Chapter 1

Introduction

The treatment of stuttering has traditionally received limited focus in many speech pathology training programs, and due to the small percentage of people who stutter, many speech-language pathologists and students in training have little experience in this area. As a result many speech pathologists question their ability to treat stuttering effectively. However, working with children who stutter can be a fun and rewarding experience. We are excited to share with you our therapy approach for young children who stutter, and it is our sincere hope that the material we present in this book will not only make you feel more confident about treating stuttering in children, but will also help you have fun while doing it!

Fun with Fluency was designed to directly treat stuttering in children ages 2 ½ to 7 years. It provides guidelines for differential diagnosis, information for planning and implementing direct fluency treatment, parent and teacher counseling tips, and many ready-to-use therapy activities.

Our Treatment Philosophy

For many years young dysfluent children received only *indirect treatment* (fluency enhancement). Indirect therapy incorporates parent counseling and manipulation of environmental variables, such as parental speech rate and communicative stress (interruptions, loss of listener attention, etc.), in an attempt to increase fluency. Historically, it has commonly been believed that drawing attention to the child's fluency problem will only make it worse. Therefore, this approach focuses on working with the parents and children are rarely seen in the therapy setting.

The earliest attempts to work with dysfluent children in a therapy setting involved play-based therapy during which the clinician modeled slower speech, increased pause time, and reduced length and complexity of utterances in order to facilitate more fluent speech. Some clinicians also began directly teaching children strategies (such as "turtle talk," "slow speech," "easy speech" and "stretched speech") in order to help them attain more fluency.

Over the past decade or so, however, direct treatment of young dysfluent children has become more widely accepted—as opposed to limiting treatment to

parent counseling and environmental manipulation. Direct treatment of stuttering is supported by several recent authors, including Prins and Ingham (1983) who state that, "stuttering (even in young children) can be successfully treated, should be treated, must be treated, if we as clinicians are to perform ethically and adequately." This movement toward direct therapy has been driven by the fact that many children are not improving through indirect treatment methods. In addition, parents are experiencing frustration and guilt, feeling that their child's lack of progress is due to their failure to create the perfect fluency environment.

We believe that there are many young children who benefit from and respond well to an indirect treatment approach *(fluency enhancement)* in which they may never receive formal therapy. Instead their treatment is focused on enhancing the child's fluency through modifying aspects of the child's environment and the communicative behaviors of the family—for example, using a slower speech rate, limiting interruptions and reducing time pressure. At the same time, however, we also believe that there are other children who make better progress with a *fluency shaping approach* that specifically focuses on teaching them fluency skills in the therapy room, beginning at the word level and progressing through conversation.

There are still other children who do not benefit greatly from either of these therapy approaches alone, and need more in order to make good progress. For these children, we integrate *modification principles* into the therapy program. Modification therapy focuses on teaching children how to change and control their stuttering behaviors, in order to reduce or eliminate the stuttering moment. When we incorporate modification therapy strategies, we can begin to talk to children about their speaking difficulties, as well as to help them weaken and break down their stuttering pattern. Table 1 provides a more detailed differentiation of these approaches.

We believe that it is time to address stuttering modification issues when children reach a point of heightened negative awareness; that is, they exhibit feelings of frustration, intolerance or unpleasantness in response to the stuttering. At this point it is no longer appropriate for the child's parents and professionals to ignore the stuttering or the child's response to the behavior. Even directly teaching fluency skills *is not enough* if the child's speaking difficulties are not verbally addressed in some way. Pretending to ignore a behavior that visibly disturbs a child inadvertently sends a negative message. If a speech pathologist witnesses a child intensely struggling through a moment of stuttering, and then acts as if it didn't happen, and the parents also ignore the child's struggles to speak, what message does that send? The child may incorrectly perceive that what he or she is doing is so bad that nobody will talk about it. Children come to expect that their parents will comfort them in times of difficulty, and they may become confused and frustrated when parents say nothing. An adult client we once treated in our practice described his

Table 1. Differentiation of Fluency Enhancement, Fluency Shaping and Stuttering Modification

Therapy Goals

Fluency Enhancement	Fluency Shaping	Stuttering Modification
Never addresses fears or avoidance behaviors for fear of exacerbating the dysfluency.	Gives little attention to fears and avoidance behaviors.	Addresses fears and avoidance behaviors.
Works toward promoting fluency through having adults in the child's environment reduce speaking demands on the child.	Works toward development of spontaneous or controlled fluency through therapy with the child.	Works toward development of spontaneous fluency, controlled fluency or acceptable stuttering through therapy with the child.
Achieves fluency through having adults model slowed speech, shorter sentences and good turn-taking skills.	Achieves fluency through teaching the child stutter-free speech.	Achieves fluency through modifying the child's stuttering pattern.
Maintains fluency through continued environmental modifications	Maintains fluency through modifying the child's manner of speaking (may recycle through original therapy program).	Maintains fluency through continued desensitization and use of modification techniques with the child.

