you to fulfil your aims about?**
>
> **Adam: about my stammer** (Appendix E, p135, line 310)

In doing so Anne ‘**opens doors that were closed’.** (Appendix E, p136, line 319)

Reflexive commentary:

Listening to Adam there was a sense of the impact of stuttering on his life straight away but also a holding back, a reluctance to reveal too much. Humour had a role. His face was very expressive at times in response to questions, lots of eye rolling and wry smiles. He listened carefully to every question and sought clarification. The humour he used did not take from the seriousness with which he addressed the questions.

Pride in his work and his own resourcefulness were evident. The impact on losing his job and having to adapt to being full time at home dad was clear and his pride in how he adapted to it. He linked this to values. He has a strong sense of who he is and how important it is to be aware of this. Of all the three participants, he had a clear sense of the need for preparation and persistence to tie in with action.

I was moved by the re-membering ceremony and the impact of his wife on his life and identity. As a man who appeared to measure each word carefully and weigh it, as if every word counted to describe his love with such sincerity was very moving. The last session of Adam’s I watched is very different from the others. It lacks the careful control of the initial sessions. He is opening up, relating to the therapist differently. His simple description of his wife who makes everything possible is moving and genuine. With Adam I had less of a sense of him as an outsider than I did the others. Yet he still appears like an observer, watchful and waiting. In this final session he is connecting openly and honestly with the therapist.

7.4.5 Subtheme 5. Moving on: I don’t want to go backwards again

Progress and not regressing appeared important to the participants. Some participants referred to prior experiences of regressions or ‘relapse’. These stories were tinged with fear and details of those past experiences. Mac was afraid of being driven backwards by fear and the reactions of others. This was a fear of the judgement of others.

> **Therapist: you are actually crossing the river now, is there anything that might wash you backwards?**
>
> **Mac: strong flow of water, maybe represented by (draws line).**
>
> **Therapist: strong water in your life that washes you backwards?**
>
> **Mac: Fear. Fear… backwards.**
>
> **Therapist: do you want a red one? (Offering markers)**
>
> **Mac: yeah. (Fear and anxiety written in red)**
>
> **Therapist: stop you from going forward.**
>
> **Mac: mainly would be fear of being judged, by people, listening, hearing their reactions to speech. Reactions before and after would increase my levels of anxiety as well.** (Appendix D, p71, lines 172-180

RT described returning home after an intensive therapy programme and relapsing to his “old ways”. In his final sessions, RT talked about moving on, wanting to do this for himself and his daughter. The importance of the father daughter relationship is reflected in the response of the outsider witness to his story.

> **Outsider Witness: He was saying something about his daughter like, I mean reading stories to his daughter, well I suppose he wants to have a, to make a better effort for her like ‘cos like she’s a probably be a driving force for like** (Appendix C, line 414)

RT had already recognised that linking in with others is important in order not to go backwards. He described the process of moving forward and backwards with his speech. RT reflected that such reversals are the substance of life.

> **RT: I don’t want to go backwards again, I’ve done that thanks... (Appendix C, line 399)**

> **I think that is life you know. You move forward. I want to progress with the speech.** (Appendix C, line 353)

Adam also talked of this desire to move forward.

> **Adam: I haven't found that value yet, but I know I have to find it. In order to progress and move on...** (Appendix E, p99, line 28)
>
> **It is important to keep moving on is important to keep, to focus on a goal.** (Appendix E, p127, line 239)

In his response to the triangulation letter, Adam talked of the initial search for a "trigger, a magic button" (Appendix L2) and in doing so acknowledged that this search for a cure has changed and that he now

> **'Love(s) the person I am because of my stutter'** (Appendix L2, p198)

This advancement demonstrated how his thinking about stuttering has evolved.

> **There may be 'good days and better days'** (Adam, Appendix L2, p198).

However, the story is acknowledged by Adam as not yet complete. A 'bad day' does not mean a diminished sense of self, or a failure to achieve. Crucially it does not result in a curtailment of activity. As he wrote

> **Adam: Like other things in life its (sic) not a case of its over now and I'm done with that** (Adam, Appendix L2, p198).

Of the other *Free to Stutter* participants that responded to the triangulation letter, Jason has struggled in the last year. It is now six years since he completed the *Free to stutter Free to Speak* programme and challenges have arisen. His "stammer is going downhill" and he was returning to the programme after time spent abroad. He wanted to address this downhill turn and was hopeful that he could. Maura, Pauline and Tracey reflected in their triangulation letters about the ongoing process of addressing the impact of stuttering, describing it as "lifelong" and "variable". RT and Adam also demonstrated this cognizance of the complexity of moving forward, they were aware that it is not about the destination, but about the journey, and the story that it entails.

Reflexive commentary:

There is a real fear of failing, of not moving on. I could sense it very strongly in RT's description of previous programmes. I think this is significant for him and how the *future will go. I need to process further with Mac's story, who has not attended therapy before and unlike the other two participants she does not have prior experience of any intensive programme so has no sense of 'failing' at a programme the way RT has; her fear is of not speaking out for herself of somehow failing herself.*

7.4.6 Subtheme 6. Action: *Fulfilling my potential today*

Actions taken and action to be taken are important for participants. For each participant there have been approaches and programmes they have tried without success. RT described attendance at different programmes; Mac had chosen not to speak, Adam described working with a Speech and Language Therapist before a presentation. From the start of the narrative process their unique outcomes have been grounded in actions that they have carried out in the past.

Past actions were described by all three participants as having variable success. These actions included avoidance, breathing techniques and slowed speech. Some of these actions were now recognised by participants as being counterproductive. Examples of such actions included avoiding speaking or participating socially and academically. Acknowledging the impact of past actions, the likely consequences and impact of future actions were discussed by all. Openness about stuttering was acknowledged by Adam and RT as an important goal. Open stuttering involves open discussion about stuttering with family and friends, stuttering without avoidance and without trying to hide it.

> **Adam: Fulfilling my potential today I'd like to start practising seeing myself as a stammerer; to stammer more openly** (Appendix E, p129, line 261)

RT's openness involved whole body awareness of the stutter.

> **RT: Then I've got to you like to stutter openly, to stop blocks kind of stops there (indicating lower stomach) just stop and you know and to use slides to real words and just get on to them** (Appendix C, line 388)

Mac wanted to practice acceptance and speech techniques.

> **Mac: Practising techniques with speech, em working to em and accept myself as I said before, em** (Appendix D, p75, lines 205-206)

RT also wanted to target his speech but to start by being less judgmental and critical of his attempts.

> **RT: I can work on what I've heard, what I've been told, to be kind of less kind of less kind of judgmental of myself** (Appendix C, line 378)

Actions also were linked with education and occupational opportunities. Mac planned to return to college, Adam decided to volunteer in a school to explore teaching and RT looked at completing a photography course.

7.5 Outcomes in action

For participants, outcomes emerged linked to occupation, peer or family support and identity. Two years after the programme, RT described the changes he had made.

> **RT: Staying out of the peer group I thought was wonderful, returning to education, clearing a 1,200-euro debt with my jobseekers allowance, buying a camera to persue (sic) my hobby once again, going to my cousins in wedding in County Clare last week and not being freaked out at the cost. There is much to do, but I am enjoying it.** (Appendix F,p139, line 25)

He described setting goals for himself that related to his life and his speech.

> **RT: I intend to have a car, new computer and to go to New Mexico to see my daughter before the year is out. A while ago it would have been an impossible dream.** (Appendix F, p140, line 27)

It was not all straightforward for him however. These changes have not necessarily brought about desired changes to his speech. His speech is still challenging at times but he was using techniques particularly in situations with family that he described. He recognised that building confidence is important to continue the process of working on his speech. He described the importance of connecting the emotions he feels to his speech and focusing on the present moment.

> **RT: Speech wise I have bad days mostly but I, now the future is brighter.**
>
> **I use soft contacts when I speak to the younger members of my family and try to remain calmer when talking to the elder members. Outside of the family, anything goes.**
>
> **With me building the confidence within myself, I will be able to work more on my speech. Learning more about inner judge and the different labels I can put on feelings will work wonders. Trying to stay in the now also helps rather than planning for the future in which nothing seems to work out as planned.** (Appendix F, p140, line 29-35)

Mac returned to education after completing the programme and studied in an animal health related field. She took paid employment for the first time after the programme which involved speaking with others in an office environment. In a letter one year after the programme, she linked pride with her identity as a person who stutters though quickly qualified that as an overstatement.

> **Mac: Yes, sometimes I'm able to accept that having a stutter and issues with anxiety make me who I am and sometimes I'm even proud (bit of an overstatement maybe)! As it makes me more of an interesting person, unique and I like that.** (Appendix F, line 4, p154)

This pride is not consistent. It is an ongoing process towards acknowledgment and self-approval. There was a struggle with "It", the strong emotions of her earlier story are evident. The use of "It" to describe her stutter is a continuation of the externalisation process in the intensive week.

> **Mac: When I'm really struggling with it, when It becomes something I hate- prevents me from being happy, interacting with other people without them thinking I'm a freak, ect (sic). It gets me really depressed and I despise it... So yes there is a great contrast there.** (Appendix F, line 6, p155)

There are more people involved; her life is more "peopled", though she expresses concerns about them judging her a "freak". Mac was aware of the disparity between her pride and her fear of being identified as a "freak" or an outsider. Her actions have included stammering openly with family and a few "select friends" and making phone calls. She struggled to be open about stuttering moving forward to a position of cautious openness but holding back at other times.

> **Mac: I'm trying to be comfortable with myself back in Dublin, I stammer openly (quietly maybe) with my boyfriend and my mother sometimes my brother and once or twice with a select friend or two but I don't let myself stutter completely freely which just builds up in my system (not healthy) and causes me stress.**
>
> **I've been making more phone calls which i'd normaly (sic) avoid bcos (sic) of my anxiety but Hold back from open stutter most of the time** (Appendix F, line 8, p155))

Strong feelings remain with regard to stuttering. Stuttering and anxiety are seen as influential and linked, but remain separate and externalised as she describes them assigning “it” to her stutter.

> **Mac: Stuttering and anxiety has a powerful influence on my memory when I try to avoid stuttering or my anxiety is bad-My memory is awful!** (Appendix F, line 13, p156)

Adam continued to work part-time and volunteered with transition year students. He recognised that the intensive course was beginning of what was to be an ongoing process.

The reflexion below pertains to the process of bracketing and the struggle to put aside or address preconceptions and other knowledges.

Reflexive commentary

As part of my work in Narrative Therapy I attend a group approximately four times a year. This group consists of therapists from many different backgrounds (family therapy, psychology, social workers) supporting the development of narrative practice in Ireland. The daylong meetings consist of a workshop element in the morning and a case discussion in the afternoon (Hegarty et al, 2015). These meetings provide a forum for exploring the challenges of working narratively. At the most recent meeting I was in discussion with another group member about the challenges of bracketing which has been foremost in my mind for some time. Aware of my research, she observed how reviewing past sessions meant I already had knowledge of the future. This was a very sharp moment for me, because I had been discussing how difficult it was to observe my role as SLT in the sessions and the questions I could have asked or the path the conversation could have taken. I was concerned about looking back as the therapist I am now, on the therapist I was then. I then realised the issue was that I was already critiquing the sessions using my ‘other knowledges’, from my world experience and therefore not paying sufficient attention to their lived experience in their present. Consequently, one of the issues that I need to consciously bracket is my awareness of the future. I am researching therapy sessions from four years ago to elicit themes of experiences of being a PWS in the process of therapy to gain understanding of outcomes for that person; and there is a sense that I ‘know’ what the outcomes are. In so far as I know where these people are now, whether they followed through on their programme, whether they attended review days, what hurdles they met when they returned after the intensive programme. This ‘knowingness’ is external to the life world of the person who stutters and requires to be bracketed and put aside. That is not to say that this ‘knowingness’ does not have a place in therapy or even in research; it just does not belong in this interpretation of this data.

7.6 The Language of Suffering

Throughout the IPA process the participants' use of language to describe experiences of suffering and times of challenge was observed and analysed. Each of the three participants, RT, Mac and Adam employed metaphors and analogies to represent and reflect their ongoing story development. Although this has been mentioned in different places within this text, this next section explores the linguistic features that emerged during the IPA process, highlighting the particular elements for each of the three participants.

7.6.1 RT

Of note in the analysis was RT's use of short truncated sentences, describing a passive sense of suffering and events occurring outside his control.

> **Decided that education wasn't my thing just kind of leave like...** (Appendix C, p44 line 85)
>
> **RT: Had to (3) like (3) stood out** (Appendix C, p22, lines 76)
>
> **RT: Yeh got kicked out. No good …Yeh moved into a new school, was put down into the bottom class, because I thought it would be easier sort of got, was bullied. ..** (Appendix C, p15-16, line 33)

He qualified his story with "dunno" or "probably" as if unused to expressing his opinion on such matters as his experiences or perhaps uncertain as to the reception this story will receive. This uncertainty was at odds with the polished telling of his initial story of Irish dancing.

> **RT: I dunno at school** (Appendix C, p39, line 46)
>
> **I dunno why.** (Appendix C, p40, Line 51)

Over the Narrative Therapy process, this use of the passive tense switched to a more assertive use of personal pronoun that indicated an ownership of strong feelings and past experiences. Leahy (2004) described how "I" reflects the authorative person in discourse. In this instance, this direct use of the pronoun linked to action. This use of the personal pronoun is more apparent as he identified actions he has taken in the past in his reauthoring conversation.

> **RT: Because I got angry, kind of anger, frustration that's kind of doing something, I'll just, could be just move.** (Appendix C, p55, lines 165-167).
>
> **That was me** (Appendix C, p52, line 121).
>
> **RT: I like to help people** (Appendix C, Day 2, line 139)

As it developed, RT's story took on an almost lyrical quality, repeating key words, pronouns in particular, highlighting ownership of emotions and actions.

> **I just back to Ireland<u>. I wanted to</u> to take photographs of Ireland <u>I just wanted</u> to, that was it.** (Appendix C, p47, line 108)
>
> **RT: My speech. My wellbeing. Happiness, my future** (Appendix C, p50, line 125)

In the concluding definitional ceremony RT's linked his actions, his sense of achievement in emphatic statements.

> **I feel that I've achieved what I wanted to** (Appendix C, line 372)
>
> **I can work on what I've heard, what I've been told, to be kind of less kind of less kind of judgmental of myself. And I've learnt that things are good** (Appendix C, lines 378-379)

7.6.2 Mac

In contrast to RT's switch from passive language to the language of action and agency as evidenced by his "I" statements, Mac used the personal pronoun from her first Narrative Therapy session. In this performance of her story, she was the central character; the story hung on her actions and her use of the personal pronoun was deliberate and emphatic.

> **After two minutes I realised I had made a *huge* mistake.**
> **I rushed over to the petrol station to ask an employee how long it was to Strokestown** (Appendix D, p58, lines 7-8)
>
> **I was determined to get to my destination. I never gave up**. (Appendix D, p59, lines 16-17)

The use of the personal pronoun by Mac denoted agency and anger. Her repeated emphasis has a refrain-like cadence that reveals strong emotions.

