

ASSESSMENT AND TREATMENT WITH PEOPLE WHO STUTTER

International Stuttering Awareness Day
Obcanske sdruzeni LOGO
LOGO, Masaryk's University
Brno, Czech Republic
October, 2004

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- I. Welcome, Introduction, and Orientation
- II. Intervention Goals
- III. Intervention Principles and Premises
- IV. Intervention Objectives and Procedures
- V. Video Demonstration
- VI. Discussion and Closing

I wouldst thou couldst stammer,
that thou mightst pour this concealed man out of thy mouth,
as wine comes out of a narrow-mouthed bottle;
either too much at once, or none at all.
(William Shakespeare)

Build therefore your own world.
As fast as you conform your life to the pure idea in your mind,
that will unfold its great proportions.
(Ralph Waldo Emerson)

NOTE: Be encouraged to use the ideas presented in this handout; however, kindly reference the following source: Shapiro, D. A. (1999). *Stuttering Intervention: A Collaborative Journey to Fluency Freedom*. Austin, TX: PRO-ED [1-800-897-3202; www.proedinc.com].

Teze přednášky "Dosahování plynulosti řeči u dětí školního věku a u adolescentů, kteří koktají", Ústav pedagogických věd FF MU v Brně, 20.10.2004.

SELECTED UNIQUE FEATURES OF THIS INTERVENTION

- The person who stutters is viewed as a whole person who communicates within a communication system, a meaningful context for communication and intervention, rather than as a disabled person in isolation.
- The intervention process is treated as multidimensional and collaborative, necessarily involving the client, clinician, members of the communication system, and allied professionals, rather than as unidimensional and solely an interaction between the clinician and client.
- The clinician directly involves other members of the interdisciplinary team, thus facilitating the necessary integration across participants, rather than focusing nearly exclusively on the client/clinician relationship.
- The client is viewed as an active and critical member of the interdisciplinary team, necessarily involved in all aspects of intervention planning, implementation, evaluation, and follow up, rather than as a passive participant who follows the direction of the clinician.
- The methodology focuses on the fluent aspects of one's communication, not only the disfluency. While numbers do not tell the whole story, 15% or 20% disfluency typically renders a speaker significantly disfluent. That also means that 80% to 85% of the individual's speech is fluent. This method first addresses the fluent component, and instructs the client in how to do more of what he already is doing right (i.e., facilitative of fluency). Only then are the remaining disfluencies targeted and eliminated. This process (i.e., facilitation) is in contrast to a preliminary and primary focus on disfluency (i.e., and the resulting perspective of rehabilitation).
- Transfer (i.e., generalization) is begun from the first contact with the client. This is in contrast to the traditional focus on transfer toward the end of scheduled treatment.
- Relapse is treated as clinically inevitable, so clients are prepared to handle it productively and with fluency facilitating control. This is in contrast to ignoring its existence which results in the client's surprise and communicative defenselessness.
- Change is treated as realistic, desirable, and possible at any age across the life span within communication systems.
- Stuttering (i.e., behaviors, thoughts, and feelings) reflects in part the consequence of active and alternative choices.
- Early intervention with young children is seen as a form of prevention.
- Regular assignments designed with, not for, the clients are viewed as a critical form of treatment that occurs between scheduled sessions.
- Multicultural considerations in assessment and treatment, particularly with persons who stutter, are addressed.
- Intervention with senior adults who stutter is viewed as providing a positive, inviting, and enlightening opportunity.

CENTRAL AND GUIDING INTERVENTION PRINCIPLES

- **Intrafamily Considerations**

Personal Constructs: Stuttering is a personal construct. Stuttering-related thoughts, feelings, and behaviors reflect in part the consequence of active and alternative choices.

Family Systems: Stuttering and other communication disorders exist, and therefore must be addressed, within a family context. The experiences of and changes in a person who stutters trigger compensatory changes in family members and significant others.

- **Extrafamily Considerations**

Interdisciplinary Teaming: Interdisciplinary practice provides for collaborative opportunities to work with and learn from people who stutter, family members, and allied professionals while ensuring the highest quality of service delivery.

Multicultural Awareness: Multicultural education invites clinicians to appreciate human diversity in all of its forms and to resolve to approach each person, including those who stutter and their family members, as individuals who are blessed with similarities and differences.

- **Psychotherapeutic Considerations**

Stuttering Modification and Fluency Shaping: Stuttering Modification and Fluency Shaping are presented as endpoints of a psychotherapeutic continuum. Understanding these two elements and the continuum that lies between them is useful for distinguishing the many treatments that are available and for designing individualized treatment for people who stutter.

DISTINCTIONS BETWEEN STUTTERING MODIFICATION (SM) AND FLUENCY SHAPING (FS)

- **Premise**

SM: Stuttering results from avoiding or struggling with disfluencies, fears, and/or negative attitudes.

