Stuttering Therapy for School-aged Children and Adolescents
What Really Matters

Lee Caggiano, M.A. CCC/SLP
Board Recognized Specialist and Mentor in Fluency Disorders
Lcaggiano@aol.com

Financial Disclosure:
Caggiano will be receiving travel support for this presentation

Non-Financial disclosure:
Caggiano is the Director of FRIENDS-the National Association for Young People Who Stutter. The position of Director is a volunteer position. Caggiano has an adult son who stutters which will be discussed in this presentation.

Stuttering

- Multi-dimensional/complex disorder
- Progress is not linear
- Factors that contribute change over time
- Can affect every aspect of a child’s life
- Fluency is not always attainable

Understanding this enables us to help child develop life changing behaviors

Stuttering can have a profound affect on every aspect of a child’s life
- home
- bus stop
- Classroom
- Lunchroom
- Recess
- ball field
- dance class
- friends

What causes stuttering?

Theories on the etiology of stuttering

- Geschwind-Galburda- delay in left hemispheric growth/ fetal exposure excess testosterone (inefficient networks of neural activity)
- Per Alm (04) Basal Ganglia disorder
- Brain plasticity- child’s experiences modify neural activities
- Atypical brain functions- some cws may reorganize to process more efficiently
- Other cws may be unable to reorganize
Theories on the etiology of stuttering

- Genetics
  - 2/3 cws had relatives who stuttered
  - more often in identical twins vs. fraternal
  - Hx in biological parents more predictive
  - Persistent females- higher proportion of relatives who stutter—higher genetic loading? Does not tell us what is inherited?

Recent findings regarding temperament of children who persist in stuttering

- More emotionally reactive, (more intensely aroused) when faced with everyday stressful, exciting or challenging situations
- Slower to adapt to change, new situations, transitions, letting go moving to next task
- Less able to control attention
- Not as able to shift their focus of attention (Karrass et al. 2006).
  Perhaps children who are more highly reactive AND have poorer attention control become preoccupied with dysfluencies… and are not as able to move on

Temperament Research

- Innate sensitivity- greater physical reactivity to discomfort
- Respond with heightened activation of limbic system—vulnerable to hyper excitability of limbic system
- Heightened activation results in increased physical tension—laryngeal tension (Kagan, 1987).

Summary: Genetics, temperament, environment

- Polygenic etiology
  - Several genes of varying influence increase the susceptibility to stutter
  - Genetics is not destiny
  - Combination of physical, physiological or and/or temperament characteristics that interact with developmental and environmental factors

Recovery facts

- Unassisted recovery 32-89%
- Probability of recovery highest from 6-36 mo. Post onset
- Majority recover within 12-24 mo post onset
- Recovery period steady decline in word/sound reps & prolongations beginning after onset

Chmela & Zebrowski, 2002
Risk factors
• Speech motor skill difficulty
• Language skills difficulty
• Temperament
• Family history
• Gender 3:1

Recovery factors
• Onset before age 3 years
• Female
• Measurable decrease in frequency soon after onset
• No coexisting phonological disorders

(Yairi, 1992/1996)

Assessment and Diagnosis of Stuttering

Stuttering behaviors
• Whole word repetitions (but-but-but)
• Part word repetitions (mom-mom-mommy)
• Initial sound repetitions (m-m-mommy)
• Prolongations (m: mommy, m: mommy)
• Blocks (m) ommy, (a) bout
• Struggling behavior, facial and/or body tension or movements
• Avoidance

Differential diagnosis
Typical dysfluency
• Less than 3% SLDs
• One to two unit repetitions
• Phrase repetitions, whole word repetitions (polysyllabic), interjections, fillers and revisions

Stuttering
• More than 3% SLPs
• Two or more unit repetitions
• Whole word repetitions (monosyllabic)
• Part word repetitions, sound repetitions, sound prolongations, blockages of sound
• Secondary behaviors