Clinical Procedures

Fluency Enhancement	Fluency Shaping	Stuttering Modification
Structure is characterized by parent counseling with the child receiving no formal therapy.	Structure is characterized by implementing conditioning and programming principles with the child.	Structure is characterized by a teaching/counseling interaction with the child.
Progress is typically measured through parental reports and periodic re-evaluations.	Progress is measured through collecting objective data regarding the fluency of the client's speech.	Progress is measured in terms of a global impression of client's stuttering problem (objective and subjective data).

Source: Portions adapted with permission of the Stuttering Foundation of America from Guitar, B., and Peters, T. Stuttering: An Integration of Contemporary Therapy. Publication # 16, 1980. Stuttering Foundation of America, Memphis, TN, 1-800-992-9392.

memories of his early stuttering as follows: "Everyone in my life danced around my stuttering. I didn't need dancing lessons, I needed someone to help me talk."

Our treatment philosophy has evolved over many years, from what once was relatively indirect to what is now a well-defined, direct approach. The recent stuttering literature reveals a lack of consistency with regard to the definition of indirect and direct stuttering therapy. For purposes of clarity, and in order to delineate our treatment program, we will define these terms as follows. *Indirect therapy* includes *fluency-enhancement techniques* such as parent counseling and environmental manipulation. Modeling and play therapy might be used with the child to indirectly enhance fluency, but without drawing attention to the child's stuttering.

In contrast, *direct therapy* involves a focus on increasing fluency through teaching the child techniques such as easy speech and stretching; it may also include the implementation of modification techniques, in which we directly address stuttering behaviors and teach the child ways to modify and manage them. As you will see throughout this book, children vary in their need for direct therapy and the degree of directness that is appropriate. These decisions are made on a case-by-case basis.

Knowing that many clinicians will feel uncomfortable with a direct approach, we would like to share some of the personal therapy experiences that have shaped our changing treatment philosophy. As specialists in the area of stuttering, it has not been uncommon for us to see children with resistant stuttering behaviors or children who have had previous speech therapy without success. Stories like these have led us to feel that in some cases direct therapy is the most appropriate course:

> Andrew, a two-year, nine-month-old male, was initially enrolled in a very indirect therapy program that was done in the home. With no mention of talking whatsoever, we spent our time in fluency-enhancing play activities. Seven months of indirect therapy yielded little change. One morning Andy asked me, "Why it is so hard for me to talk?" Not quite sure how to respond to a two-year-old, I told him that his talking was not all grown up yet and lots of little children have trouble talking sometimes. Following this incident I shifted to a more direct therapy approach in which I taught Andrew to do "easy speech" during therapy and openly discussed his speech difficulties. He began improving immediately. Within months, Andrew was dismissed from therapy.
>
> Kimmy, a four-year-old female, had been receiving indirect therapy for four months. One day she came to therapy in a severe regression. In tears, she would preface every hard word with the starter "eyah."

My first inclination was to put her on my lap and hold her while she cried. While I was struggling to decide how to respond to her tears, Kimmy told me she was "afraid to talk, afraid her words would get stuck." I knew I needed to respond to her fears and validate the pain she was feeling. I asked her why she was scared of getting stuck in her words. Even though she could not answer that question, it was the first time anyone had talked about her stuttering. I think it felt good to both of us. We then talked about the "new word" (eyah) she was using to help her talk. She said it was like "chicken talk" because the next word was hard and she was afraid to say it. Today, Kimmy is twelve years old and, since the initiation of more direct therapy, has not stuttered since kindergarten.

Caitlyn, a four-year-old female who began therapy in the midst of her parents' divorce, was exhibiting significant struggle and tension behavior as well as secondary behaviors. Of most concern was her head banging behavior during her most difficult moments of stuttering. After many sessions in which I attempted to eliminate this behavior through fluency-shaping principles, I saw no change. One day, shortly after Caitlyn banged her forehead on the table to interrupt a block, I modeled the same behavior. Caitlyn was shocked and ignored me. After I did this several times she asked me, "Why did you do that? Didn't that hurt?" I responded, "I don't know why I did it. But it sure didn't help me get my word out!" Caitlyn never again banged her head to help her talk. She has been out of therapy for six years and remains fluent.

Experiences such as these made the need for a more direct approach apparent to us, but direct therapy with young children was relatively uncharted territory. *Treating the School-age Stutterer* by Carl Dell (1979) served as an early model for the type of therapy we felt was necessary, especially for children who exhibited relatively advanced stuttering behaviors, evident struggle and tension, and strong negative emotionality. With these children we found it critical to begin to address those issues directly and in a timely manner.