> **I can build up the courage to do it and that I have learned, that I have a right to, I have a right, and that I shouldn't be afraid**. (Appendix D, p65, line 65)

Reflections

A powerful aspect of this process is the constant repetition of key words and phrases that I hear in my mind when I read and reread the transcripts, so much so that I do not need to play the DVD's to hear the intonation, silences and repetition that create *a poetic or song like effect .It reminds me of the first Interpretative Phenomenological Analysis (Leahy et al, 2012) I completed. I felt then that particular phrases took on a poetic frame, as if the chorus of a song or a poem. Intonation, use of silence and repetition are all parts and parcel of the texts that I have been immersed in for so long. Speedy (2008) describes this as listening with 'another ear' and has co created with her clients poetic representations of their words that evoked powerful responses. These texts formed a core component of her thesis. Within the IPA process I feel that there is room for such texts that represent the 'heart and soul' (Speedy, 2008; p94) of the words and phrases of the participants.*

7.7 Metaphors

White (2007) argues that the use of metaphor in an externalising conversation is highly significant. A metaphor may invoke specific understandings of 'life and identity' (White, 2007; p31) that influence the actions people take to solve their problems. Metaphors abound within the Narrative Therapy sessions. These are metaphors that people have taken up in defining the actions taken in the past that allow them to challenge the influence of the problem on their lives. Consistent with this understanding of metaphor was Adam's ongoing 'battle' references that emerged in the externalising conversation.

7.7.1 Adam: viewed as a knight into battle

> **Not being ruled by it. I suppose before I would let's not be ruled by it lets try and overcome it and become more fluent and whatever** (Appendix E, p103, line 60).

He identified that there will be "inner battles" (Appendix E, p107, line 89) that may not be apparent to others. In his reauthoring conversation that detailed a successful presentation he gave he identified how important it is to succeed.

> **Therapist: and it was important to you to...**
>
> **Adam: to succeed**
>
> **Therapist: so succeeding would be, in terms of identity, important?**
>
> **Adam: very important** (Appendix E, p112-113, lines 122-125)

The struggle Adam identified with the use of this metaphor is an internal one. It was a challenge to his sense of identity; he was attempting to push himself.

> **To push me to stand out, to want to embrace it** (Appendix E, p121, line 187)

There are mountains to climb, obstacles to be overcome and challenges to be faced.

> **Adam: it's important because I, I know there is more challenges out there for me** (Appendix E, p126, line 234)
>
> **Adam: makes mountains small I can overcome obstacles gives me support to fulfil my aims.** (Appendix E, p136, line 310)

His wife recognised and supports him in his attempt at these challenges and there was a sense of a knight going into battle armed with bravery and persistence.

> **Therapist: what else does she see in you?**
>
> **Adam: bravery...**
>
> **Adam: the ability to see it through.**
>
> **Therapist: the ability to see it through and...**
>
> **Adam: the ability to see it through, stickability and persistence** (Appendix E, p134, lines 295-230)

As with many knights faced with challenges it was with her support he succeeded. It is Anne who makes the mountains small.

> **Adam: makes mountains small I can overcome obstacles gives me support to fulfil my aims.** (Appendix E, p135, line 310)

In his triangulation letter, Adam described, "shutting himself up" in his early life, as if in a tower of his own making (Appendix L2 p1 paragraph 3). There is a fairy tale element to this story; to the researcher he emerges as the knight who has rescued himself.

He described his earlier search for a "cure" as "the trigger, the magic button" (Adam, Appendix L2; p1), highlighting his need to escape the influence of the problem but this magical result eluded him yet he remained hopeful that there is magic, this time in the therapy process itself.

> **The Narrative Therapy takes a hold. What's this? What's the magic? How does this work?** (Adam, Appendix L2; p2)

There was also an alternative self, one he can see in a mirror, if he could just reach though and get there; but this was not an easy task. There was a sense of compulsion in his repeated use of “I have to” and his failure to finish this sentence is emblematic of the challenge he appears to feel that acceptance of stuttering and himself as a person who stutters was.

> **It’s probably since, the Mirror that I put up to myself, the sense I have to embrace it. *I have to, I have to become its*** (Appendix E, p103, line 60)

7.7.2 Mac: from darkness into light

For Mac, the metaphor used is one of moving from darkness into light, from a position of outsider to insider.

> **Only mad people would walk there in the dark** (Appendix D, p58, line 11).

She described the lights of cars showing the way as she walked in the dark to her destination.

> **The only illumination of any kind was headlights from cars coming behind me. It was extremely dangerous walking on a dark country road.** (Appendix D, p59, lines 14-15).

This metaphor is developed further during the reauthoring conversation when she described her “burning urge” (Appendix D, line 61) to speak out. This burning desire was highlighted some days later in her definitional ceremony. It is so strong that she feared it may consume her. There are risks in following this burning desire.

> **I’d have a burning desire to answer I’d be so afraid of it, and people’s reactions that I wouldn’t answer and then I’d feel that I would give off the impressions that I just didn’t know the answer and feel kind of stupid.** (Appendix D, p93, line 367)

The risk however for not following her desire was to be lost in herself and to herself.

> **Mac: I be so lost in myself. So kind of dark emotions or whatever.** (Appendix D, p93, line 369)

In developing the outsider witnesses’ response, the therapist asked the witness to reflect on images that come to mind. The witness responded, reflecting the metaphor of light.

> **Therapist: and is there anything in her story that you can say that’s kind of like my story, I felt that too.**
>
> **Martin: yeah**
>
> **Therapist: what?**
>
> **Martin: she’s kind of in a she’s in a bright pool**
>
> **Therapist: she is in a bright pool.**
>
> **Martin: yeah**
>
> **Therapist: tell me more about the bright pool, is a bright pool of light or a pool of water.**
>
> **Martin: bright pool of light. (**Appendix D, lines 412-419)

The second witness also acknowledged the contrast between light and dark.

> **Student: and wearing all white, opened the door of a house though it was all dark, there was a younger child inside there, a girl sitting in a corner it just looked empty.** (Appendix D, line 482-483)

In conclusion Mac identified that in taking action she was moving into the light away from the darkness of her earlier experiences.

> **God I was in a very bad place a lot of times, being in the dark, I always felt I was in the dark and because kids when kids are young no one explains that side of life, no one explains things the way they probably should Em I felt like I was the little young girl in the dark who was so confused Em felt there was no way out of the darkness and when she was saying that, me like from the outside looking in, in a spacious green gorgeous garden in white.** (Appendix D, lines 505).

7.7.2.1 Madness and metaphor:

Pauline described how she worried others might see her as mad. Mac and Pauline in their own ways appeared to be concerned with others perceptions of them as mad or outsiders.

> **Pauline: I thought the staff must feel sorry for me or think I am mad** (Appendix L1, page 183, line 15)

Mac was afraid of others reactions to her speaking out (Appendix D, line 367). Mac did not speak out and berated herself for appearing “dumb”

7.7.3 RT‘s journey

RT engaged with twin metaphors of a journey and a separation of mind and body. The journey involved “taking steps” and “moving forward” and “leaving behind” work and education.

> **RT: One day I just left** (Appendix C, p47, line 107)

This leaving necessitated him being one-step ahead; of bullies, of work and of commitments.

> **RT: always one step** (Appendix C, p20, line 60)

In the final sessions the journey became one of moving towards something rather than leaving behind.

> **RT: There is a path, kind of steps I can take** (Appendix C, line 380)

This journey metaphor was reflected by his outsider witness Cian, who introduced a battle metaphor that surprised RT. Adam was not alone in his use of the battle metaphor. The Outsider Witness in RT’s Definitional Ceremony described an image of RT as a “fighter”, someone who did not give up.

The use of “now or never” suggested that RT was on the edge of a breakthrough and in using these words; Cian suggested something about his own experience of stuttering.

> **Cian: Well he kept saying like he doesn’t want to go backwards, he wants to go forwards maybe like like he can improve, that he has gained, he won’t go backwards, he has gained , he has made sufficient ground this week, he doesn’t want to go backwards because maybe at the back of his mind he might be a bit worried that he might go backwards , but he has the support and the image is that he is a fighter like he is saying its now or never** (Appendix C, line 420)

The introduction of the notion of himself as a fighter was reflected upon by RT, turning it into a separation of mind and body, it meant he is “tougher, in control” (Appendix C, line 445). In this way he returned to an earlier metaphor of mind body separation. He relinquished the effects of the problem on his life, and on his mind.

7.7.3.1 RT: Mind, Body and Soul

In RT's Externalisation conversation, there was an initial sense of separation from the embodied nature of the problems that have arisen from his 'pest'. His problem narrative identified how it was his body that had let him down; his stutter was a pest that continued to challenge him. This was reflected in his valuing of his 'mind' in the reauthoring conversation.

> **RT: my mind the way I think** (Appendix C, p41, line 59)
>
> **RT: My mind. I am always able to look at new things. I can if I get stuck kind of one way I can see which step I do next. With speech.** (Appendix C, p53, lines 150-153)

He knew that he could prevail, if he could just follow his mind, he would be the "master of his mind, body and soul" (Appendix C, line 180).

> **But I would just say do it keep calm don't lose the head**. (Appendix C, p55, line 168)
>
> **RT: oh yeh it is there (identifying chest) I can have more patience with myself** (Appendix C, p56, Line 170)

On the final day in his Definitional Ceremony RT located the stutter in his body and highlights the "new things" that his mind could lead him towards.

> **Then I've got to you like to stutter openly, to stop blocks kind of stops there (indicating lower stomach) just stop and you know and to use slides to real words and just get on to them, then new things, like few weeks touch wood (taps head)** (Appendix C, line 388).

Following attendance at a review day RT wrote in response to an email from the therapist. In this letter, RT reconciled his mind and his body when he talks of "the spark is me".

> **When I spoke of the spark, I may of used my hand on my right side to describe because it felt like a light coming in, but in fact, I didn't know where I was getting the strength from** (Appendix F, p148, line 7).

7.8 Triangulation

On completion of the analysis for the three participants, follow up letters were sent to all eleven participants of the study. Written or emailed responses were received from eight of eleven participants. Excerpts are included from the correspondence received from Kate, Maura, Pauline, Tracey, Jack, Colm, Jason as well as Adam. The full responses are included in the appendices (Appendix L). Grammar and spelling errors are not altered in the excerpts. The themes that emerged were not a surprise to Kate:

> **Kate: the outcomes in which you have come up with do not surprise me at all, they are what I would have also taught (sic) and felt over recent years.** (Appendix L1, page 180, line1)

She linked the themes of Impact, Hope and Will together; they led to the fourth, Identity.

> **Kate: The outcome for me has to tie in all the four points together, with going through and experiencing firsthand the first three they have given me the resources and tools in which I have gained over the years which relates to point number four, which is the person I have become in recent years** (Appendix L1, page 180, line 5)

7.8.1 Impact of stuttering

Impact of stuttering was acknowledged by many of the participants, particularly strong negative feelings and a sense of powerlessness. Maura wrote that the impact of stuttering is a theme that she strongly identified with.

> **Maura: I can appreciate the themes you have mentioned. Powerlessness, helpless, embarrassment were all as a result of the impact stuttering had on my life.** (Appendix L1, page 190, line 4-5)

Suffering and impact of stuttering across work, family and school were a factor for Tracey.

> **Tracey: I agree with your findings, particularly in terms of the strong impact of stammering on family, work and school. I can totally relate to the suffering associated with stammering along with a sense of powerlessness and not speaking out – familiar feelings throughout my life**. (Appendix L1, page 188, line 4)

Kate in particular, had difficult times in school and was bullied.

> **Kate: The demons I had towards my stammer and the negative impact it had on me while growing up and going to school.** (Appendix L1, page 181, line 5)

Adam reported that he was "still keen to tell my story" despite the early impact of stuttering that resulted in avoidance.

> **Adam: Maybe that's because of an early life of shutting myself up.** (Appendix L2, page 197, paragraph 3)

Pauline described how stuttering was held responsible by her for the reactions of others to her

> **Pauline: Up to now I have always linked negative response or indifference from people as being mainly due to my stutter.** (Appendix L2, page 183, line 18)

7.8.2 Hope

The transformative nature of hope was recognised and Adam reported how he has journeyed to the course with hope. His initial hope was for 'a cure', something that will take the stutter away despite his awareness that this was unrealistic. His expectations were high.

> **Adam: I was hopeful that something might happen. A trigger .The magic button (**Adam, Appendix L2; page 197)

Maura's letter reflected the transformative nature of hope. Hope for her, was something that developed over the programme leading to acceptance.

> **Maura: as the week progressed, I remember getting a feeling of hope followed by a reluctant acceptance that I will never change and therefore, never 'cured'. However, I had to accept this if I was ever going to accept my stammer in time.** (Appendix L1, page 190, line 61-62)

Pauline referred back to her "determination" with humour and pride. She recalled a story she told in Narrative Therapy as her unique outcome that reflected her determination. This act of determination led to further actions as she reauthored her story.

> **Pauline: Some of the themes that emerged from the narrative therapy have continued. I have continued with my value of keeping going and getting things finished like the curtains. I had another curtain project which was unfinished for a long time but I completed it over Easter :-) On a more serious note I completed the 300 hours needed for the Teaching Council unpaid in a school, it took over a school year. It was disheartening at times as alot (sic) of the time students were absent but I kept going.** (Appendix L1, page 182, 10-14)

7.8.3 Will

The theme of Will incorporated actions, preparation, linking in with others identifying own resources and moving on.

Actions taken include work, travel and involvement in support groups. Three participants referred directly to the mindfulness component of the *Free to Stutter Free to Speak* programme. They have engaged with the practice of mindfulness. Mindfulness is the conscious awareness of thoughts, feelings, and surroundings and accepting this awareness in a non-judgemental way (Boyle, 2011). This conscious awareness without judgement appears to support the externalisation process in Narrative Therapy.

> **Pauline: The mindfulness has been a great tool to use as it has given me the space to respond or just notice my experiences** (Appendix L1, page 183, line 20)

> **Jack: The outcome so far is that I've become much more mindfull (sic) of my stammer** (Appendix L1, page 184, line 5)

> **Colm: Personally learning to be mindful of how I freely administered tough judgement** (Appendix L1, page 193, line 2)

7.8.4 Identity

The aspects of the theme identity that resonated with the research participants as evidenced in their letters included acceptance, values and determination. Pauline wrote of how her determination had seen her through a university degree and she had qualified as a teacher.

> **Pauline: I thought the staff must feel sorry for me or think I am mad but I have been given more work there until the end of the school year. So the determination to complete the hours made a positive impression.** (Appendix L2, page 183, line 15)

The externalisation process continued for her, she continued to stand back from her negative thoughts. Acceptance of others and of herself was a change she identified.

> **Pauline: even though I still have negative thoughts like I mentioned above I question them, am more objective about them and now believe that most of the time that i (sic) need to accept the way people are and the way they react to me is not because of my speech, this is the way they are** (Appendix L1, page 183, line 19)

Acceptance resonated strongly for Maura also.

> **Maura: I have finally accepted I have a stammer and a (sic) I finally have a feeling of liberation** (Appendix L2, page 191, line 65)

Adam wrote in his letter of his acceptance of himself as a person who stutters. In reference to his earlier use of a battle metaphor, he had relinquished the “fight”.

> **Adam: Live with it. Accept it. And that for me is my inner peace. I don’t have to fight this. I don’t have to struggle with this...I am more comfortable with myself as a stutterer and love the person I am because of my stutter. It has made me who I am.** (Appendix L2, pages 197-198)

7.9.5 Linking in with others

All participants reported that the support of others played a significant part. Some like Kate had actively engaged with support groups, while others talked openly about stuttering with close family and friends for the first time. Tracey regarded the openness about stuttering as “crucial”. Adam described his experiences of the Narrative Therapy.