Treating school-aged children and adolescents who stutter: what really matters

STUTTERING IS

Hiding Burying myself in books Holding back Whispering Using bad habit Trying to be perfect Ignoring people Annoying Words caught in my throat Being stared at Not talking Avoiding Words caught in my mouth Scary Handicap Embarrassing Eating lunch by myself Trying to hide my speech Not chiming in Stealing up Chicky Launching in yourself Redirecting attention Saying other things Covering up Doing more Worrying all the time Throat drying up Hesitating Being paranoid Never volunteering
The ABCs of stuttering

Affective  
Behavioral  
Cognitive

It is logical to define stuttering in terms of the amount of stutters and set goals accordingly…. but in doing so we address only the part of the disorder Stuttering is not only what we can see, often behaviors that are most disabling are those we can’t see.

Clinical decision making

Treatment approaches
Fluency shaping  
Stuttering modification

- Stuttering is learned  
- Changing speech patterns to increase fluency  
- Structured/easily measurable  
- Difficulty in carryover-higher rates of regression

Favored by clinicians with n personal history of stuttering (Manning, 94)

- Innate: increases as result of fear/avoidance  
- Changing stuttering to decrease tension  
- Teaching/counseling component  
- Difficulty in learning (Shapiro, 1999)

Fluency Shaping  
changing speech patterns to increase fluency

- Reduce rate of speech  
- Slight prolongations  
- Light contacts  
- Gentle onsets

Turtle talk, phrasing, pausing, scale, speeding tickets, cards  
Stretchy talk, sliding, easing, Silly putty stretchy men  
Discriminate old vs. new  
Imitate- follow our model  
Produce- hierarchy increased linguistic/social

If fluency is the goal of therapy- we may be encouraging failure if fluency is not attained...

and for many fluency is not attainable

Bill Murphy, 2000

Stuttering Modification

Stuttering Modification

Some children need more than fluency shaping: they may become more aware, anxious, frustrated, intolerant of their stuttering, exhibiting signs of struggle and avoidance

(Walton & Wallace, 1999)

“We may not always have a choice as to whether or not we stutter, but we always have a choice as to HOW we stutter”

Charles Van Riper
Treatment approaches
Stuttering Modification

• Changing stuttering to decrease tension-making speaking easier
• Decrease tension to modify the stutter before, during, after the stutter
• Decrease avoidance/struggle behaviors
• Address attitudes and emotions
• Increase comfort speaking

Stuttering Modification

• Identify stuttering tallying, One finger exercise
• Voluntary stuttering
• Cancellations
• Pull-outs fist analogy, silly putty
• Preparatory Sets
• desensitizes to MOS increases comfort
• decreases avoidance/struggle behavior
• reduces tension after moment of stuttering
• reduces tension at moment of stuttering
• Reduces tension before moment of stuttering

Transference

• Must begin at onset of therapy
• Clinician and client involved in activities
• Individual hierarchy of activities for client
• Design activities to ensure success
• Engage family/friends in therapy

Clinical Insight

"The mark of an experienced clinician is not knowing what strategies or techniques to use. Every clinician should have that information. The mark of an effective clinician is reflected in her clinical insight about why and when to employ it."

(Clinical Decision Making in Fluency Disorders, Manning, 2001)

Understanding Secondaries

• May result from the child’s feeling of loss of control over the speech mechanism and the resulting feeling that he is doing something bad or wrong. The child “pushes” to get the word out, increasing tension in speech or other muscles
• Sometimes an unrelated movement like blinking eyes or tapping a foot may seem, to the child, to help the word come out so he is likely to continue the behavior

Secondary behaviors that might accompany stuttering

• Loss of eye contact
• Blinking, head nods or jerks
• Arm or leg movements
• Rise in pitch or loudness during repetitions or prolongations
• Use of starter sounds
• Garbage speech
• Avoidance behaviors
Avoidances

- A person who stutters may do several things in the attempt to avoid stuttering: changing the word they want to say, saying "I don't know" even when they do know, never volunteering to read or answer questions, allowing others to answer for them.
- A really "good avoider" ("covert" stutterer), may hide his stutter so much that few people realize he is in constant struggle to keep from stuttering and fear of being "found out".