FS: Stuttering is learned.

- **Behavioral Treatment Goals**

SM: In decreasing order of desirability, goals include spontaneous fluency, controlled fluency, or acceptable stuttering.

FS: Only spontaneous or controlled fluency are acceptable goals. Any evidence of noticeable stuttering is regarded as a program failure.

- **Affective Treatment Goals**

SM: Fears and avoidances related to stuttering are reduced by identifying, studying, and understanding thoughts, feelings, and attitudes about communication and oneself as a communicator. Positive social/vocational adjustments are targeted directly.

FS: No attempt is made to reduce communication-related fears and avoidances or impact the attitudes of the person who stutters. As a result of improved fluency, however, fears often reduce and positive social/vocational adjustments are made indirectly.

- **Procedures**

SM: Much attention is given to reducing speech fears and avoidance behaviors. The client is taught to be more fluent by various techniques to modify stuttering. Fluency is maintained by reduction of fears and avoidance behaviors.

FS: Little attention is given to reduction of speech fears and avoidance behaviors. The client is "programmed" for stutter-free speech via specific contingencies. Fluency is maintained by modifying the manner of speaking and, if necessary, reinstatement of fluency by recycling through the original program.

- **Structure**

SM: A less structured format (i.e., a teaching/counseling interaction) is utilized.

FS: In contrast, the format is highly structured (i.e., typical of behavioral conditioning and programming).

PRESCHOOL CHILDREN: ASSESSMENT AND TREATMENT OVERVIEW

- **Preassessment Procedures**
 - Case History Form, Audio or Video Tape Recording, Preliminary Phone Call, Preassessment Conference
- **Assessment Procedures**
 - General Considerations
 - Parent Interview
 - Preparation
 - Social Greeting
 - Questions and Dialogue
 - Parent-Child Interaction
 - Child-Clinician Interaction
 - Speech-Language Sample Without Communicative Pressure
 - Structured Activities Without Communicative Pressure
 - Speech-Language Sample and Structured Activities
 - With Communicative Pressure
 - Trial Management
 - Fluency Shaping
 - Stuttering Modification
- **Post-Assessment Procedures**
 - Normal Disfluency and Incipient Stuttering
 - Speech Analysis
 - Frequency of Speech Disfluency (i.e., Disfluency Frequency Index)
 - Type of Speech Disfluency (i.e., Disfluency Type Index)
 - Molecular Description of Disfluency
 - Rate of Speech
 - Secondary Characteristics
 - Severity Rating
 - Adaptation and Consistency
 - Other
 - Diagnosis
 - Prognosis and Recommendations
 - Post-Assessment Parent Interview
- **Treatment Premises**
 - *There is a fine and invisible line between normal disfluency and incipient stuttering. Identifying this line and making such a distinction requires analysis of the child's behaviors, thoughts, and feelings, and a professional judgment on the part of the clinician.
 - *Intervention with preschool children and their families requires understanding of the communication environment, full support and involvement of all members within the communication system, and identification and elimination of potential precipitating and/or perpetuating factors.
- **Treatment Goals**
 - *Spontaneous (i.e., normal sounding) fluency.
 - *Maintenance of a positive attitude (feelings and/or thoughts) toward communication and oneself as a communicator.
- **Treatment: Parent Intervention**
 - Behaviors**
 - *Help the parents learn how to react to and interact with the child without drawing attention to the disfluency.

- *Encourage the parents to be good listeners.
- *Simplify, soften, and slow the daily speech model to which the child is exposed. Reduce other forms of stimulus bombardment (i.e., visual, auditory, emotional) to the extent possible within the communicative environment.
- *Give the child as much fluent talking experience as possible. Try to minimize the amount of experience the child has of talking disfluently.
- *Prevent the child from becoming aware of his stuttering.
- *Reduce the pace of activities and overall tension as much as possible.
- *Identify and reduce or eliminate all fluency disrupters.

Thoughts and Feelings

- *Seek to understand the parents' unique interpretation of their world (and specifically the experience of the child's disfluency), their inherent assumptions, and the patterns of communication among the family members.
- *Help the parents understand the relationship between their thoughts, feelings, and assumptions and their behaviors. What one does often reflects what one thinks or assumes, and one's thoughts are confirmed (or challenged, thus requiring revision) by observed behaviors. By discussing with parents their observed behaviors, the clinician has an opportunity to gain insights about the parents' thoughts and their current knowledge base about stuttering.
- *Identify the parents' behaviors that are supportive of and conducive to the child's communication development. Only then, within this positive context, do we discuss possible revisions.
- *Invite and address parents' questions and involve them actively in implementing the recommendations after discussing, demonstrating, and directing them first.
- *Identify and understand the parents' feelings of guilt and anxiety. Identify, explore, and confront as necessary thoughts, feelings, and behaviors that might have a negative impact on the child's speech fluency.
- *Be a ready source of knowledge, understanding, and support.