As we began this journey of change, we found the road frightening and uncertain. These feelings quickly subsided as we began to see children respond positively to the more direct nature of our treatment procedures. We hope our experiences provide you with encouragement and direction as you begin your journey.

The Fun with Fluency Approach

The *Fun with Fluency* therapy approach is described in detail in chapter 4. In brief, these are the important aspects:

Modeling: The clinician continuously models all techniques—such as easy speech, soft articulatory contacts, continuous voicing and overarticulation—throughout the therapy process. We have found that modeling is the most effective way to enhance learning and, at a certain point in therapy, we encourage parents to begin modeling easy, smooth speech at home. Modeling is gradually withdrawn during the counter-conditioning stages of therapy, where the child learns to remain fluent in the presence of fluency disrupters such as fast rate, interruptions or loss of listener attention.

A continuum of direct therapy strategies: Practicing a hierarchy of strategies—such as easy and stretchy talk, then bouncing, then hard speech, etc.—is an important part of the therapy approach. This continuum of strategies is listed on page 34 in chapter 4. You will determine how far to progress down this hierarchy, depending on the characteristics of each child's stuttering and the degree of negative awareness demonstrated.

A hierarchy of increasingly longer and more complex utterances: For each strategy on the continuum of direct therapy, the child begins practicing at the one-word level and progresses systematically through increasingly longer or more complex phrases, sentences and conversation. Linguistic complexity is carefully balanced against length to control the difficulty of utterances. Mastery at the phrase level is especially critical because it lays the foundation for conversational speech. This hierarchy is outlined in table 6 (page 30).

Reinforcement: Positive reinforcement and feedback are used heavily at first to increase motivation and self-esteem. Reinforcement needs to be appropriate to the child's age and interests. It may include social praise, the use of counters such as an abacus or a pegboard, small toys, and later on, trips to fast-food restaurants. We do not ever advocate the use of negative reinforcement in any form during fluency treatment.

Other aspects of therapy that are important to a child's success include practicing techniques out in the community and counseling parents and teachers. These areas will be discussed in chapters 5 and 6 respectively.

Scheduling Therapy

Scheduling is based on the child's needs and what is practical for the family. In general, therapy is recommended twice weekly for thirty to forty-five minutes per session. For children with severe fluency disorders, or those who have experienced previous therapy failures, short-term intensive therapy, up to four times per week, may be warranted at first, after which therapy would continue on a weekly or twice-weekly basis. This intensive therapy effects a rapid initial change that may serve to motivate the wary child or parent. Short-term intensive therapy may also be the most practical option for families who live a long distance away and cannot commute to the clinic on an ongoing basis. Once a regular schedule has been initiated, it is best that the frequency not be reduced until the child has established and maintained fluency for a minimum of three months. At that time, the frequency of therapy may be halved, and the child should demonstrate stabilization of fluency for another three months before frequency is further reduced. Continue to reduce treatment by 50% at each interval.

Measuring Progress

Because of the nature of the treatment process, it is important to measure progress according to several criteria, rather than relying solely on percentage of fluency. For example, over time a child might stutter less frequently, but develop *secondary behaviors* (physical and/or linguistic behaviors that occur in response to the stuttering, such as hesitations, inappropriate inhalations or word substitutions). Although the frequency of primary stuttering behaviors is less, the development of secondary behaviors indicates that the child's stuttering is actually progressing, not improving. Similarly, as a child learns through therapy to stutter with more control and respond to the stuttering moment with less fear and negativity, the frequency of stuttering may not change immediately, but the stuttering pattern will begin to change. One or more of the following changes are early indications of progress: advanced stuttering behaviors (that is, blocks and prolongations) change to more repetitive behaviors; individual stuttering moments are less severe; the duration of core behaviors (that is, repetitions, prolongations and laryngeal blocks) decreases; secondary behaviors decrease in frequency or severity; or the nature of the child's fluency cycles changes (increased periods of fluency and shorter cycles of stuttering). As the child progresses through therapy, the cycles of fluency should generally increase in duration, while episodes of stuttering should occur less frequently and be less and less severe. (Periods of remission are not unexpected.) Initially, watch for the child's stuttering to change to an easier, less complex pattern. Only then would you focus on increased fluency and increased talking.

Before we discuss specific treatment strategies for the young child, it is important to consider assessment and the various aspects of differential diagnosis.

The key to early, effective intervention is the accurate differentiation between normal disfluencies and abnormal dysfluencies. (Note that we use *disfluency* to denote typical developmental nonfluencies, and *dysfluency* to indicate a disorder.) Due to the cyclical nature of stuttering in its early stages, the inherent variability of the disorder, and lack of agreement in the literature regarding the prospect for spontaneous recovery, accurate diagnosis can be a difficult task. In the next chapter, we will discuss various aspects of differential diagnosis, including danger or warning signs that suggest the need for direct intervention, risk factors and the progressive levels of dysfluency.