Avoidances

- Be aware of the silent child
- changing the word they want to say
- saying "I don't know" even when they do
- not volunteering to read or answer questions
- allowing others to answer for them.

- A really good avoider ("covert" stutterer), may hide his stutter so well that few people realize he is in constant struggle to keep from stuttering and fear of being "found out".
- It is more difficult to suffer without knowing a way out, than to face unknown challenges." (unknown author)

“What I’d Like to Say-What I Say”, 15 yrs

Iceberg

Stuttering is not only those behaviors we can see- often behaviors most disabling are those we can’t see
- fear
- shame
- isolation

Addressing attitudes and emotions in stuttering therapy

Why address negative feelings and behaviors

- Interferes with the child’s ability to communicate effectively and manage stuttering successfully
- Interferes with the families ability to support the CWS and his treatment
- Negative emotions can act as a filter, allowing only pieces of the therapeutic message to get through
"Overcoming stuttering is more often a matter of losing fear of stuttering than a matter of trying harder" (Conture & Guitar, 2001)

What message is the child "hearing" from our therapy?

Desensitization
- Shame and shame induced guilt- can be prevented/reduced through gentle exposure

Motor training/ mental training
Learning skills requires both behavioral and mental training.
- A basketball player can have all the motor training in the world, but once on the court can "choke in a NY minute" without the necessary mental training.

Working on attitudes & emotions
- Increase self-confidence in speaking situations
  - Positive self-talk
  - Problem solving
  - Role-playing
- Increase comfort with stuttering
  - Provide unconditional acceptance & support
  - Discuss stuttering, feelings about stuttering
  - Empower client
  - Participate in social/support group experience

How to working with attitudes & emotions
- Desensitize to fear & expectancy of stuttering
  - de-awfulize stuttering (Bill Murphy, 1998)
  - model easy stuttering
  - Use voluntary stuttering within/outside therapy
- Increase awareness of avoidance behaviors
  - identify behaviors used by others to avoid/escape
  - Identify own avoidance/escape behaviors

"The Cafeteria", age 16
Teasing

• 81% of children studied reported being bullied at school at some time
• 56% of those children were bullied about their stuttering at least once a week or more
• Parents are not always aware of bullying
• Bullying creates cycle of increased speech struggle, heightened shame and desire to avoid & hide stuttering

Langevin, 1998

How to address teasing

Empower the CWS with strategies: problem solve with teacher and SLP, school social worker or psychologist
• Increase understanding and respect for differences
• Zero tolerance for intolerance
• Suggest classroom presentation
• Problem solve with child
  • Why others tease
  • Why children react
  • How to stop reacting
  • Learn about bullying
  • Role play various responses
  • Educate classmates about stuttering

Ramig & Bennett, 1995

Developing functional treatment goals

what is most interfering with effective communication

Goal of therapy

improve ability to communicate without struggle, avoidance, fear, embarrassment or shame
and
develop/maintain healthy attitudes towards communication

To say what they want.....
When they want...
To who they want ....... and where they want.

“The bottom line” (Dale Williams, 2006)

“When something works, you will reach a point where stuttering isn’t the first thing you think about when your eyes pop open each morning. Nor will you fall asleep each night rehashing the day’s failures.”
Goals must be measurable
Goals must be functional
Goals must be realistic

What effect will this goal have on child in 5 years?
What message will child perceive?
Does this goal contribute to the maintenance or development of self-confidence?