> **Adam: Each person’s experience is lived and shared. Sometimes I can relate to it with similar experience, more times I can’t. But always there is empathy. We’ve all crossed that emotional bridge at the beginning when the ground rules**

> **are set. I felt open and vulnerable yet happy to reveal who I am and this was successfully done to my peers through NT.** (Appendix L2, p197-198)

The importance of linking in with others evidenced in these comments is in strong contrast with the isolation described in the earlier therapy sessions.

7.9.6 Outcomes identified from the Triangulation letters

Each individual who responded to the follow up email highlighted the outcomes relevant to them. The outcomes related to the themes identified earlier. Four out of eight respondents did not describe speech related outcomes. All four males who responded refer to their speech directly as an achieved outcome or desired outcome.

> **Still having good and bad days even good and bad hours** (Jack) (Appendix L1, page 184, line 5)
>
> **...unfortunately the stammer has gone downhill in the last year or so** (Jason) (Appendix L1, page 186, line 6)
>
> **.....my stammer has budged quite a bit over the years** (Colm) (Appendix L1,page 193, line 2)
>
> **I lived through a stage where I wanted to prove I could speak in public. I have good days and better days and I try and stutter more fluently** (Adam, Appendix L2, page 198)

The four females who responded highlighted the actions they had taken rather than changes to their speech. Kate described herself as more outgoing and determined to succeed.

> **Kate: Overall the outcome for me has turned into me been a lot more outgoing, beginning to experience and enjoy life, not letting anything or anyone hold me back anymore with the determination I now feel I have to succeed at what ever I put my mind to.** (Appendix L1, page 181, line 6)

Tracey described reduction in impact as an outcome.

> **Tracey: Stammering currently only has a limited impact in my life.** (Appendix L1, page 189, line 7)

Maura had taken action.

> **Maura: my biggest fear was public speaking amongst peers especially, and as recently as last week, I gave a 15-minute presentation... I am working full-time and got a moment of madness last September to do my Masters (August deadline) so all in all, I'm not sure when I'll ever have a free weekend again…** (Appendix L1, page 191, line 13)

Pauline persevered through challenges to complete her degree and higher diploma and was working as a teacher. She highlighted and valued her own determination in completing this process. Having completed teaching hours to gain her diploma, she is now registered as a teacher and working part time.

> **Pauline: on a more serious note I completed the 300 hours needed for the Teaching Council unpaid in a school, it took over a school year...but I have been given more work there until the end of the school year. So the determination to complete the hours made a positive impression.** (Appendix L1, page 182, line 13)

Colm described how his attitude has changed.

> **Colm: began a slow turning in attitude and I soon enough began to be a bit softer and loving towards myself. That was a great change for me and one I can now appreciate.** (Appendix L1, page 193, line 2-3)

For two of the participants, speech remained an ongoing issue. Jason reported that his speech was a challenge still. Following his original programme attendance his attendance at the review days was limited and he was now returning to the programme. "A difficult year" had resulted in increased overt stuttering behaviours, life had impacted on his stuttering, and in turn his stuttering was impacting on his life.

> **Jason: I'm going on another ... course in a few weeks actually – things were going great for a few years after my first course but unfortunately the stammer has gone downhill in the last year or so.** (Appendix L1, page 186, line 6)

Tracey recognised that it is a process, working towards outcomes that are acceptable to her.

> **Tracey: in my experience stammering is a life long condition that has impacted me to varying degrees throughout my life, coping with stammering is not a once off fix, rather it is a process.** (Appendix L1, page 189, line 7)

Taking action to ameliorate the early impact of stuttering is identified by the participants as a process that takes time and effort.

7.10 Summary of IPA themes

The Interpretative Phenomenological Analysis yielded four major themes for people who stutter in the process of Narrative Therapy; Impact of stuttering, Hope, Identity, Will and a fifth theme relating to each individual's Unique Outcome. These themes emerged from a detailed analysis of Narrative Therapy sessions supported by the Narrative maps that accompanied the sessions and the subsequent emails and letters from the participants. In the following chapters, the results presented in chapters seven and eight will be discussed in the light of contemporary literature.

Chapter 8

Discussion: Reflections on Themes

The participants in this study are people who stutter. Following Interpretative Phenomenological Analysis of their Narrative Therapy sessions, themes emerged that detailed their experiences as people who stutter at the beginning and throughout the process of Narrative Therapy. Strong themes of suffering and negative impact of stuttering on activities of daily living and key aspects of identity emerged. Hope and identity in transformation lead to will and action. The participants' responses to these themes accentuate the ongoing nature of change and the challenges in dealing with the impact of stuttering. Outcomes described in these letters relate to education, occupation, relationships with others and reduction in avoidance of situations and fears linked to stuttering. Fluent speech is not indicated as the primary outcome for many of the participants.

8.1 Introduction

This chapter provides a brief summary of the findings of this research. Inferences from the superordinate themes will be considered and I will reflect on implications for intervention and measuring outcomes. I will consider the findings from the standardised outcome measures in the context of these superordinate themes and, in keeping with the phenomenological approach, pay attention to the particular, and the lived experience of people who stutter. The themes and the outcomes that were analysed statistically will be considered with reference to the extant literature in stuttering and intervention outcomes.

8.1.1 A review of findings

The purpose of this study was to understand the outcomes from Narrative Therapy as offered within the FTS programme for people who stutter from their lived perspective, and to explore these in relation to the standardised assessments taken over a three-year period of the programme. Four superordinate themes emerged from analysis of Narrative Therapy sessions: the Impact of Stuttering; Hope; Identity and Will with a fifth theme relating to Unique Outcomes. The outcomes from the statistical analysis of the standardised assessments suggested clinically significant changes in attitudes, thoughts and feelings about stuttering and quality of life.

8.1.2 Research Questions

The first question that this study posed focused on the nature of outcomes from a Narrative Therapy intervention programme *Free to Stutter Free to Speak* . In any therapy intervention, the therapist and client at the center of the therapy have at the forefront of their minds the question, “does this intervention work?” Narrative Therapy in the *Free to Stutter...Free to Speak* programme appears to address the covert aspects of stuttering leading to the second question to the forefront of this research. The second question that concerned the study was the relationship between the outcomes from Narrative Therapy and those of the standardised assessments. It is clear from the statistical analysis that the programme *Free to Stutter Free to Speak* was successful in addressing the covert aspects of stuttering as identified by the standardised assessments the WASSP, the OASES and the S24 and this is discussed later in this chapter. The major themes that emerged from the Narrative Therapy sessions are considered and I look at what outcomes look and feel like for people who stutter, as reflected by the themes that emerged. Finally, I also address here the narrative process that has emerged in this research and the key components therein for example, the client-therapist relationship.

8.2 Identifying the Outcomes from Narrative Therapy

The evidence from this current study strongly suggests that Narrative Therapy in the *Free to Stutter* programme in addressing the covert aspects of stuttering, results in outcomes that are recognisable not only clinically but by the people who stutter who participated in this study. This finding emerges not only from the statistical analysis of the assessment results, but from the IPA analysis of the Narrative Therapy sessions. In summarising outcomes from this research, it is important to acknowledge that Narrative Therapy does not set out a specific goal or a desired outcome at its outset. The focus is on picking apart a problem-saturated story and creating a means for the person to re-author and develop a preferred narrative that fits with their values, hopes and dreams. Participants have developed a preferred narrative that aligns with the objective measures of success. In utilising a Narrative Therapy approach for the *Free to Stutter Free to Speak* programme, the aim was to address the problem-saturated stories of people who stutter attending the programme. It was hypothesised in addressing these stories that the problem-saturated stories of people who stutter may incorporate negative thoughts and feelings linked to stuttering. In this way a Narrative Therapy focus could address the covert aspects of stuttering as described in the literature. As discussed in an earlier chapter, not all outcomes are intended ones, and although many of the participants reported changes to thoughts and feelings related to stuttering, other outcomes from Narrative Therapy emerged.

This research highlights that for many of the participants, the outcomes of Narrative Therapy were not directly speech-related. Outcomes were concerned with actions, either at work or in education. A key component to the actions taken was linking in with others, be it new groups, such as other programme participants and support groups, or reconnecting with family. The outcomes reported in this research related also to self-acceptance and identity. These were not the stated goals of the therapists involved in the programme, again stressing the importance of recognising each individual's goals at the onset of therapy. It brings to mind a participant in this study, who, on the first day of the programme many years ago identified his goal as having a girlfriend and getting married. He felt that if he could be comfortable with himself as a person who stuttered, someone else could be too.

8.2.1 The OASES, WASSP, S24 and Narrative Therapy

Three standardised outcome measures were used to evaluate the participants' response to stuttering, attitudes to speaking situations and to communication: the Overall Assessment of the Speaker's experience of Stuttering (OASES) (Yaruss & Quesal, 2006), the Wright Ayre Stuttering Severity Profile or WASSP (Wright & Ayre, 2000) and the S24 (Andrews & Cutler, 1974b).

The OASES, WASSP and S24 reflect the positive changes reported by the participants. The OASES results here suggest a reduction in the impact of stuttering, with statistically significant positive changes for the research participants over a minimum of a two-year period. These positive changes over this timeframe are reflected in the increased actions and agency identified in the later Narrative Therapy sessions. The statistical analysis revealed moderate effect sizes. As the reactions to stuttering decreased over the period of the intervention and the follow up time frame, communication in everyday situations became less problematic. As Narrative Therapy addresses the impact of stuttering, perhaps people take action, resulting in significant positive changes to quality of life, or indeed as the thoughts and feelings about stuttering undergo revision in Narrative Therapy, people are inspired to take action. The changes to quality of life arguably are as a result of increased participation in daily activities with a wider network of support available.

As the participants reported increased engagement with others and participation in education and work, these changes were also reflected in their WASSP subtests, particularly reduced avoidance and sense of disadvantage due to stuttering. The S24 results also indicated a reduced impact of stuttering on communication attitude of the participants. With increased participation, thoughts and feelings about stuttering reduced thereby mirroring the Narrative Process of reauthoring, where actions (as identified on the Line of Action) both past, present and possible future steps are related to the thoughts and feelings (Line of Identity). Narrative Therapy explicitly encourages participants to draw these conclusions and verbalise these connections for themselves.

In the WASSP results, the Stuttering Behaviours subtest was the only one where changes in scores were not statistically significant. This subsection is based purely on the person’s own self-rating. This study did not include the standardised measures such as the SSI4 (Stuttering Severity Instrument 4th edition), which could have provided a direct comparison with the self-report data. This subtest result contrasts with the OASES results where participants’ perceptions of their communication in daily situations show continued improvement, indicating that communication in daily situations is not solely judged by perceptions of speech behaviour alone. Despite the lack of statistically significant supporting data for the stuttering behaviours, there was a significant reduction in impact, with changes to avoidance, thoughts, feelings and sense of disadvantage due to stuttering. The results mirror those of the OASES. The similarity in results suggests that perhaps one assessment only be administered in a clinical setting. With one hundred items the OASES may be time consuming for a client particularly if literacy is an issue.

8.2.2 Standardised Clinical Assessment Measures and Narrative Therapy: Capturing the Same Construct?

The findings from all three measures highlight a reduction in negative attitudes and feelings towards communication, with improved quality of life and an increased knowledge of stuttering.

Despite the positive changes in the scores of the S24, the changes were less significant and more variable across the group than those that emerged from the other two assessments. This difference is perhaps a testament to the purposes behind the development of the S24. The development of the OASES and WASSP were driven by the wider awareness of the impact of stuttering and the redevelopment of the ICF focusing on activity limitations and participations. The S24 was originally conceived as an instrument to establish the impact of stuttering on communication attitude (Stipdonk, Lieftink, Bouwen, & Wijnen, 2014). In recent research, Stipdonk et al., (2015) found that communication attitudes in people who stutter co-vary with their degree of extraversion. In other words, they identified that the S24 picks up on more than just stuttering-related communication attitude. The results of the S24 may be influenced by factors other than attitudes to communication, acknowledging the degree of the individual’s extraversion as highlighted by Stipdonk et al., (2014). Stipdonk et al., (2014) suggest that therapists need to take personality aspects, such as extraversion, into consideration in stuttering diagnosis and treatment particularly as it might have implications for the therapy approach. As no measures of extraversion or personality traits were included in the *Free to Stutter Free to Speak* study it is not possible to identify if the personality traits of the participants influenced the results from the S24. There may be no significance attached to possible extraversion measures and the findings from this current study. The significance may be in the fact that a difference between results from the OASES and the WASSP and those of the S24 was identified and the implications for therapists of these differences will be discussed further.

The positive outcomes from the OASES, WASSP AND S24 are in line with the outcomes from Narrative Therapy and the participants’ own reports on outcomes. However, self-rating scales are designed to elicit responses to particular questions on a particular day. The self-evaluation of one’s own story addresses the issues that are important to the person and is a highly individualised approach to intervention and the process of change. The standardised assessments suggest that change has taken place across a number of parameters; Narrative Therapy shows what those changes look like on a daily basis for the person who stutters.

Staging posts within Narrative Therapy

Identifying whether there were stages within the Narrative Therapy process was one of the research questions of this study. The processes that emerged within Narrative Therapy are addressed here following the format of the themes that arose from the IPA process. The first staging post to emerge is the significance of addressing the impact of stuttering.

8.3 Impact of Stuttering

In this study, suffering and stuttering emerged as intertwined. Each disruption of speech impacted on the participants' participation in daily activities. Strong feelings of anger, fear and embarrassment were closely tied to speaking situations. Work, family and social life were impacted. Mac described a "complete lack of communication" with family when things were bad. There was frustration with this lack of communication that led to anger for RT. There is the implication that suffering has become a fixture in Mac's life and the darkness that has descended in the past looms when her communication struggles are paramount. Impact of stuttering on quality of life, including academic achievement and peer relationships has been reported in the literature (Klompas & Ross, 2004; Koedoot et al., 2011) but few reports address how to deal with this impact. CBT (cognitive behavioural therapy) has been utilised (Helgadottir, Menzies, Onslow, Packman & O' Brian, 2014; Menzies et al., 2008) as part of fluency shaping programme to address stuttering related anxieties with a degree of success reported, but this current research highlights how the impact of stuttering can go beyond the moment of stuttering itself and becomes entwined with the person's sense of self, sense of identity as a person who stutters. The impact of stuttering is such that the person who stutters identifies as such, and identity as a person who stutters emerged as a major theme of this research. As CBT addresses thoughts and feelings in the moment of stuttering, providing a challenging counterpoint to persistent negative thoughts, Narrative Therapy aims to facilitate the identification of one's own resources and values in order to address the problem-saturated story.

Narrative Therapy goes beyond the 'now' and the present day, engaging with the detailed history of the problem and in doing so appears to address the past impact of the problem for the participants of this intervention programme. The outcomes of this study accentuate the importance of addressing the impact of stuttering, acknowledging past impact in order to move forward in the reauthoring process. Furthermore, the need to monitor and evaluate this process over a lengthy period of time is apparent. Following the *Free to Stutter Free to Speak* programme there is a reduction in impact reported in the results of the OASES and WASSP assessments. The total impact scores (OASES) demonstrated a statistically significant reduction in impact of stuttering and improvement in quality of life that was maintained over the three year interval as evidenced by the Friedman and Wilcoxon signed ranks analysis and by the effect sizes calculated. These results are supported by the themes that emerged from the IPA analysis. In particular, quality of life and communication in daily situations continued to improve following the intensive treatment programme. Reactions to stuttering had lessened, though information about stuttering had shown some deterioration. This finding suggests that it is important for people who stutter to receive up to date information about stuttering and its etiology on an ongoing basis. The WASSP results demonstrated a reduction in the sense of disadvantage and avoidance due to stuttering that continues up to and including the final time point. These results link to the reduction in impact described by participants in their letters. For the participants, outcomes are described that address work, education, feelings and attitudes to communication and interaction with others. These outcomes are further reflected in the participants' feedback to the triangulation letter and the highlighting of actions taken and the acknowledgement of Hope. These outcomes are in direct contrast to the initial theme of Impact that emerged from the Interpretative Phenomenological analysis.