• **Treatment: Direct Intervention**

Objectives and Procedures

(1) Establish and Transfer Fluent Speech

- *Establish fluent speech through play by modeling within a fun context what the child should sound like (i.e., talk, listen, and have fun).
- *Continue suggestions provided under "Parent Intervention" above.
- *Provide specific feedback/praise for the child's fluent speech. Observed disfluency should remind the clinician and parent to continue to praise the fluent speech when observed. Offer correction only indirectly in the form of modeling and expansion.
- *While providing praise for the child's fluency, the clinician may need to offer correction. Do so by directing the child to listen to your speech and to help you when it gets too fast (e.g., "Sometimes I forget and I need a little help from my friends"). When the child's speech increases in rate or demonstrates patterns of noticeable disfluency, the clinician should approximate the child's pattern, thus inviting the child's correction. The rationale here is to provide the child ongoing support for what he (the child) is doing right and for the clinician to wear the weight of correction when necessary.
- *Avoid singling out a child from among other people to slow down.
- *Use slow, relaxed activities to regulate speech fluency (singing, guessing games, I spy).

(2) Develop resistance to the potential effects of fluency disrupters.

- *Gradually and deliberately introduce contraexamples (hard, fast speech), inviting the child's correction of the clinician, more frequently. Remind the child in advance to use slow, easy speech even when the clinician "forgets."
- *Reintroduce the conditions that formerly resulted in stuttering (e.g., interruptions, abrupt topic shifts, distraction).
- *Introduce challenge to each of the recommendations given under "Parent Intervention" above.
- *Important note: The clinician's responsibility is to ensure that the child remains successful. No positive aim is served by the child's failure. Success is the biggest internal motivator.

(3) Encourage expression of feelings about communication and oneself as a communicator as appropriate.

*Ensure that the child's attitude toward communication and himself as a communicator remain positive.

*Be open, accepting, and nurturing toward the child about his speech and all other areas of potential.

*Be receptive and responsive to the child's affective expressions.

*Create opportunities for the child to express feelings and to be supported for having done so.

*Listen to, hear, and understand the child.

(4) Maintain the fluency-inducing effects of treatment.

*Once the child is speaking fluently both inside and outside the clinical setting with a variety of speakers, with and without potential fluency disrupters, all the while accepting of himself as a communicator, begin to reduce the time spent in directed play treatment.

*Decrease the frequency of treatment sessions.

*Schedule abbreviated reevaluations with decreasing frequency.

SCHOOL-AGE CHILDREN WHO STUTTER: ASSESSMENT AND TREATMENT OVERVIEW

- **Preassessment Procedures**
 - Case History Form, Audio or Video Tape Recording, Preliminary Phone Call, Preassessment Conference
- **Assessment Procedures**
 - General Considerations
 - Parent Interview
 - Teacher Interview
 - Child Interview
 - Speech-Language Sample Without Communicative Pressure
 - Structured Activities Without Communicative Pressure
 - Speech-Language Sample and Structured Activities With Communicative Pressure
 - Trial Management
 - Fluency Shaping
 - Stuttering Modification
- **Post-Assessment Procedures**
 - Speech Analysis
 - Frequency of Speech Disfluency (i.e., Disfluency Frequency Index)
 - Type of Speech Disfluency (i.e., Disfluency Type Index)
 - Molecular Description of Disfluency
 - Rate of Speech
 - Secondary Characteristics
 - Severity Rating
 - Adaptation and Consistency
 - Feelings and Attitudes
 - Other
 - Diagnosis
 - Prognosis and Recommendations
 - Post-Assessment Interview (i.e., Parent, Teacher, Other Participants)
- **Treatment Premises**
 - *School-age children who stutter must understand the nature of their own speech fluency and be in control of it before effecting reduction in disfluency.
 - *Clinicians must manage not only characteristics of speech fluency, but what each child thinks and feels about communication and himself as a communicator as well.
 - *Effective intervention requires an understanding of the child's communication environment and active participation of the child, his family, and others in all aspects of treatment planning, implementation, evaluation, and follow up.
- **Treatment Goals**
 - *Spontaneous or controlled speech fluency.
 - *Establishment and/or maintenance of a positive attitude (i.e., feelings and thoughts) toward communication and oneself as a communicator.
- **Treatment Objectives and Procedures**
 - (1) Increase and Transfer Fluent Speech**
 - *Construct a "safe house" within which fluency blossoms, children (i.e., and clinicians) grow, and magic happens.
 - *Invite treatment objectives from the child.
 - *Create opportunities for the child to experience fluency success.

*Heighten the child's awareness of his speech fluency. Make the child's speech fluency (i.e., and only then, disfluency) the object of study.