Goals for stuttering therapy
behavioral/affective/cognitive

- Behavioral: to decrease frequency and severity of stuttering
- Affective: to prevent/decrease negative feelings associated with speaking
- Cognitive: To modify attitudes/beliefs, thoughts that may interfere with successful communication

Behavioral
Goal: To decrease frequency and severity of stuttering

1. Objective: to decrease tension during stuttering
   1. By decreasing rate of speech
   2. using easy onsets
   3. using phrasing
   4. using voluntary stuttering, cancellations, pull-outs
   5. alternating between hard stutters and easy stutters

2. Objective: to decrease use of defensive behaviors (avoidance, escape, struggling)
   1. increasing awareness of behaviors
   2. tallying MOS

Affective
Goal: prevent/decrease negative feelings re: speaking

1. Objective: To become desensitized to stuttering
   1. By increasing understanding of stuttering
   2. Speech production, etiology, types, progression, relapse, myths, tx goals, rationales
   3. By tolerating discussion of stuttering
   4. Parents, friends with therapy session
   5. Discussion outside therapy
   6. Classroom presentation
   7. By acknowledging and discussing speech difficulties
   8. By observing listener’s reactions to stuttering

Cognitive
Goal: Modify attitudes/beliefs, thoughts that may interfere with successful therapy

1. Objective: To increase tolerance of speech imperfections
   1. By becoming aware of negative self-talk
      • use positive self-talk, reframing

2. Objective: to increase internal loci of control
   1. By becoming aware of choices (empowering)
   2. Will be aware of negative self-talk & its effect
   3. By using positive self-talk, reframing
   4. By improving problem solving skills
   5. By increasing awareness by ID behaviors
      • In other while watching video
      • In self while watching videotaped
      • Explaining use of defensive behaviors
      • Identifying difficult speaking situations

Cognitive Objectives to decrease use of defensive behaviors

- Will objectify stuttering (normalize) by
  • reframing thinking using positive self-talk during 5 sessions
  • Using problem solving skills during 2 group sessions

- Will increase internal loci of control by
  • using role-playing in 3 session

- Will develop self-advocacy skills by
  • developing treatment plan/goals

- Will increase parental involvement in therapy process by
  • discussing concerns with clinician, parent support group
  • discussing etiology/therapy goals/ recent findings with clinician, parent groups
The CWS in the classroom

- Involve the child in private discussions regarding speech and stuttering
- Ask the child his opinion about accommodations in the classroom
- Give the child responsibility for making decisions about his speaking in the classroom

When talking with the child who stutters

- Refrain from giving advice such as "just slow down", or "relax" or "remember to use your speech techniques"
- Do not hurry the interaction: add pauses before you take a turn talking and during talking
- Remember your body language and facial expressions convey your level of comfort

PLEASE DO NOT

- Tell a child to stop stuttering
- Threaten to punish him
- Help him with the word
- Tell a child to think about what he is going to say
- Ask him to take a deep breath before speaking
- Ask him to stop and start over
- Suggest avoiding or substituting words
- Pretend dysfluencies do not exist

IEP Goals- Client will:

- Use easy stutters with 80% accuracy during task with classmate
- Discriminate between fast and slow by identifying clinicians models (by producing same) 15/20 trials
- Use light contact, easy onset, cancellations to modify moment of stuttering answering question in class (in cafeteria, during class presentation) with 80%
- Will raise hand in class 3 times a day
- Identify avoidance behaviors used during situations
- Demonstrate an increased understanding of stuttering by defining the following term: stuttering, struggle, bouncing, stretching, avoidance

ASHA's Guidelines for Practice in Stuttering Treatment

- Help client reduce number and severity of stuttering events
- Help client reduce the number of maladaptive or defensive reactions to speaking and stuttering
- Help client increase their speaking & social activity
- Help client transfer fluency skills to everyday activities
- Collect reliable data during assessment and communicate it to other professionals

Concomitant disorders

- Articulation difficulties
- Language difficulties
- ADHD
- Tourettes—tics are initiated voluntarily in reaction to an involuntary sensation
- Obsessive-compulsive disorder
The Role of Support

- The missing piece in stuttering therapy
  - Ties together the Affective, Behavioral and Cognitive aspects
  - Creates a link between therapy and the outside world

Need for support

- Stuttering affects entire family
- Greater understanding of stuttering
- Leaders in the field of stuttering encouraging participation
- Being with other children who stutter
  - Not alone
  - Empowers them
  - It is OK to stutter

Group therapy/support

- Provides relief from sense of isolation
- Allows safe environment to express and share feelings, thoughts regarding stuttering
- Step in transferring skills from therapeutic setting to more social setting.