These findings suggest that the primary goal of treatment for some people who stutter may be the reduction of disablement in the ongoing experience of stuttering. Reducing the impact of stuttering through a process of narrative conversations may address the internalisation of stigma fostered by negative attitudes of the public and people who stutter towards stuttering that were described in an earlier chapter. The very act of participating in education and work environments and fulfilling one's own potential affirms the right to do so and provides validation of self-worth for many of the participants in this study.

8.4 Identity: a storied affair

Self-worth and self-acceptance, knowing who you are, along with values and self-determination emerged resolutely in this study as subthemes of Identity. Identity emerged as a theme in the Narrative Therapy sessions but as an identity of two halves. The first was a sense of "other", the second half, a sense of identity in transition as the Narrative Therapy sessions progressed. White (2007) describes identity as an "association of life" (p 128) rather than a core-unchanging construct. Identity is described as a life story developed from infancy through early childhood, to the ideological challenges posed by adolescence, through to the adult who authors his or her own personal myth (Bauer et al., 2008; McAdams, 1993; Mullet, Akerson & Turman, 2013; Pulkkinen & Kokko, 2000). This association of life is composed of significant people and identities linked to an individual's past, present and future. Key to this understanding of identity is that it is a social achievement (Leahy et al., 2012; McAdams, 1993; Speedy, 2004a; White, 2000, 2005, 2007; White & Epston, 1990). As a social achievement, identity is co-constructed between the person and society. Life is a "storied affair", we narrate ourselves into being, and thus create stories we can live by. Narratives are fundamental to our sense of self and how we make sense of the world (Labov, 2016). We make sense of ongoing events by thinking through the past and exploring our storied sense of self. Bauer (2008) describes how narrative identity gives unity, purpose and meaning to a person.

Alternatively, otherness is defined as feelings of negative distinction, isolation, or lack of fit within a given social context based on one or more aspects of one's identity in relation to other group members and group norms (Pifer & Baker, 2014). This sense of other was clearly articulated by RT when he identified that the Irish dancing community was not for him and Mac when she talked of herself as the mad person alone in the dark. Adam took a stance as the quiet observer, not quite part of groups but watching "to stand back and focus", speaking out is not what he would normally do;

'I expressed an opinion. Normally I would be a lot...'

Narratives allow us to give meaning to the significant events in our lives (Labov, 2016). Our narrative identity provides 'life with unity, purpose and meaning' (Bauer, McAdams and Pals, 2008; p82). We construct and reconstruct our stories to make sense of these events and create meaning for ourselves (Bauer et al., 2008; White, 2007). Personal growth and development is bound to this process of constructing and reconstructing meaning (Dirkx, 2012).

Narrative Therapy aims to challenge the underlying assumptions we have about ourselves as people and the context in which we live, work and play (White, 200ob, 2007; White & Epston, 1990). Transformation can be evident in the narratives we tell; stories of growth that are common across gender, ethnicity and socioeconomic status (Bauer et al., 2008). Bauer (2008) describes narratives of transition leading to transformative learning that emphasized personal growth, difficult experiences that were transformative, with a culturally shaped script of redemption. Narrative Therapy encourages the description of difficult experiences as with illness (Charon, 2006), allowing the person to develop their own script of redemption as he or she identifies their unique outcome and re-authors the story in a way that is meaningful for them. By reconstructing the stories in Narrative Therapy to make sense of past events, people who stutter are recreating for themselves a new way to engage with their own identity that acknowledges past events yet allows forward movement. This process or reconstructing stories to engage with identity is described as a “migration of identity”.

8.4.1 Migration of identity

The metaphor of *migration of identity* has been used in Narrative Therapy to describe how a person, as they make significant changes in their lives, carries with them their cultural training and yet must learn the culture of the ‘new land’ that they now inhabit (Crocket, 2004). Narrative Therapy elicits the values, hopes and dreams that each participant holds to. As these values are identified by the participants in this study for example ideas and expression, success, contribution and role as a parent or in family, the process becomes one of migration, the identity becomes one of identity in transformation.

In the process of migration, past experiences are acknowledged, particularly those experiences of being a person who stutters. This migration of identity is triggered by a disruption. In the literature, such disruptions are linked to chronic illness (Franks, 1995; Hunt 2000). Individual experiences are central to how we put together a sense of our identity (Abrahams, 1986) and one such experience is that of illness.

Illness can disrupt our narrative of self, creating challenges to our identity (Hunt, 2000). Yet the very narratives of illness can be used to restructure a sense of self and create a revised identity as a response to the disruption caused by the illness (Bauer & McAdams, 2010; King et al., 2000). Illness, or in this instance a speech disorder such as stuttering, can become the transformative difficult experience that is a key component in the narratives of transition.

Mac introduced her story by saying “only mad people would walk there in the dark”, suggesting that for her, this is an identity lived on the fringes of how society would expect her to be. Her sense of self is influenced by social anxiety, describing isolation and reluctance to talk. Her fears of “messing up a little” are countered by the awareness that she has “been through a lot”. This initial story of suffering is challenged by a new story of personal growth, one developed as an alternative to despair with hope creating an identity of determination and perseverance;

> **‘Even though I did experience em hurt by actually speaking out and sharing my ideas whatever em I can build up the courage to do it and that I have learned, that I have a right to, I have a right, and that I shouldn’t be afraid’.** (Appendix D, p65, line 65)

This awareness of her right to do so, leads to what White calls a “migration of identity” (White, 1995). This migration of identity from a life lived on the fringes to a story of determination results in what Bauer (2008; p81) describes as a “culturally shaped script of redemption”. Key in this process for the participants is acceptance of stuttering as a component of the person’s life; this however does not mean that they do not wish to change it, but by accepting it, there is more they can do as Mac says:

> **‘I was kind of like if I can do that, maybe I can improve and be more comfortable’.** (Appendix D, line 105)

8.4.2 Self-acceptance.

Acceptance of stuttering has been found to be an important factor in successful management of stuttering (De Nardo, Gabel, Tetnowski & Swartz, 2016; Plexico, Manning & DiLollo, 2005). In discussing acceptance, it is important to acknowledge that this is acceptance of loss, the loss of an ability to do an everyday taken-for-granted skill and the values that people attribute to that skill. It is also an acknowledgment that acceptance does not refer to giving up or reluctance to change or progress in therapy. It is acceptance that this is a factor in a person’s current situation or status. Acceptance of stuttering, as with acceptance of disability is an ‘adjustment of the person’s value system such that their actual or perceived loss does not negatively affect the value of existing abilities or the person as a whole’ (De Nardo et al., 2016; p28).

In exploring coping strategies of people who stutter, Plexico, Manning, and Levitt’s study (2009b) identified four value changes common to people who exhibit self-acceptance. These include accepting that stuttering is a “part of the self” rather than a defining characteristic and viewing stuttering from a broader often more positive perspective. The participants in this current study acknowledge their values of success, contribution, ideas, expression, role in family and as a parent as part of this broader perspective. As supported by the comments of some of the participants of this study, recognition of these values alongside the acceptance of stuttering may lead to action. Mac now is actively involved in an animal welfare group and described the importance of turning up, even if there are events where she might have to talk a lot. This self-acceptance of herself as a person who stutters was reflected when she stated:

> **‘I can define who I am and my stutter just comes along with me’** (Appendix D, line 504)

Adam struggled with the notion of his identity as being that of a person who stutters. He has had difficult experiences, acknowledging anger and resentment but then the transformation occurs in the Narrative Therapy sessions; he wanted to accept it but on his terms. He can be wryly humorous about it but found it difficult:

> **‘So tonight I had a chat about acceptance and he mentioned he would try and love me, or at least learn to love me and he gave me a big hug’.** (Appendix E, p96, line 8)

In this new story, he also recognised the need for support from others (the group and the support group at home). For the three participants, Adam, Mac and RT, whose narratives were analysed, difficult experiences led to transformation, with narratives that emphasized personal growth and a script shaped by their own personal stories of redemption. Narrative Therapy appears to elicit transformational narratives through the close questioning of the problem story and the development and embedding of the alternative and preferred story through the reauthoring process. Identity accepted and yet transformed appears to be a significant point in the narrative process that leads to transformation. Each participant was aware of and describes this transformation that for some connects directly to action. In this process of identity transformation “*Hope”* is present.

8.5 Hope

Hope has been associated with human wellbeing, health, and quality of life (Kylma, Duggleby, Cooper & Molander, 2009). Researchers describe how hope is considered as a protective factor, whereas long-lasting despair or hopelessness may threaten holistic wellbeing and health (Kylma & Juvakka, 2007). Kylmä and Juvakka (2007) explored hope from the perspective of adolescents with cancer, identifying two aspects of hope; intentional hope directed *towards* something and hope *experienced* as an inner resource. The hope of adolescents in Kylmä and Juvakka's (2007) study was enhanced by factors related to their experiences and social network and factors situated between these two groups of factors. For those adolescents, hope consisted of looking forward to the future, trust, connection with others and wishes that refer to something positive.

8.5.1 The dual nature of hope

This dual nature of hope is reflected in the subthemes of the participants' narratives here. It is a transformative force, they are moving towards something, while their pride, fulfilment and humour reflect "hope" as an inner resource. For the participants in my study, hope also involved connection with others, particularly the importance of the social network within the programme and after the programme was completed. Counteracting the impact of stuttering, hope emerged early on within the Narrative Therapy sessions. It provided a counterpoint to the suffering experienced by the participants; acknowledging how "hope is associated with suffering and despair" and yet also "a life-promoting factor" (Kylma and Juvakka, 2007; p262). This is neither hope for, nor an expectation of, a cure of stuttering, but hope for a different way of living, as evidenced by Mac's wish to be "being more comfortable" (line 93-94) and RT's wish to "just to be more able" (line 380).

Mattingly (2010; p3) describes hope as a paradox; "It is to be reminded of what is not and what might never be". It is the future of what if, what may come to pass but also the knowing that it may never be. Mattingly describes this intimate relationship of hope with despair as an ongoing conversation. When RT expresses hope initially, it is because he is all too familiar with this paradoxical conversation which is shaped by his experiences culturally and by his suffering. When RT lets go of hope, he gives value to acceptance which paradoxically, allows hope to grow, not hope of a cure but hope that he can survive the impact of his stuttering and develop in a new world, a world where stuttering also lives but does not determine his own personal outcome. This thinking forward involves humour;

> **'I move forward 'cos every door opens. Well no possibly if the door doesn't open (laughs) you got to try' (mimes pushing).**

8.5.2 Hope as an action-focused practice.

Mattingly (2010) describes hope as a practice, encouraging one to live a life worth living even when suffering or in the face of chronic or debilitating illness. In a study of women with ovarian cancer, Reb (2007) found that the women associated hope with the ability to return to normal, participate in meaningful activities and survive the disease. Mac wants to participate in life, to work to a new normal, whatever that may look like for her.

> **And seeing myself as not necessarily a better person, but in my eyes being more comfortable, and a happier person** (Appendix D, p74, line 199)

By acting in a transformative way, by speaking out, she opens up a space for hope (Mattingly, 2010). In this manner, for the participants, hope is closely linked to action. It is not so much hope as a happy ending, but hope as a narrative of progress (Mattingly, 2010). Reb (2007) identified that hope was necessary for people to find meaning in their lives, when faced with the consequences of a life-threatening disease. The impact of stuttering, while it cannot be considered life threatening, has significant consequences for people who stutter. The practices of hope as demonstrated in the narratives by Adam, RT and Mac and in the letters of the other participants, serve to mitigate the impact of stuttering.

8.5.3 Therapists' role in fostering hope

Mattingly (2010) describes how therapists struggle to regulate the hope of patients, encouraging the right amount of hope and dealing with 'patients denial'. The struggle to regulate hope has its origins in the therapists' desire to do the best for their clients, reflecting their clients' goals and hopes while simultaneously recognising the limitations of what is possible. Therapists may work to maintain their own hope and yet regulate the expectations of their clients (Mattingly, 2010). Here I suggest that therapeutic hope is not a form of denial, but a consciously chosen attitude and approach by both the therapist and the person who stutters. The therapist fosters recognition of the client's own resources and in doing so highlights actions the person has taken in the past to enhance their own quality of life. Indeed, quality of life may be improved by fostering hope (Matutina, 2008). The therapist has a role in shepherding hope, in supporting it but not creating a sense of "false hope or expectations” of a cure for stuttering, rather reflecting on what the client’s own values and resources makes possible for them in the future.

When treatment has not been “successful”, people who stutter may blame themselves or may subtly be blamed (Mattingly, 2010). Examples of this in the literature on treatment for stuttering include references to failing to adapt to a new way of speaking (Cream et al., 2004), difficulty in adjusting to a new role as fluent speaker (DiLollo, Neimeyer & Manning, 2002) failing to practice (Euler, Lange, Schroeder & Neumann, 2014) or lacking in motivation with personality, locus of control, speech attitudes and participation in anti-relapse activities (Craig, 1998; Venkatagiri, 2009) some of the personal factors described. These examples are the antithesis to the practices of fostering hope. They do not reflect the efforts a person may have made to engage in therapy, and in so doing, may inhibit further action by the person, as reflected when RT describes the efforts he made to reach a course and arrived late (RT line 320-322).

Therapists may caution against what they see as excessive hope (Mattingly, 2010) and traditional discourses may encourage ‘reality checks’ against unrealistic or false expectations. Within the current structure of health care, the medical model can emphasize the repair or fixing of a particular body part or the rehabilitation of a particular function (Charon, 2008), thus implying or suggesting that the role of the clinician is one of specialist or expert. In undertaking this role, positioning oneself within this particular discourse of expert communicating with the (non-expert) patient, expectations of outcomes require careful management. Not all body parts can be fixed, not all functions returned to what they were or what they aspire to be. The adoption of this stance has an implied directive to provide the ‘reality checks’ necessary to ensure realistic expectations. In Narrative Therapy there is not a direct imperative to correct or challenge hope, indeed it may be seen as a valuable stance towards reality (Mattingly, 2010). This, for the therapist, is the starting point in the process, acknowledging hope, and not denying its possibilities. Weingarten (2005) describes hope as “a verb, not a noun”. Hope is helping people feel connected when stuttering makes them feel isolated. The findings of this study here, suggests that the therapist has a role in developing the practices of hope through Narrative Therapy and the practices of hope if fostered, allow the person who stutters to take actions that are meaningful to them and result in long lasting changes. The absence of long lasting change or increase in the overt symptoms, have been referred to in the literature as relapse.

8.5.4 Relapse and the Practice of Hope: a stage in the Narrative Therapy process

The Oxford English Dictionary (2016) defines hope as desire combined with expectation and hopeless as the want of hope and despair. For the purposes of this study I describe hopeless and hopelessness as the absence or the want of hope. This absence of hope may therefore be described as the lack of recognition of one's own resources combined with a lack of forward focus. This want of hope possibly is the stage that is traditionally described in the literature as "relapse". Adam's description of seeing opportunities encapsulates what it means to have hope.
Adam says:

> **Seeing opportunities… I am capable of more if I want to take that on** (Appendix E, p117, line 158)

Or indeed Hope may be an acknowledgment of own resources, but the difficulty is with Hope as an action focus practice, with moving forward, as RT described following his return to Ireland after a fluency shaping programme.

