TWO CASES OF RE-EMERGENT STUTTERING IN PARKINSON’S DISEASE

Ryan A. Millager*, Laura Z. Ferriero*, Alina Carter*, & Ellen M. Kelly†

*Massachusetts General Hospital  †Vanderbilt University

TREATMENT CONSIDERATIONS

Counseling & patient education
• Solution-Focused Brief Therapy (Burns, 2005)
• Counseling regarding progressive neurologic disease

Behavioral speech therapy
• Stuttering identification & modification (Conture, 2001)

Lee Silverman Voice Treatment (LSVT®)
• Intensive, evidence-based program for hypokinetic dysarthria with focus on diaphragmatic breathing (Duffy, 2005; Trail et al., 2005)

CASE HISTORIES

Client A (Vanderbilt)
73-year-old male
Stuttering re-emerged ~5 years post PD diagnosis
Seventeen one-hour sessions (over 5 months)
Clinical observations:
Blocks and tense prolongations with facial concomitants at the beginning of utterances; reduced loudness, especially trailing off at ends of utterances.

Client B (MGH)
63-year-old male
Stuttering re-emerged ~1.5 years post PD diagnosis
Seventeen one-hour sessions (over 2 weeks)
Clinical observations:
Blocks and tense prolongations with sound and whole-word repetitions; reduced eye contact; facial grimace; reduced loudness; monopitch, monoloud speech characteristics.

TWO TREATMENT APPROACHES

Client A:
Client A was initially offered LSVT® to address hypokinetic dysarthria. He was not agreeable to this approach, with concerns that increased loudness and emphasis on speech articulation might exacerbate his stuttering.

He was then directed to a fluency specialist, with 1x weekly treatment in an initial course focusing on patient-counseling (solution-focused brief therapy) and review of stuttering modification strategies. Follow-up “refresher” sessions given at irregular intervals per client request.

Client’s self-identified targets: increase in overall management of stuttering, increased satisfaction with communication abilities, precise articulation, and longer pauses at phrase/sentence boundaries.

SELECTED OUTCOMES:

Client B:
Client B had previously been seen by an outside SLP to address fluency concerns with prior focus on stuttering modification. Past medical history was significant for anxiety/depression.

He was seen at MGH for additional concerns re: hypokinetic dysarthria, although ongoing concern was pervasive communication. He was then directed to a fluency specialist, with 1x weekly treatment in an initial course focusing on patient-counseling (solution-focused brief therapy) and review of stuttering modification strategies. Follow-up “refresher” sessions given at irregular intervals per client request.

Treatment focused on diaphragmatic breathing and increasing vocal loudness (1-hour sessions, 4x per week). Trained hierarchical speech tasks including word-, phrase-, and sentence-level communication.

SELECTED OUTCOMES:

CONCLUSIONS & DISCUSSION

• Broadly, Client A perceived improvements over a 17-month period for communication abilities and stuttering management, with significant variability in performance from week to week.

• Client B exhibited some improvements toward goals in speech loudness and fluency, although carryover to spontaneous speech was limited in this short-term intervention design.

• This case study contributes to reports of persons with re-emergent stuttering in PD (see Lim et al., 2005; Shahed & Jankovic, 2001).

• Loudness treatment did not appear to exacerbate stuttering in either case, although general body tension may have increased with diaphragm effort.

• Neither approach explicitly addressed psychological components of progressive/re-emergent processes, a potentially important consideration.

• Formal LSVT® treatment protocols were not attempted with either client—would these patients benefit from a more intensive treatment?

SELECTED REFERENCES