What a child can gain from a support group

- Understand he is a part of a group of adults, teens and other kids
- View stuttering and fun in the same context
- See his stuttering as the norm rather than different
- Stutter freely because it doesn’t really matter

Child’s ability to communicate well, increases with the parents’ level of understanding and acceptance of stuttering

Family involvement and support services in stuttering therapy
Involving parents in process

- Teach to normalize stuttering
- Increase their knowledge of stuttering
- Encourage to speak openly & honestly
- Praise child for communication
- Participate in therapy sessions
- Keep clinician informed of progress/changes
- Acknowledge difficulty of using techniques
- Participate in parent support groups

Counseling parents

- Respect primary role of parents
- Identify feelings
- Validate feelings
- Distinguish between their emotions and child’s
- Compare their assumptions about feelings with child’s actual feelings
- Clarify/summarize parent’s statements
- Reflect what you have heard
- Praise parenting skills—honesty, awareness
- Offer suggestions and reassurance
- Uncover emotional responses to child’s stuttering

How we provide support outside of therapy

“Nothing is as effective as a good support group for increasing a person’s social involvement” (Manning, 1991)

“Parent groups can enlighten, educate, desensitize and empower” (Short, 2000)

Be aware of the message to parents

Not necessarily the message we intend on giving, but the message that is received.

What a parent can gain from a support group

- Share feelings in a group of parents who understand
- Grow from an emotion-centered focus to a problem-solving focus
- Share stuttering experience with own child rather than being outside the issue

Families

“A successful family is one that feels empowered” (Luterman, D. 1991)

- Individual/groups
  - Families are safe to explore thoughts and feelings
  - Increase comfort with stuttering
  - Parent Groups
    - Groups of parents of same/different age CWS
    - Invite teen/adult who stutters to join group
Counseling

"As much as one might want to, one cannot save another’s spirit. One can only inspire it to fight and save itself"

Donna Williams, “Nobody, nowhere”.

The SLPs job is to support, listen carefully, make occasional suggestions about new things to explore, model the desired attitudes, and ask questions. In short, have a very special kind of conversation with the client”. (Woody Starkweather)

Treatment Factors That Influence Outcomes
Zebrowski (2007)

Extra-therapeutic Factors 40%
Specific Technique 15%
Expectancy (Hope) 15%
Therapeutic Relationship 30%

Characteristics of Effective Clinicians

- Sense of humor
- Empathy, not sympathy
- Ability to listen
- Congruence
- Ability to view self as a cooperative partner in therapy process
- Recognizes the need to create independence, rather than dependence

(Manning, 2001)

Counseling

Helping clients
- reframe their life situations into something positive (Luterman, 91)
- focus on the present, illuminate the possibilities
- find their own answers, experience internal sense of control, learn to care for themselves (Zebrowski, 2005.)

"Counseling is a problem-solving, directive and rational approach to helping normal people". (E.G. Williamon)
- Notice-not evaluate
- Observe=not judge

Cognitive Therapy

- Helps clients change feelings by helping them evaluate their by helping them evaluate their thought processes and core beliefs
- Goal is to change the way client perceives himself & his stuttering.
- By decreasing avoidance behaviors and becoming more assertive, speaker makes significant changes in stuttering, quality of communication, as well as lifestyle. (Manning, 1994)
Meeting the client where they are

Identifying what the client is currently doing while working at their own pace, with the client steering. The clinician has no set expectations or demands for what the client should be doing.