> **'You move forward...then everything, everything stops'** (Appendix C, line 356)

Engaging in cycles of attending several often radically different programmes for treating stuttering over time is often characterised in the literature as "relapse", the implication being that gains made in one intervention programme are lost and must be retrieved. This constant re-engagement has been viewed as emblematic of cycles of relapse that the person has failed to maintain changes and, therefore, is returning to therapy to regain what has been lost. The data from this study provide a contrasting characterisation: such a pattern constitutes the active practice of hope. In persisting with treatment, RT is honouring hope. He is moving forwards with each programme he attends. He brings with him strategies he has learned from each programme (voluntary stuttering is one example) and an increasing acknowledgment of his own resources. In Jason's letters (Appendix L1) however, there is an acknowledgment that the impact of stuttering varies with time and experiences and that a return to therapy brings with it a renewed sense of hope.

> **Things were going great for a few years after my first course but unfortunately the stammer has gone downhill in the last year or so.**

Hopefully the course will be of help again this time. (Appendix L1, page 186, line 6)

Exploring the experiences of the participants here through the Narrative Therapy sessions offers insights into a different understanding of this process that is referred to as relapse. In co-constructing the narratives of change, neither therapist nor client is solely responsible for the outcome, thus negating the issue of blame or failure that can accompany unsustained progress. Instead, the requirement is for the acknowledgment of resources and identifying the means of moving forward. As a shared venture, possibilities for change are explored and accepted or discarded as not relevant at this time. Movement is forward while acknowledging past actions and values that have lead to this current position, thus reflecting the hopes of the person. In reflecting historical actions while planning future possibilities the therapist encourages the person who stutters to develop a narrative of progression that is closely linked to the person's hopes.

8.5.5 Implications of hope

The twin elements of hope that emerged from this study, hope as an inner resource and hope that is future-focused with emphasis on actions, have implications not only for therapy but also for assessment. Linking to this perception of hope, the literature clearly identifies that hope can be a significant resource for people facing serious and life threatening illness (Kylmä et al., 2009; Schrank, Stanghellini, Slade, 2008). My findings also suggest that there is a role for the therapist in developing the practices of hope. This leads to the questions of how do we as therapists, and people who stutter, measure hope. Indeed is it necessary to measure hope? In order to measure hope, there has to be an understanding of what hope is for each person. Is there such a parameter as "sufficient" hope? How do we recognise what is "sufficient" hope to move forward? Is it adequate to identify hope as an inner resource or are both elements of hope necessary for progress to occur? Perhaps the absence of hope comes from not acknowledging our own resources and values and this leads to despair. I postulate here that hope and its practices are considered in the ongoing dialogue about what is described as relapse. If hope is a consideration in our conjectures about relapse, we need to ask how we use this new understanding of hope to direct our interventions. A measure of hope may allow the therapist or person who stutters to identify if therapy is appropriate at that time. It may also direct intervention towards recognising resources or readiness for taking actions. Hope therefore has implications not only for therapy, but for assessment. Future research is required to consider how hope could be meaningfully explored in the context of measuring readiness for change.

8.6 Unique outcomes

Each participant in this study identified a moment that became pivotal in the Narrative Therapy session. These moments have been referred to variously as “sparkling” or unique outcomes (White, 2007) or innovative moments (Matos et al., 2009). As previously discussed unique outcomes describe moments of significance for a person that are at odds with their usual story they tell about themselves. They are unrelated to outcomes from interventions that are described previously. As an entry point into a new and alternative story, unique outcomes serve a distinct function. In Matos et al.’s (2009) study, an attempt was made to categorize innovative moments and link them to outcomes from therapy, in order to identify the innovative moments that lead to the most successful outcomes. “Without words” (RT); “Never giving up” (Mac); “Speaking out” (Adam) involve Matos et al.’s key principles of action, reflection and protest, that exemplify unique outcomes that lead to successful outcomes from Narrative Therapy. For each of these three participants, an action taken is described, followed by a reflection on the event. These actions and reflections are ‘mapped’ for each person (see statement of position map 2 chapter 3). In this process, the person is invited to justify their action and the value they ascribe to the action. (The role of the therapist in recognising this moment, and following this entry point into an alternative story will be discussed at a later stage). In justifying actions and values, protest emerges. As RT says “I don’t do the obvious” and Mac states “that I have learned, that I have a right to, I have a right, and that I shouldn’t be afraid”. This reconceptualisation of a previous event, the reframing of an occurrence that might have been originally identified as embarrassing (getting off the bus too early/ underperforming at interview), shameful (walking off stage), or an occasion of fear (being lost in the dark) is a transformative moment in Narrative Therapy. Failure to reconceptualise this story could lead to the person’s returning to earlier stages in the process, and further detailing of the problem story.

Narrative Therapy addresses this shared understanding in the joint excavation of the problem-based narrative. Sustained positive outcomes have been reported in research (Ogden & Hills, 2008) where certain conditions were met 1) the function of the unhealthy behaviour was disrupted 2) the individual perceived that their choice over continuing the unhealthy behaviour had been reduced or limited 3) and behavioural model of treatment was adhered to. Narrative Therapy aims to disrupt the problem-based story and by doing so create an opportunity to recognise alternative ways of being and living. This reconceptualisation leads to a new awareness of personal values for the participant and the planning of future actions. It is a period of reflection and reorientation that leads to action.

8.7 Will: Actions taken

Within Narrative Therapy on the *Free to Stutter* programme, individuals identified their own unique outcomes, reauthored their narratives to embed these preferred outcomes into their own lives, galvanising them to prepare and take specific actions. The longitudinal nature of this research has allowed the observation of this process unfold from beginning to the end of the research process while acknowledging the process for many participants continues and is lifelong. The actions provide evidence for the new narrative as a way of life; Mac's social activism has resulted in a return to college and work; Kate, Tracey and Pauline completed their studies. Maura challenged herself at work and has engaged in further studies. Colm stated that he is kinder to himself and Jack is more mindful. There is evidence that empowerment arises through social action (Fisette & Walton, 2014) and, for some of the participants, this action is immediately visible, for others it is small incremental steps towards social actions and activities.

At one point in each re-authoring conversation the therapist asked the person at the centre of the Narrative Therapy session on the *Free to Stutter* programme the question 'what does this make possible for you now?' In doing so, the person is challenged to identify actions and future steps that they can take as a result of the conclusions drawn relating to their own values.

> **SLT: Plan how you are to do these things, what are your plans for your self**
> **RT: I'm goinga just start off slowly and just working everyday just what I can then I'll be going to the first review, I'll meet up with James or Frank, I might be able to get some of the feedback how I've progressed or gone backwards** (Appendix C, line 389-391)

A significant action for many of the participants appears to be linking in with others and the importance of connection is affirmed by Speedy (2004, 2008) among other authors (Epston, 1998; White, 200b).

8.7.1 A more peopled life

> Loneliness is not a longing for company; it is a longing for kind. And kind means people who can see who you are, and that means they have enough intelligence, and sensitivity and patience to do that. It also means they can accept you, because we don't see what we can't accept, we blot it out; we jam it hastily in one stereotypic box or another (French, 1997; p152).

When French (1997) writes of loneliness in her tale of feminism and voices silenced by the powerful discourses in society, she may as well be writing about the human condition in general, for people who live on the margins and for whom stories of hurt and illness are the stories of their everyday lives. For people who stutter, support groups have been found to be a significant factor in reducing internalised negative attitudes about the self (Boyle, 2013b), counteracting the isolation and self- stigma that may be a factor for people who stutter (Boyle, 2013a). In RT's Narrative Therapy sessions there are stories that he has chosen to tell; these stories represent breaches in the "canonical state of affairs" (Mattingly, 2010). They highlight the extraordinary stuff of the everyday lived experience of being a person who stutters. They are stories of escape (returning to Ireland); stories of independence and rebellion (Irish dancing and school) and stories of redemption through the development of new roles (fatherhood) and return to past hobbies (photography). There is early evidence of narrative misreading and misunderstanding by parents and schoolteachers, furthering a sense of isolation for both RT and Mac in their narratives.

Within the definitional ceremony, narrative mindreading leads to transformation. It is no coincidence that the witness in the definitional ceremony is also a person who stutters, and can identify the cultural "borderland" (Mattingly, 2010; p7) that RT inhabits. His witness shares experiences of therapeutic approaches that were not successful, and he 'gets' the stories of the group participants:

> **'I can relate to all the lads, relate to all the stories like, its very similar like. Thoughts and emotions and stuff'** (Appendix C, line 429)

The witness further identifies that a key factor for RT is that he is no longer alone.

> **cos he is not on his own any more like regards being a person with a stammer like , he has contacts** (Appendix C, line 423)

The definitional ceremony provides the link between the changes the person makes in therapy and the wider outside context in which the person lives. It addresses the twin issues of invisibility and marginality (Myerhoff, 1986) that emerge for minority groups. Provision of a definitional ceremony in many ways acknowledges the need for support in the participants' efforts to establish their preferred stories across different contexts (Leahy et al., 2012).

When transformation has occurred, particularly in an intensive therapy setting, there is the concern that the new way of thinking and being may not be well received on the return to everyday life (Manning, 2010); accommodation of new values and behaviours may be a source of conflict within the home of origin (L. Brown & Brown, 2009). Support following the intervention from the others who attended the programme is highlighted by the participants as a significant factor in moving forward. This is augmented by the continuation of the Narrative conversation made possible by the use of narrative documents. As Adam states:

> **See how it goes, to change and to adapt and to take a new perspective from here, talk to other members here or other members the self-help group in Cork, and just keep battling it** (Appendix E, line 231)

Narrative Therapy therefore provides opportunities for people who stutter to perform their story. In the *Free to Stutter Free to Speak* programme, Narrative Therapy sessions take place in small groups of three, wherein each person is supported in the re-authoring process. The group members are then invited to take part in each other's definitional ceremonies as outsider witnesses.

The definitional ceremony provides an audience of key people, giving the person an opportunity to be seen and heard, reflecting on the changes they are making and providing support to the new emerging narrative. The outsider witnesses served to amplify the changes in the new story and give "authority" to the new preferred narrative (Leahy et al, 2012; White, 1995). In performing the narrative of their lives within the definitional ceremony; "People become more conscious of themselves as they see themselves, and more conscious of their participation in the production of their productions of their lives" (White, 1995; p4).

In the definitional ceremonies reported here, both RT and Mac are struck by the reflections of their outsider witnesses and the transport that resulted for the witnesses and themselves. This is in contrast with the initial theme of Impact, where family and others have failed to acknowledge the challenges and sense of isolation experienced by people who stutter. People who stutter sometimes report that they had joined support groups demonstrated significantly higher self-esteem, self-efficacy and life satisfaction (Boyle, 2013b). The research described here indicates that for people who stutter, a key action is to link in with others, particularly those who also stutter and have shared experiences. This finding is supported by the literature (Boyle, 2013b; Yaruss et al., 2002). The definitional ceremony is an entry point to linking with others and it furthers the understanding of how important living a ‘more peopled life’ is for people who stutter. To ensure long-term progress it is important to provide opportunities as in Narrative Therapy where connections can be made with others that support the changes the person who stutters is making. A challenge to the development of such reciprocity is the isolation felt by women who stutter.

8.7.2 Women’s voices: the silent side of stuttering.

Women have typically been under-represented in research studies in stuttering, reduced to a line in participants’ details. In early childhood years, epidemiological studies have indicated that both boys and girls stutter (Yairi & Ambrose, 2013, 2005) but persistence is more common in males. Perhaps this is why women’s perspectives on this disorder have been relegated to a line on gender in results tables. At this point in time, the literature does not report on any study focused on stuttering from a uniquely female perspective. Despite the *Free to Stutter Free to Speak* programme running since 2009 there have been only six female participants over the seven years out of a total of twenty four. Of the five female participants contacted within the time frame of this research, all agreed to participate. The high number of female respondents is noteworthy relative to the proportion of females that stutter.

What is striking in the stories of the female participants in this research study is the impact of stuttering across every domain (education, occupation and relationships) resulting in avoidances of activities of daily living and yet not impacting on the articulate expressions of hope and despair. The female participants presented with less overt stuttering than the male participants but substantial covert aspects to their stuttering. In their responses to the follow up email from the researcher the female participants (four responses) highlight their outcomes from the programme in terms of participation.

> **Overall the outcome for me has turned into me been a lot more outgoing, beginning to experience and enjoy life, not letting anything or anyone hold me back anymore with the determination I now feel I have to succeed at what ever I put my mind to** (Appendix L1, page 181, line 3, Kate)

> **On a more serious note I completed the 300 hours needed for the Teaching Council unpaid in a school, it took over a school year.** (Appendix L1, p182, line 13, Pauline)
>
> **Stammering currently only has a limited impact in my life.** (Appendix L1p189, line 7, Tracey)

> **I gave a 15-minute presentation to parents and peers.**
> (Appendix L1, p191, line 13, Maura)

By contrast, all four male participants highlight the function and impairment of function that is related to their speech.

> **Still having good and bad days even good and bad hours if I'm honest** (Appendix L1, page 184, line 5, Jack)
>
> **...but unfortunately the stammer has gone downhill in the last year or so** (Appendix L1, page 186, line 6, Jason)
>
> **... My stammer has budged quite a bit over the years** (Appendix L1, page 193, line 2, Colm)
>
> **I lived through a stage where I wanted to prove I could speak in public** (Appendix L2, page 198, Adam)

Adam alone of the four respondents raised acceptance of himself as a person who stutters, though Colm reports that he is less judgmental of himself than he was previously.

Pauline, Kate, Mac, Tracey and Maura were strongly goal-oriented towards work and education. Three were students (two mature) at the time of their attendance, one was working and the fifth wished to return to study. The impact of stuttering for these women related strongly to work and educational opportunities and consequently the outcomes they identify relate to work and education. In her response, Maura talked of giving oral presentations, Pauline talked of persevering with her teacher training, Kate completing her degree and Tracey described the impact on work and school;

> **I agree with your findings, particularly in terms of the strong impact of stammering on family, work and school** (Appendix L1, line 3, Tracey

Mac also returned to education but as a mature student. Perseverance and determination were key themes for all. Humour featured strongly along with pride in accomplishments. These participants formed strong links with each other, even those from programmes that occurred on different years and maintained contact after the various course days, linking in with each other, supporting each other after the programme completed. The implication from these findings is that addressing the impact of stuttering through Narrative Therapy can lead to long-term changes in how people who stutter participate and function in their lives. It is not possible, however at this time to clarify if the female responses here are representative of the broader group of women who stutter, or the participants of this programme in particular or indeed, if they differ substantively from their male counterparts in areas other than function and participation. Comparisons at a future date could shed some further light on the outcomes for females who stutter. Acknowledging the emphasis that people who stutter place on particular outcomes, be it function or participation, directs the focus of intervention accordingly. If one of the factors directing intervention is linked to the gender of the participant potential gender differences in outcomes will need to be explored further.

8.7.3 Resources: preparation and determination

The findings from this research suggest that agency results when the person identifies their own resources and strengths. This process involves the reframing of previous experiences, highlighting resources and strengths. In Narrative Therapy, identification of resources occurs in the re-authoring conversation. It is not the role of therapist to name these resources and strengths, but rather the person themselves names identifies and names these resources and strengths. The person becomes an active participant in their own history, providing their own explanations for their destiny, past and future (White, 1995). This is described by White (2005) as reflexive self-consciousness, allowing people to assume responsibility for their own lives and identifying their own options for shaping and the production of their lives. Influential in the development of this reflexive self-consciousness is the beliefs each person has about their own health and wellbeing. These beliefs an individual has, can impact on what their desired outcomes look like.

8.8 Wellness, Health beliefs and their impact on outcomes

A healthy state is one that allows an individual to carry out the things they desire to do in their everyday life (Senior & Chenhall, 2013). The World Health Organisation's definition of health goes beyond the absence of illness, and focuses on structure, function and activity. In the absence of health there is illness, or indeed a lack of "wellness". Wellness consists of three aspects: the biomedical (absence of illness or in this case a speech disorder, stuttering), the functional (ability to carry out daily tasks, speak freely in everyday situations) and wellbeing or vitality (Bishop & Yardley, 2010).

This understanding of wellness was further acknowledged with the development of the ICF and the subsequent creation of the OASES and WASSP. As discussed earlier, the results of the standardised outcome measures in this study reflected changes to quality of life and demonstrated an increase in each individual's wellness in particular the functional and wellbeing aspects of this "wellness". These results support the themes that emerged in this current study. The themes highlight that it is the functional and wellbeing dimensions rather than the biomedical that is of prime importance to people who stutter who attended this Narrative Therapy programme. The ability to carry out the daily tasks of living without restraint, to speak one's mind, to undertake study or work without fear of restriction is paramount for the participants.

> **Mac: I want to not hold back maybe I can achieve**
> **Therapist: and what are you not going to hold back?**
> **Mac: stammering.** (Appendix D, line 126-128)

People have beliefs about the causes and solutions to their health problems (Ogden et al., 2008; Ogden et al., 2009). Both the OASES and WASSP assessments measure the impact receiving information and knowledge about stuttering has on the person's thoughts and feelings about stuttering. These beliefs may be influential in influencing the outcome of intervention as evidenced by Tracey when she talks of her beliefs about stuttering's onset and course.

> **In my experience stammering is a life long condition that has impacted me to varying degrees throughout my life** (Appendix L1, page 189, line 7)

Health beliefs relating to causation and solution of stuttering also impact on the therapy programme people choose to attend. Tracey refers to coping with stuttering as a process not a "once off fix" (L2, page 189, line 7); RT refers to a previous programme attended for fluency shaping as “Bootcamp” (Appendix C, page 30, line 136). Maura acknowledges how hope was instrumental in challenging her beliefs of a “cure” for stuttering.

> **As the week progressed, I remember getting a feeling of hope followed by a reluctant acceptance that I will never change and therefore never be ‘cured’. However, I had to accept this if I was ever going to accept my stammer in time.** (Appendix L1, page 190, lines 6)

There is hopefulness in her new understanding of stuttering. This hope is the connecting factor between her beliefs (relating to causation and solutions) and her sense of wellness.

Life and illness can also be considered within a cultural context. The story the client tells enmeshes the disease/disorder in a web of meanings that make sense only in the context of a particular life. Treatment requires the exploration of both the unique details of the client’s life combined with the shared cultural aspects that constrain his/her illness experience (Kleinman, 1988). The individual’s beliefs about causation and solutions form a central component of both their unique details and culture. The results from both the statistical analysis and the thematic analysis here suggest that Narrative Therapy allows for the creation of a shared understanding between therapist and client of the problem, its causes and the client’s preferred outcome, resulting in sustained positive outcomes.

Narrative Therapy disrupts the problem-based story during the externalisation conversation and in doing so creates an opportunity to recognise alternative ways of being and alternative ways of performing a preferred narrative. At the core of this disruption is the process whereby the therapist and the client excavate and elaborate upon a clear understanding of the person who stutters’ belief about causation and possible solutions. Following the externalisation conversation, the unique outcome stories of each participant highlight their own beliefs and values; and how these are visualised; “without words”; “speaking out” and “persistence” reflect values and “wellness” beliefs. They emphasize taking actions. This suggests that Matos et al (2009)’s study linking particular unique outcomes (those involving reconceptualising and new experiences) to positive outcomes from intervention may be open to another interpretation. I suggest that the unique outcomes here reflect individual’s health and wellness beliefs and these may be the key predictors of sustained positive outcomes.

It is important, therefore, that the focus of intervention reflects each person's health beliefs in order that the solution is congruent with these beliefs. While the scores on the OASES and WASSP reflect changes in wellness they do not specify what the individual's beliefs about wellness are, Narrative Therapy explores these beliefs with the problem-based story and in its exploration of the alternative story through the re-authoring process. The processes involved in Narrative Therapy emerge not necessarily as clearly defined stages but as overlapping conversations that require further deliberation.

8.9 Process: Stages in Therapy Outcomes

Kleinman describes how the "chronically ill live at the margins of society" (1988; p44). For people who are ill, the Illness is the lived experience of monitoring everyday bodily processes (Kleinman, 1988). For people who stutter, their daily interactions and functions are self-monitored with reference to their speech, and to their thoughts and feelings that relate to speech and speaking situations. The participants' responses to the emails and the close questioning of the therapist in Narrative Therapy reflect this preoccupation with lived experience.

The metaphor Kleinman (1988) provides of chronic illness is one of a volcano that menaces and erupts that is out of control. Stuttering too can wait silently like a volcano, erupting at unpredictable and for the person, some predictable moments. It follows the trajectory of a chronic illness in assimilating to a life course, contributing so intimately to the development of a particular life that stuttering becomes inseparable from the person's life history.

When people who stutter attend therapy, the process frequently commences with a narrative that describes the development of their stuttering and an awareness of its impact. This "illness narrative is a story that the patient tells…to give coherence to the distinctive events and long term course of suffering" (Kleinman, 1988; p49). This narrative gives shape and finality to their loss, with Mattingly (2010) describing this narrative as a kind of "biographical breakdown". The results of my research highlight the nature of this loss, the impact of stuttering on the everyday life and lived experience of the person who stutters. In this instance, Narrative Therapy is used to counteract the illness narrative, not by denying the narrative itself but by privileging the unacknowledged narrative, the unsaid hints that reflect the hopes and alternative stories that exist side by side with the problem based narrative.

The findings from this research clearly link stuttering with the ICF (WHO, 2001). Stuttering impacts on function, impacting the ability of the person who stutters to communicate, resulting in limited participation in occupational and social activities. This impact on function and participation is elicited early on in Narrative Therapy sessions. The impact of stuttering (regardless of severity of overt symptoms) is a main concern of the participants in this study. Narrative Therapy addresses the impact directly through the externalisation conversation and the statement of position map 1 (Chapter 3; Table 3.1), where the effects of the problem are mapped.

Emerging from the themes of Impact, Hope, Identity and Will is not a sense of chronology, but a sense of staging posts towards an outcome that is acceptable for the individual who stutters. These staging posts are neither limited nor defined by time, but are subject to the tricks and reversals of life and narratives. The starting point of impact appears to be significant; in addressing the problem based story in Narrative Therapy, the life limitations and difficult experiences due to the disorder are addressed, thereby addressing the functions of the problem. One can hypothesize that the individual who cannot move beyond the impact of the disorder will not be in a position to move forward with Hope. This inability to transcend Impact and address the key elements linked to the theme of Identity (particularly the subthemes of values and acceptance), lead to a greater understanding of those clients in therapy who appear “stuck” or subject to many relapses and reversals. Each participant brought “Hope” with them as discussed earlier, though the therapist had a role in developing the practices of hope. It is in the later reflections within documents that the strength of these practices of hope emerge, the humour, the pride in achievements and the sense of fulfilment. The significance of documents in furthering these practices and encouraging reflections on therapy and the purposes of the therapy is evident in the final letters of the participants.

Identity develops throughout the lifespan, it is not a single stationary entity that one can say, this is it now; this is the core sense of identity. There are influences on the development of one’s identity and within the lifespan of identity development there are stages. Narrative Therapy acknowledges the skills and values needed by the individual to move forward in a process described as the migration of identity. This process is a significant factor within the development of narratives of transition and transformation. In not abandoning who they are, the participants are encouraged to reflect on the skills and “other knowledges” that they possess and bring these forward in the process of transformation, thus fulfilling Bauer's third stage of a culturally shaped script of redemption. This script is shaped to the culture of the individual's own life and experiences.

Although Will is described last in this study, the theme of Will emerges early on, as participants' identity their own resources and values, acknowledging earlier successes, contributions made and the roles as parent or partner. In this way they start to move forward. In recognition of this, I postulate that these themes are not chronological but overlap. The role of the therapist in promoting these developments emerges as that of co-expert, in a relationship focused jointly on exploring and unpicking the workings of the problem story and identifying the resources that make future actions possible.

8.9.1 Client –Therapist relationship

The central task of any consultation between client and therapist is the co-creation or co-construction of an agreement detailing the nature of the problem that is the centre of the consultation. Such agreements are crucial in the development of an action plan and management of the presenting problem. However, discrepancies can arise when any therapist and client meet to discuss health-related issues. Ogden (2001) describes the interaction between doctor and patient as the place where a doctor not only learns about the patient's language but also reflects upon their own models and use of language. Research has concluded that GPs and patients do not have a consistent shared understanding about what constitutes good or poor health (Ogden et al., 2001; Ogden & Jubb, 2008). A lack of shared understanding of the nature of the problem can result in communication breakdown and a sense of impasse for the client. Such breakdown at the early stages may impact on the outcome of intervention.

Narrative Therapy addresses this shared understanding in the joint excavation of the problem-based narrative. In mirroring the language of the person who stutters, reflecting their own metaphors and their naming of the problem, the therapist gains an insight into the person's own understanding of what a lack of "wellness" looks and sounds like for them. By the therapist adopting this stance, the client is encouraged to assume authorship of their own life and relationships as hopes and values are identified and explored. Young et al. (2008) highlighted the effects of the narrative posture of collaboration and partnership between the therapist and the client, particularly the importance of using the client's own words in reflecting back. The therapist's role is to facilitate the building of a narrative that will make sense of and give value to the client's experience. Kleinman refers to this facilitation as "empathic listening" (1988; p50).

Core to this empathic listening is uncertainty, which must be central to the experience of the therapist as it is to the client. Narrative Therapy does not provide answers but encourages the client to decide those answers for themselves.

> **Therapist: you tell me about those events, because I don't know** (Mac; Appendix D, line 45).

This enquiry is genuine and creates a sense that therapy is collaboration and the client a colleague and a co researcher in excavating the problem narrative. Therapists place themselves in the lived experience of the patients' illness by listening to person's narrative (Kleinman, 1988) and by doing so Mattingly and Lawlor (2001) suggest that the therapist creates moments in therapy which are open to possibilities and recognition of capabilities. These moments are referred to as healing dramas (Mattingly & Lawlor, 2001; p31); moments when something is at stake for the person. A healing drama emerges initially through talk supported by the therapist that becomes embodied and performed within the session.

> **Therapist: so it's really important to try and attend… It is very important for you to be there.** (Appendix D, line 54)

The role of the therapist is to recognise possibilities and sites for transformation. Mattingly and Lawlor (2001) give examples of such healing dramas and recognise how such dramas can be suppressed by a clinical culture given to value the routine over the dramatic; where diagnosis frames what we recognise as appropriate treatment and where there is a disconnect between what we believe to be important for our client at one level and what our professional knowledge claims to know. This discussion of other knowledges echoes the writing of Foucault (Foucault, 1980) on naive knowledges which are undervalued in comparison to other more expert knowledges. For example, scientific knowledge may have a higher status on the hierarchy of power than more local or traditional knowledge (White, 2007).

Narrative Therapy focuses on individual, personal knowledges as opposed to professional knowledges. It gives testimony to the benefits of relinquishing power, valuing these other client-centered knowledges, and trusting in the client in creating a therapeutic alliance that is of a different nature to that in more traditional approaches to therapy for stuttering (Leahy et al., 2012). In elaborating on narrative phenomenology, Mattingly (2010) describes a framework for hearing stories of despair and hope. Narrative mind reading, narrative emplotment or narrative pre-understandings and storytelling are the narrative acts described.

In narrative mindreading we ascribe motives to those around us. We place actions in contexts that allow us to make meaning from them. Such narrative apprehensions are socially and culturally rooted. In the Narrative Therapy sessions here, the therapist, in an effort to understand the meaning behind the actions of the client, asks them what the purpose behind the action was or the value that the person links to that action.

> **Therapist: So, it was a challenge. So what does the fact that while you initially found it difficult to make a success of taking care of the children say about what is of most value to you?** (Appendix E, lines 145-146)

In Narrative Therapy, the therapist does not assume that her interpretation will be accurate or indeed that her interpretation is the ‘right’ one.

> **Therapist: well, a change of tactic, great to be able to change, just to be, flexible, that’s the word coming to me. To be flexible in yourself**
> **Adam: yeah.**
> **Therapist: does that word fit for you, or is there a word that fits better?** (Appendix E, lines 207-210)

In this way, choice of language and a negotiated language for the problem or value in this case under discussion impacts on client goals. By carefully negotiating a word that accurately describes their values, and identifying what they aspire to, the client starts to progress forwards. In the same way, what clients choose to believe about causation impacts on treatment and they may neglect alternative solutions that do not fit with their beliefs about causation.

Having a choice has been found to be a greater predictor of outcome than the act of making a choice (Ogden, Daniells & Barnett, 2009). Choice is also recognised as impacting on intrinsic motivation, task performance and life skills (Ogden et al., 2002; Ogden et al., 2009). In Narrative Therapy, the choice is offered from the beginning, when the therapist invites the person to talk about the problem that concerns them, the story that is significant to them. And so in having a choice of topic for discussion, emplotment is co constructed as the therapist and the client negotiate and create a plot structure within the clinical time (Del Vecchio Good, Munakata, Kobayashi, Mattingly & Good, 1994). Recognising the components of this framework allows the forward movement of the story. White and Epston (1990) describe how this forward movement engenders a search for new meanings and new possibilities. This search for new meaning for events is evident in the discussion between Adam and the therapist as they carefully negotiate an understanding of what it has meant to stay at home with his children.

Mattingly (1994) talks of time as a key element in therapeutic emplotment; a whole is created out of a succession of events occurring over time. Narrative time is configured. Each event that occurs may have significance as well as contributing to a sense of the whole story. Action and motive are key structuring devices. The individual actions and motives of different people create narrative time. Narrative time is about movement; moving towards a desired endpoint.

Therapist: From seven roughly, that's when you remember him from?
RT: yeh.
SLT: and you left school.
What age did you leave school at?
RT: 15 (Appendix C, p14, lines 18-22)

Del Vecchio Good et al., (1994), use narrative theory to examine how physicians create therapeutic progress, desire and hope while structuring clinical time. Mattingly's (1994) description of narrative time and therapeutic emplotment is derived from a study of field notes involving a patient with serious injuries in which she describes the role of the therapist as setting in motion a story that is meaningful to both therapist and client. In Narrative Therapy, narratives are told about times of trouble and transformation, suspenseful time and motives (human time); a desire for things to be different.

When RT tells the story from the point of view of his stutter it is time on which the story hangs. He references events from childhood, schooling and adulthood. The therapist questions him about events leading to an understanding of the values that he holds. In Narrative Therapy this is described as double listening, in describing what a person fears or despairs against their values and desires emerge (White, 2005).There is a sense of regret and loss with the telling linked to time that has passed and opportunities missed;

'Stupidity. It was you know no need for it' (Appendix C, p41-42, lines 63-64)

Drawing the story together over time, describing the times of trouble (leaving school early) and transformation:

> **'I just (clicked fingers) happened, I just got the idea I was just like (demonstrates motorbike). It was hundreds of people going 'what!'** (Appendix C, p37, line 26)

When RT talks of walking away from therapy:

> **'One day I just left, back to Ireland'** (Appendix C, p47, line 107-108)

This statement reminds and reinforces that for some individuals compliance can be a "terrible thing" (Mattingly, 2010; p111) for the individual, with a cost that perhaps does not fit with the story that they wish to tell honouring their values. The creation of an intelligible story for the person at the centre of the action is vital to their sense that life is meaningful (Mattingly, 1994) as the stories we tell are shaped by our motives and intents.