Counseling Goals

- Identify and explore their feelings, behaviors & attitudes about themselves & stuttering
- Develop a realistic perspective on the significance of their stuttering
- Identify their typical affective, behavioral and cognitive coping patterns and the success of these patterns
- Apply their successful coping patterns to their stuttering.

Cooper, E. (1997)

Goal of listening is to understand client’s perspective

Counseling Skills

- Reflective listening
- Reframing
- Encouraging risk taking
- “Tell me and I will listen”

Listening

- Listening to the whole story
- Listening with mindfulness toward strengths, resources and resiliency
  - Does not mean therapist ignores client’s pain or becomes a cheerleader.
  - Listen for 1) what client experienced
  - 2) what client did
  - 3) how client felt

Karver et al.(2005)

Listening skills

- Open and closed ended questions
- Encouragers
- Paraphrases
- Reflection of feelings
- Summarization
- Confrontation

Reframing

- Looks at positive side of situation
- Client can re-examine their assumptions
- Should give the client a jolt
- Sometimes so focused on problem, we don’t see the challenge

Examples:
Accepting Listener

"It is virtually impossible for one person to damage another by listening to him, by trying to understand what the world looks like to him, by permitting him to express what is in him, and by honestly giving him the information he needs. The clinician delays his judgment and tries to accept clients as they are, and as they will become". (Luterman, 1991)

Counseling responses

- Content Response
- Counterquestion
- Affect Response
- Reframing
- Sharing self

Content Response

- Provides information
- Establishes clinician’s credibility
- Follows the Medical Model
- Keeps clients in cognitive realm, often superficial level

Examples:
  - "Why does my daughter stutter?"
  - "That is a very complex question. There are many theories about the etiology of stuttering. Stuttering is a multifactorial and has a genetic/neurological basis."

Counter Question

- Asks client how he/she came to this opinion
- Encourages client to reveal their thoughts
- Forces client to rely on inner resources
- Moves client/clinician relationship beyond initial stages

Examples:
  - "Will you be able to help my daughter communicate?"
  - "Well, what is it about he communication that makes you say she has trouble with it?"

Affect Response

- Empathetic listening
- Listening/seeing the world through clients eyes and reflecting feelings back
- Even inaccurate responses will encourage the client to clarify
- If the form is learned (and not the substance) will sound like parroting.

Example:
  - "I don't want my son to be teased".
  - "I understand. Is this something you can relate to growing up as a child who stuttered?"

Sharing self

- Sharing personal information and experiences
- Gives client examples of how clinician or others have viewed challenges
- Builds credibility and trust

Example:
  - "I just worry because I am afraid her stuttering will hold her back".
  - "I understand. Sometimes I worry that my child's difficulties may also get in his way."
Challenges

Reluctance
• Natural hesitancy to change or new behaviors
• Fear about difficulty of change, fear of failure, or shame about problem
  Acknowledge reluctance, help clients understand that change is

Denial
• there is only so much pain one can bear

Resistance
• Pushing back reaction when client feels being coerced
• Motivation to change is not coming from client
• Acknowledge resistance, involve client in therapy process and help understand resistance

Yaruss (2010.)

Validating feelings

• Acceptance of the client at face value
• Client’s struggle is respected
• Thoughts, feelings, and behaviors are accepted, believed and considered understandable given the trying circumstances

• Duncan & Sparks, 2002

Solution Focused Brief Therapy

• What are your best hopes?
• What is good enough?
• Miracle question
• What has been better since we last met
• What will be a sign that you are doing more of the things that are good for you?
• What will tell you that we do not have to meet again?


“I have found that therapy is a two-edged chisel; it shapes the therapist as well as the client” (Van Riper, 1979)

References


Support Resources

• Friends: The National Association of Young People Who Stutter www.friendswhostutter.org

• Stuttering Foundation www.stutteringhelp.org www.stutterSFA.org www.stutteringhomepage.com