One of the prerequisites for the forward movement of the story in Narrative Therapy is the shared understanding of the person in therapy and the therapist of what this forward movement should look like. In each interaction there can be multiple narratives; one for family, one for the patient and one for other professionals (Del Vecchio Good et al., 1994). This multiplicity of narratives has been reflected in the previous IPA analysis of a definitional ceremony (Leahy et al., 2012) and highlights the importance of the stance taken by the therapist of curious partner in unpicking the problem narrative rather than as an 'expert' professional passing judgement or making diagnoses.

> **The role of the therapist is for me a facilitator. I see you as someone nurturing and developing this. But fundamentally you become a motor bus conductor; you just have to prod and poke (wrong words) and get me to hold my stutter. Live with it, accept it. And that for me is my inner peace. I don't have to fight this. I don't have to struggle with this.** (Appendix L2, page 197)

The process of Narrative Therapy is engendered by the emergence of a strong therapist client relationship that has been reported in previous literature as a common factor in successful treatment (Plexico et al., 2005, 2010). In Narrative Therapy this relationship is one in equal measures, of equality and curiosity. The reflective nature of the questions, with movement across a timeline of past, present and future actions provides opportunities to create staging posts towards outcomes that are acceptable and indeed desired by the client.

Chapter 9

Implications from the research findings, methods and beyond

In considering the themes that emerged from this study in conjunction with the results from the statistical analysis it is clear that Narrative Therapy has some interesting and informative things to say about people who stutter and the problems that are present in their lives. The findings from this research suggest that the role of the therapist in Narrative Therapy in engendering hope, acknowledging impact and uncovering values that lead to action is a significant positive factor in reaching outcomes.

The outcomes that emerged relate explicitly to reduction of Impact, addressing work, education and relationships. In reducing Impact, Hope identifies what is possible for the future, recognising core values and beliefs of each individual. In this way, outcomes are individualised and real, elaborating upon the person's own sense of wellness and vitality. In the following section, I discuss the implications of these findings, firstly how best to use narratives to individualise assessment and therapy to the person; how this research adds to the data on outcomes and on "relapse"; the use of documents in Narrative Therapy and the potential in relation to people who stutter; finally I reflect on the process of this research itself.

9.1 Stories can help identify a suitable therapy approach

The level of fluency (or stuttering) a person exhibits may be only moderately related—or even unrelated—to the adverse impact he or she experiences (Blumgart, Tran, Yaruss & Craig, 2012; Koedoot, Versteegh & Yaruss, 2011; Yaruss, Coleman, Quesal & Conture, 2012). Careful consideration and consultation with the client are required when identifying suitable therapy approaches. This research indicates that the impact of stuttering in conjunction with the overt behaviours is a primary concern for people who stutter and this factor needs to be addressed when considering intervention. The initial problem-based story as detailed and performed by the client is the key to identifying suitable therapeutic approaches. The externalisation conversation outlining the effects of the problem clearly indicates if the impact of stuttering is such that an approach including addressing thoughts and feelings about stuttering is required, or whether an approach focusing on overt stuttering behaviours is more relevant to the person who stutters.

9.2 Assessment

Assessment for people who stutter has been contentious, with disagreement over the focus of the assessment (what should be measured) and who does the measuring. As if in response to this position, Narrative Therapy does not involve a traditional assessment. It does not engage with this debate. The person who presents for therapy determines whether or not the problem requires intervention. The problem that is presented at the onset of therapy is the problem of concern to the person. The therapist does not decide upon the problem or the starting point of therapy nor the end point of therapy. This perspective can be a challenging point for Speech and Language Therapists, within a care system where traditionally outcomes need to be quantifiable in order to evaluate service delivery and treatment efficacy.

The purpose of assessments for people who stutter have traditionally been twofold: (a) the identification of fluency disorder with the detailed description of particular speech behaviours and an evaluation of thoughts/feelings/attitudes to communication of the person in order to have a baseline measure and plan therapy; and (b) use of these measures as a method of recording change over time and outcomes from therapy. Uncertainty or indeed allegiance to a particular approach, be it fluency shaping to target overt symptoms or stuttering modification to target the covert symptoms, has led to the use of multiple assessment measures for this particular client group. Researchers have used up to ten different measures in some studies exploring stuttering, measures of anxiety, attitudes to change, percentages of syllables stuttered and measures of speech naturalness and speech rate. In this study, results from both the OASES and WASSP were very similar, suggesting it would have been sufficient to administer only one of them. The OASES contains over one hundred items and is suitable for most participants; however for those where literacy is an issue the shorter WASSP may be more appropriate. The S24 results may be influenced by extraversion factors and therefore may perhaps not be as appropriate to measure outcomes from therapy for people who stutter, though Stipdonk et al., (2015) suggest that it can be used to explore personality types with a view to selecting appropriate therapy approaches.

In a therapist’s attempts to uncover every aspect of stuttering, the person at the centre of the process may become invisible and marginalised. Narrative Therapy is concerned with such issues of invisibility and marginality. It centres the person who stutters as the focus of therapy. The person’s story is the key, not the results of multiple administered assessments. Many of our assessment tools may overlap as they attempt to measure across the same parameters, indicating that it is not necessary to use multiple assessments.

The problem story itself as told by the person who stutters is the starting point in therapy in a Narrative Therapy approach. Concerned as it is with the person naming the problem, followed by a detailed description of the effects of the problem (Ryan et al., 2015), the impact of stuttering is highlighted, clearly identifying the limitations to function and participation. The difference between telling a problem story and the process involved in Narrative Therapy is that in Narrative Therapy, the therapist invites the person to take a position on the problem and its effects. This functions therefore as the assessment, and serves as a baseline measure from which people who stutter can explore and reflect on the changes that they are making.

9.3 Narrative Therapy highlights requirements for action or agency

With the emergence of the problem story, as in statement of position map 1 (see chapter 3) the person takes a position on the problem and then justifies this position. In taking a position, readiness for action and agency may be determined. If the impact of the problem is such that the limitations to activities of daily living and quality of life are considerable, then the person may be more willing to engage in action to reduce the impact. For the participants in this study, the impact of stuttering extended across many domains: family, education, work, suffering and a feeling of powerlessness. The impact and feelings relating to stuttering are reflected in their OASES and WASSP scores taken pre-intervention. Both RT and Mac had total

OASES scores in the severe range and Adam's score was in the moderate range. It is possible to hypothesize therefore that the externalisation conversation, as documented in the first statement of position map, links with the OASES and WASSP scores. In detailing the impact of stuttering, the person who stutters and the therapist could be described as co-constructing a narrative about assessment. The narrative is describing the problems experienced by the person who stutters, and gives space within the therapeutic setting to explore whether the person feels it is the right time for change, or indeed whether change is necessary.

9.4 Outcomes from Narrative Therapy

Outcomes from Narrative Therapy for people who stutter have not been documented until now. The process has been explored (O'Connor et al., 1997; Ramey et al., 2010) and at least one attempt has been made to link the particular process within Narrative Therapy with the final therapy outcome, though that study explored domestic violence (Matos et al., 2009). This current study, despite limited numbers, is the first attempt to describe outcomes from Narrative Therapy for a small cohort of people who stutter. It adds in some small way to the collection of evidence for Narrative Therapy as a means of engaging with the problems experienced by people who stutter. In linking the outcomes from the IPA analysis with the statistical analysis of the OASES and WASSP scores, the aim was to see if there was 'good fit' between the two and if the standardised measures backed up the IPA analysis and lent weight to the proposed findings.

Previous possible outcomes from Narrative Therapy suggested by Speedy (2008) included "living a more peopled life" and discharging oneself from therapy; however these were hypotheses derived from many years of clinical experience. Therefore it is encouraging to reflect that the data from the study reported here does support these hypotheses, acknowledging the importance of connecting with others and the participants arriving at a place where therapy is no longer required, as they take action themselves in support of their own values.

This study underscores the significance of increased function and participation as outcomes for some people who stutter. It is not enough to have a reduction in overt stuttering behaviours, it is the increased "wellness" and vitality of a life lived, knowing who you are and acting in a manner that reflects values, ideas and expressions that emerged as important in the analysis of the data. Hope with humour, pride and fulfilment matter. A reduction in hope can result in reduced awareness of one's own resources and consequent failure to move forward. Weingarten (2010; p7) describes reasonable hope as "working not waiting; we scaffold ourselves to prepare for the future".

9.5 'Relapse'.

Despite apparent "success" in therapy, relapse to previous levels of stuttering and attitudes, feelings and thoughts, has been reported frequently in the literature, particularly following fluency shaping programmes where the emphasis and intended outcome is fluent speech (Block et al., 2005; Blomgren, Roy, Callister & Merill, 2005; Bothe, 2003; Herder et al, 2006, Kuhr & Rustin, 1985; Langevin, Kully, Teshima, Hagler, Prasad, 2010; O'Brian et al., 2003). An early question that arose within the current study was whether relapse or reversion to the original story was observable within the transcripts of the Narrative Therapy sessions. The re-occurrence or return to earlier aspects of the problem-based story in Narrative Therapy has not been reported in the literature and there appears to be, as of yet, no narrative explanation for what has been described in some literature as relapse. One of the questions pondered is whether the analysis of narratives clarifies the role or story of relapse relating to people who stutter. In one study, Del Vecchio Good, Munakata, Kobayashi, Mattingly, and Good (1994) describe narratives of immediacy, hope, struggle and progress fragmented, echoed by Mattingly (1994); "Chronic illness and suffering often generate a narrative loss as well as physical loss, the fracturing of a life story as patients restructure their lives in new ways" (p814).

Relapse in Narrative Therapy is not a return to the beginning or a prior stage in therapy, but a narrative of progress that is ongoing yet fragmented. People and things change over time in a non-linear fashion; there are "tricks and reversals" (Mattingly, 1994). With each twist and turn in the story, the story becomes more detailed and elaborate and each "trick or reversal" is significant, in that they may be sites for future transformation. Examples of such reversals include RT's return to the "old ways" after a programme, Jason's speech having "gone downhill" and Jack's "good and bad days and hours". Each leads to further questions in narrative conversations. An example would be to ask RT to elaborate on the "new ways" that contrast with the old or to ask Jason to describe what it is like to be "on top of the hill".

As with all narratives, the endings are uncertain and unpredictable, but it is recognising the tricks and reversals as sites for transformation that allows for change in Narrative Therapy. These “tricks and reversals” enhance our understanding of what is often termed relapse. With each reversal the illness story is developed further, as the person describes an action, reflects and protests and with each subsequent retelling move towards reconceptualisation and further action. An example of such reconceptualisation is Pauline’s reframing of other people’s responses.

> **Up to now I have always linked negative response or indifference from people as being mainly due to my stutter. Even though I still have negative thoughts like I mentioned above I question them, am more objective** (Pauline; Appendix L1, p4)

The therapist has a role in identifying these moments. Therefore the therapist him/herself is crucial in this process and the outcome can be dependent on the relationship that exists between the person who stutters and the therapist. This relationship is enhanced by the use of documents; letters and emails that serve to “continue the conversation” between sessions or review days.

9. 6 Documents in Narrative Therapy: A narrative of resistance

“The recording of a case is a profound ritual act of transformation through which illness is made over into disease, person becomes patient, and professional values are transferred from the practioner to the ‘case” (Kleinman, 1988; p130). Case files are the property through the HSE of the person about whom they are written, and may be accessed through the Freedom of Information act. However, for many people these files are seen only on the desk of the professional, unshared before being put away in a filing cabinet. They are referred to as “case” files. The professional is concerned with documenting the progress or otherwise of the “disease” or “disorder” and sometimes the impact on the patient.

Alongside this concern for documentation is the desire to reflect best clinical practice in a clearly written format. Such documentation has a purpose and a significance within health professional spheres, serving as evidence to a service delivered that is quality assured and measurable. In doing so, the therapist or practioner may record very little of the words of the participant. Indeed the participant may be lost in translation. There may be no sense of the person within the case file at all, without any reference to the words spoken by them or the process they are personally engaged in. Mattingly and Lawlor (2001) describe how transformative moments are not recorded in notes, and may be described dismissively in conversation by both therapists and medical staff.

The use of documents in Narrative Therapy, as previously described, serves a particular purpose. These documents serve to validate the experiences of the person who stutters, using the words of the person themselves to record moments of change and significance in therapy. They become a record of times of transformation and struggle. Therapeutic documents can be seen to consolidate and to thicken stories that are only faintly held onto (Speedy, 2004b). They may also lend authority to the stories being told. In the study reported here, therapeutic documents served a dual purpose. The maps taken at the time of the sessions validated the transcripts of the research and for the person who stutters, served as a reminder of the process that they participated in, a reminder also of possible future actions. The letters and emails between the sessions maintained the momentum of change, encouraging the person to continue the reauthoring process and plan future actions. Alongside the letters, the recording of White's statement of position and reauthoring conversation maps (Appendix G) have been kept and maintained by the participants.

The significance of the act of recording cannot be underestimated. On the completion of both Adam and Mac's Narrative Therapy sessions, there were moments of reflection and review, when the therapist revisited the map and sought confirmation not alone of the story that the person has told, but also of the particular words used. In doing so, the words of the participant were highlighted further and given a value above that of the interpretation of the therapist. This has implications for the therapist in how notes are kept following sessions and how correspondence between therapist and client is conducted. It is a possibility that in the future a "library of change" may exist to follow from Epston's "Archives of Resistance" (Epston, 1998) to anorexia. This library may consist of the maps and additional personal letters of people who stutter not as testimonials to therapy but as personal testimony to the process they engaged in resisting the impact of stuttering on their lives.

9.7 Research Process

9.7.1 Critical reflections: strengths and limitations of this study

It is inevitable in any research like this that there are a number of aspects that limit the impact of the results. As a small-scale study with eleven participants, it is limited like all qualitative research as to generalizability. However, the aim was not to make generalisations but to open up this area to scrutiny, to explore outcomes from Narrative Therapy for people who stutter. As is usual with qualitative research, the sample size is small and the method of sampling was purposive. Furthermore, the purposive nature of the sampling meant that people with alternative viewpoints were not included, for example, people who felt that Narrative Therapy was not the approach for them or people who stutter who do not receive therapy. The study participants had all engaged with Narrative Therapy and may have been more positive in their feedback views (see participants' letters) than those who had decided not to participate in the study, though Jason's response describing his current difficulties provides a counterpoint to the positive feedback. Triangulation letters were returned in this instance with the knowledge that the authors were identifiable, no gatekeeper was used because having consented to the study it was required that their letters be linked to their own data. However in doing this, the tone of the feedback may have been influenced in a positive way.

A further potential source of bias in this study is the gender ratio. Stuttering as a disorder is widely regarded as affecting more males than females (ratio of 5:1) (Yairi & Ambrose, 2005) but this sample of eleven has five female participants and this may have impacted on the results in some as yet undetermined way. One may wonder whether females for some unspecified reason are more likely to participate in research studies, though if so this "bias" could be found in all published research. Gender participation is not an element that this researcher could control for as all participants of the *Free to Stutter Free to Stutter* programme were contacted through a gatekeeper and invited to participate. As with qualitative studies in general, there was no control group for this study. It might have been interesting to contrast the outcomes from Narrative Therapy for people presenting with different communication disorders, or a cohort of people who stutter who had not been in receipt of Narrative Therapy but an alternative treatment. The majority of the participants were within a similar age bracket of twenties to forties and again this was dependent on those who participated within the programme.

9.7.2 Technical issues

This study utilised video recordings of Narrative Therapy sessions taken over a three-year period. The original purpose of these recordings was not for research purposes but for development of personal clinical skills as I and a colleague began to work in Narrative Therapy. Following Narrative Therapy sessions, the videos were reviewed to enhance our understanding of the practices of Narrative Therapy and to develop further lines of narrative enquiry for the following session. It is humbling now, to review sessions from six years ago and identify points of significance missed and questions that could have been asked. In stumbling through Narrative Therapy then, I acknowledge now the power of co-excavating the problem narrative and how people get there in spite of their therapist's inexperience. As these videos were not for research purposes, there were problems with quality of recordings. In particular, I reflect with upset the definitional ceremony RT was central in, a year after the programme wherein he identified the "spark was me" (Appendix L), a very powerful and moving ceremony, totally inaudible due to faulty equipment and therefore not included in this research.

9.7.3 Critically reviewing Narrative Therapy

It is important to acknowledge that the development of Narrative Therapy has not been without criticism. Narrative Therapy has arisen from a postmodern background. The central tenet of Narrative Therapy is a way of knowing the self as constructed through and in language with others; it is referred to as a "storied self" (Speedy, 2008; White, 2007). In Narrative Therapy, the self is "relational, fluid and exists in narrative form" (Flaskas, 1999; p21). This is in direct contrast to the modernist understanding of the self as a concrete entity, a thing that can be observed, recorded and discovered. Modernism assumes that the object under investigation has a reality separate to the person investigating it. Post modernism, from which Narrative Therapy arises, sees the self as self-in action, constantly created and co-created in relationships and in language with others. Self is not a discrete entity, rather it is 'multileveled' with narratives formed not just in the context of friends and family, but created within our wider social network, acknowledging the culture, class, race and religion and the powerful institutional realities of our society, for example justice systems and politics (Foucault, 1980; Madigan & Law, 1992).

Flaskas (1999) critiques this view of the self as post-modern and narrative with a three-pronged approach. She writes that narrative is but one way of knowing the self. According to Flaskas, people report a sense of a 'core' self rather than a narrative self that is co-constructed through language. She quotes Paterson (1996) as recognising a dual notion of self, (i.e., an autonomous or core self and a relational self). In contrast to this, White (1990, 2007) contended that people constitute discourse and are constituted through discourse, that is, we speak ourselves into existence by performing specific discourse. Flaskas's (1999) second point concerns how Narrative Therapy encourages awareness and use of capacities and strengths that the client has. However, limits go hand in hand with capacities (Flaskas, 1999) and there are limits to the possibilities we have for our lives. Flaskas describes realness to the social and interpersonal contexts in which we live that she feels is not acknowledged in a narrative understanding of the self. Her third and final point challenges the narrative and postmodern statement that we can only know our self through language. Her alternative is to acknowledge the 'pre languaged self': we have experience that exists outside language, (e.g., early attachment patterns and emotional experience that exists outside words).

In contrast to Flaskas's views, as a Speech and Language Therapist by profession, I recognise that within Narrative Therapy the emphasis is on "discourse and discursive practices" rather than on "language". Discursive acts indeed can reflect the pre-languaged self, discourse describes the way meanings are generated and exchanged by people in real-life contexts (Graddol, 1994). Discourse is a crucial level in all types of human linguistic communication; it is impossible to communicate without understanding the coherence between utterances (Sanders & Spooren, 2015). Discourse situates the story being told within the context of a wider discourse and the speaker-hearer relationship, and these relationships may be signalled by the use of discourse markers (Heine, 2013). Unlike language, discourse and discursive acts put the emphasis firmly on particular sets of actions (Madigan & Law, 1992).

In acknowledging the post-modern stance of Narrative Therapy, I acknowledge the move away from the concept of "expert knowledge" and language, and recognise the performance of each of these stories. The role of the person as expert on their own lives and their own problems is reflected in this postmodernist stance, and contrasts directly with the traditional attendance at therapy with an "expert" to analyse and treat the presenting problem. The problem is just the problem; the person at the centre of the narrative names the problem, and with an increasing sense of agency from this process, works towards an alternative way of living and storying their life.

Narrative Therapy is neither driven nor restricted by time. Unlike some programmes addressing stuttering there is no understanding that goals will be met within a particular time frame. Success is not measured by the time taken to reauthor the story. Indeed, in Adam's earlier conversation (Appendix E, page 95 onwards) it is noted by the therapist how he externalised the problem within one session. Externalisation within one session has also been reported in earlier research by Ramey et al. (2009, 2010). The continuation of the Narrative Therapy process between sessions by email or letter allows a certain flexibility that may be conducive to its implementation within the Irish health services. Although in the intensive programme described (*Free to Stutter...Free to Speak*) Narrative Therapy occurs on a daily basis this is not an essential requirement and it is frequently described as occurring on a weekly or monthly basis (Speedy, 2008; White, 2007).

However, for the novice practioner, support and training is a requirement. Team working for support and reflection is detailed in the Narrative Therapy literature (White, 1995) and within the current health service constraints there are challenges with this approach to multidisciplinary working. At this current time of constraints and cutbacks within the health service it may not be feasible to provide the support necessary when experienced Narrative Therapy practitioners within the Speech and Language Therapy profession are few and far between.

The application of Narrative Therapy to Child and Adolescent Mental Health Services (CAMHS) (Jørring and Jacobsen, 2014) and to the everyday classroom problems experienced by children (Hegarty, 2012) demonstrates that Narrative Therapy has increasingly broad applications. The flexibility of an approach such as Narrative Therapy that is not devised for the treatment of a single disorder, but instead focuses on the skills and knowledges of the person themselves lends itself to a health service that aspires to put the needs of people to the forefront of its endeavours.

9.7.4 Critical reflections on IPA

A detailed in-depth study of narratives will not have the impact of a large-scale random controlled trial. In pursuing a qualitative analysis of narratives it is acknowledged that the sample size will necessarily be reduced. In acknowledging this shortcoming, however, it is important to reflect on the choice of IPA over other qualitative approaches. IPA was selected because it reflected the need for in depth interpretation and acknowledged the use and power of language. This phenomenological approach of IPA very powerfully accesses the experiences of peoples in their own words, treating them as experts on their own lives and as such provides a comfortable synchrony with Narrative Therapy and the underpinning philosophy of Foucault. The evidence for the themes that emerged, are the words of the participants themselves.

The challenges of pursuing a phenomenological approach are linked closely with the process itself, the very immersion in data required for interpretation and analysis can lead to charges of bias. To ensure validity and reliability, a rigorous approach to analysis is required, with reflection, supervision and peer discussion. Disconfirming case analysis, if possible, is also a key factor to this process. In attempting bracketing, this researcher acknowledges the likelihood that one can never truly bracket every thought, emotion and past experience or preconceived beliefs: the key to bracketing is to acknowledge these thoughts, emotions and experiences, reflect on them and move onwards. As a researcher immersed in the data, the themes that emerged describing the phenomenon of outcomes form Narrative Therapy become personalised. The process of immersion is such that this description of the phenomenon may be too closely experienced and not as transparent to the reader as it is to the researcher. There is also a risk within IPA that the researcher may focus on one or two aspects of the coding only and unintentionally neglect aspects within her own analysis, seeing only what is apparent to her and letting her unintentional bias shine to the fore. In seeing themes emerge, the phenomenon itself may be neglected. Brocki and Wearder (2004) highlight in a review of IPA studies that rarely the questions are included when describing the semi-structured interview that took place and this does little to ameliorate the development of bias. In this current research, by using past Narrative Therapy sessions for analysis, sessions that were recorded for therapeutic purposes rather than research, the likelihood of interviewing bias by the researcher is reduced. The challenge here was giving equal weight to all aspects of the analysis, the linguistic as well as the emergent themes and identifying how they worked together to form a cohesive whole.

Exploring outcomes for people who stutter and their particular experiences of a Narrative Therapy programme involving the application of IPA was not without its challenges. While the themes that emerged were rich and detailed in the process of Narrative Therapy leading to the outcomes; to complete this process, an interview with each of the three participants followed by IPA analysis might have furnished further evidence of the participants' experience of outcomes.

The use of IPA has been documented in many studies describing various phenomena as experienced by individuals, including management of stuttering (Plexico et al., 2005, 2010). A quarter of all IPA studies surveyed by Smith (2011) described peoples' experience of illness yet there are no published articles to date, describing its applications to outcomes. In applying IPA the process leading to outcomes is highlighted as well as the outcomes themselves.

In considering IPA as a methodology it must be considered whether a different approach would have addressed the issues reported in this research in a more meaningful way and led to similar or indeed different findings. Key to understanding why IPA was selected is to reflect on the rationale behind it; IPA researchers analyse what people say in order to understand how they are making sense of their experience. It is a linguistically based approach concerned with close reading of participants' reports (Smith, 2011). An alternative methodology such as discourse analysis, while also linguistically based, examines what participants say in order to learn about how they are constructing accounts of experience (Smith, 2011; Smith et al., 2009). IPA focuses on peoples' different understandings of their experiences in an attempt to understand a phenomenon. This understanding of participants' experience of Narrative Therapy was felt to be a key component in exploring their outcomes that are reported from the statistical analysis. Smith (2011b) suggests that IPA lends itself to mixed method studies as described here but few guidelines are recommended to ensure the balance between qualitative and quantitative findings is reached. This researcher attempted to ensure and demonstrate rigour in both qualitative and quantitative methods by the detailed recording and reporting of the systematic collection of the data, the detailing of the data sources, and providing a detailed description of how the data was analysed with the inclusion of process logs. In this research, the precepts of Smith (Smith, 2011b; p60) were followed as closely as possible when he states;

"For me, a good paper, whether qualitative or quantitative, shows us what the data are, how the data were obtained, and what the data means."

9.7.5 Therapist, Researcher, Service Provider

Thoreau (1910; p3) wrote of the challenges of describing experiences from one's own perspective:

> "In most books, the *I*, or first person, is omitted; in this it will be retained; that, in respect to egotism is the main difference. We commonly do not remember that it is, after all, always the first person that is speaking. I should not talk so much about myself if there were anybody else whom I knew as well. Unfortunately, I am confined to this theme by the narrowness of my experience."

In describing any experience, it is imperative to acknowledge the unspoken "I" that is the author of the text. As described earlier, there is a risk of researcher bias in any study requiring interpretation. However, in the research reported here, the researcher had three different roles. The first was as Speech and Language Therapist in the employ of the HSE South, and in this role I provided a service to the people who stutter who took part in this study. Indeed it was this work that fuelled my interest in this research and drove it forward. While my work formed the impetus for the research it also as Thoreau suggests, confined the research to the narrowness of my own experience and interest.

In undertaking the second role as researcher, I became aware through the reflective process of the challenges inherent in having dual roles and reflecting for the purposes of research on one's own work. I attempted to address this by the inclusion of the Narrative Therapy recordings of a second Speech and Language Therapist.

As the research neared the end, the third and most silent and heretofore unacknowledged role emerged. As a healthcare professional in the employ of a Healthcare provider there is an onus to provide timely and effective intervention and I began to reflect on whether there was a need within to justify a novel approach to the treatment of stuttering. The systems reported in Chapter 4 to ensure reliability and validity provided necessary counterbalance.

9.8 Future Signposts

9.8.1 Signposts for research

It would be beneficial to replicate the study across another sample and extend the database on outcomes from Narrative Therapy. With a wider cohort, it might be possible to identify particular unique outcomes that relate to increased agency and action. Furthermore, it would be interesting to explore and analyse narratives from other programmes for people who stutter. In particular, future research might explore and contrast Narrative Therapy with alternative approaches that address the covert aspects of stuttering (the thoughts and feelings associated with stuttering) such as CBT. The analysis of the narratives from people who stutter not involved in therapy could also provide an interesting contrast to the data here. There is some data on late recovery from stuttering in the literature, but so much is still unknown about late recovery and the narratives from that cohort could potentially enhance our understanding of recovery. Of particular interest to me, the use of documents in therapy, maps, emails and letters, requires further exploration. FTS is an intensive programme and as such not easily accessible to all potential participants. Further research might explore whether the intensive nature is an essential component of the treatment or whether a non-intensive programme would be as beneficial.

9.8.2 Signposts for Therapy

Reduction or amelioration of the impact of stuttering is an important factor for people who stutter. How the therapist chooses to address this with a person who stutters requires careful consideration. The role of the therapist and the positioning of the self as non-expert could be a key factor as suggested here. Definitional ceremonies, the team of life exercise and reflecting teams with the involvement of carefully chosen outsider witnesses, are some ways in which a therapist could include the family of the person who stutters and significant others into the therapy session and broaden the support network for the person who stutters, creating a “more peopled life”.

9.8.3 Documents

The fact that the folders participants took away with them from the end of the programme are still present in their lives, with many reflecting on them years later, is testimony to the power of documents. Emails and letters of narrative enquiry never went unanswered from participants and they became the “lifeline to the self” that Epston describes. They allowed space to reflect on the previous narrative sessions and forward movement in the stories, embedding them further as the new preferred narratives. Acknowledging the power of the person’s own words, reflected back to them in writing either through narrative maps or letters after sessions, centres the person who stutters and their problem story as the focus of the therapy, and rebalances any power differentials that exist. It is worth exploring the impact of documents further through research and through clinical practice.

9.9 Conclusion

This research was driven by a need to further understand and explore the nature of stuttering, particularly the assessment and measurement of stuttering. The flaws that were evident to the researcher in the assessment process (who measures and what are we measuring) became particularly conspicuous at the juncture when this researcher and a colleague were developing a new programme for people who stutter, incorporating Narrative Therapy. In our efforts to provide a quality, evidence-based service, a plethora of standardised assessments were explored and discarded as time consuming, unavailable or impractical. In conclusion, assessments of the overt features were completed with the Stuttering Severity Instrument 4th edition (SSI4) (Riley, 2009) and covert features with the OASES, WASSP and S24. Yet, while the results from the programme appeared promising they did not address what the real nature of outcomes was for people who stuttered from this particular Narrative Therapy intervention.

The research reported here tentatively documents perceived outcomes that counter the impact of stuttering, addressing issues of invisibility and marginality. Outcomes relate to a sense of “Wellness”, a sense of our being in the world, a particularly phenomenological response to the research question. This process of exploring outcomes is not yet complete, and in many ways has only begun.

This study concludes on the same note it began, with Jack running out of the bank humiliated. In a world where stuttering is a feature of the daily life of 1% of the population, the inability to provide consistent intervention with meaningful outcomes for the person who stutters is not this researcher’s only concern. Acceptance of difference, positive reactions from the bank teller might have made all the difference to Jack’s experience that day in the bank. Intervention that reduces the impact of stuttering requires the involvement of the wider community in which the person who stutters lives.

Jack succeeded in emigrating. He is employed but misses home. He married and knows it is unlikely he will return to Ireland to live. He feels less an outsider there, than he was here. His life is one of activity and social participation. He requested the names of Speech and Language Therapy contacts for his new country, but did not like the therapy on offer as it focused on speech correction, on fluency shaping only.

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