*Develop or improve use of fluency facilitating techniques during instances of stuttering.

*Transfer fluency facilitating techniques to extraclinical settings.

(2) Develop Resistance to Potential Fluency Disrupters

*Engage the child in activities with gradually increasing degrees of competition.

*Reintroduce direct fluency challenge.

*Address the situations on the top rung of the child's communication hierarchies.

*Prepare for relapse: Relapse Happens!

(3) Establish or Maintain Positive Feelings About Communication and Oneself as a Communicator

*Prepare the child for the likelihood of being teased. Empower him with constructive strategies to withstand the potential ill effects of teasing.

*Help the child maintain positive thinking about communication and himself as a communicator.

*Talk with the child in positive ways. How we talk with children powerfully influences what they think about themselves.

(4) Maintain the Fluency-Inducing Effects of Treatment

*Help the child become his own clinician.

*Decrease the frequency of scheduled treatment.

*Maintain regular maintenance checks of decreasing frequency for at least two years post-treatment.

*Build in regular, child-initiated benchmarking.

*Deliberately revisit the past.

*Reexamine the child's personal construct.

*Integrate treatment changes within the communication system.

• **Working With School-Age Children Who Stutter and Have Concomitant Language and/or Phonological Impairment**

• **Working With Parents**

*Access To Parents

*Respecting the Primary Role of Parents

*Meeting Parents' Needs

• **Working With Teachers and Other School Personnel**

*Build rapport/establish collegueship with teachers.

*Banish elitism - All colleagues in education are equal.

*Provide teachers with Strategies to facilitate fluency in the classroom.

*Advocate for all children, particularly a child who stutters.

*Provide the child with more opportunity to speak on days when he is fluent, less when he is more disfluent.

*Expect the child to participate in regular assignments, but provide flexibility and support when adjustments need to be made.

*Shift perspective to see through the eyes of the child who stutters.

*Provide all children, particularly those who stutter, regular support for their daily victories.

*Prevent singling out a child who stutters.

ADOLESCENTS, ADULTS, & SENIOR ADULTS WHO STUTTER: ASSESSMENT AND TREATMENT OVERVIEW

- **Preassessment Procedures**
 - Case History Form, Audio or Video Tape Recording, Preliminary Phone Call, Preassessment Conference
- **Assessment Procedures**
 - General Considerations
 - Client/Family Interview
 - Preparation
 - Social Greeting
 - Questions and Dialogue
 - Speech-Language Sample Without Communicative Pressure
 - Structured Activities Without Communicative Pressure
 - Speech-Language Sampling and Structured Activities
 - With Communicative Pressure
 - Trial Management
 - Fluency Shaping
 - Stuttering Modification
- **Post-Assessment Procedures**
 - Speech Analysis
 - Frequency of Speech Disfluency (i.e., Disfluency Frequency Index)
 - Type of Speech Disfluency (i.e., Disfluency Type Index)
 - Molecular Description of Disfluency
 - Rate of Speech
 - Secondary Characteristics
 - Severity Rating
 - Adaptation and Consistency
 - Feelings and Attitudes
 - Other
 - Diagnosis
 - Prognosis and Recommendations
 - Prognostic Musings
 - Prognostic Indicators With Adolescents, Adults, and Senior Adults
 - A Prognostic Caveat - Chronic Perseverative Stuttering Syndrome
 - Recommendations
 - Post-Assessment Interview
- **Treatment Premises**
 - *Adults who stutter must understand, be in control of, and thereby increase their speech fluency before they can effectively reduce their disfluency.
 - *Clinicians must help adults who stutter manage not only the behavioral aspects of stuttering, but the more central thoughts and feelings about communication and themselves as communicators as well.
 - *Effective intervention must consider and be responsive to intrafamily (i.e., personal constructs and family systems), extrafamily (i.e., interdisciplinary teaming and multicultural awareness), and psychotherapeutic (i.e., fluency shaping and stuttering modification) factors.
 - *Change is realistic, desirable, and possible at any age across the life span.
 - *Intervention, particularly with senior adults who stutter, is a positive, inviting, and enlightening opportunity.
- **Treatment Goals**
 - *Spontaneous or controlled speech fluency (i.e., acceptable stuttering may be an appropriate goal in some cases).

Podklady k přednášce "Dosahování plynulosti řeči u dětí školního věku a u adolescentů, kteří koktají", Ústav pedagogických věd FF MU v Brně, 20.10.2004.

*Establishment and/or maintenance of a positive attitude (i.e., feelings and thoughts) toward communication and oneself as a communicator.

- **Treatment Objectives and Procedures**

- (1) Increase and Transfer Fluent Speech**

- *Establish the treatment setting as a "safe house" where clients and clinicians learn with and from each other and, as a consequence, grow together.

- *Invite treatment objectives from the client.

- *Create opportunities for the client to experience fluency success.

- *Heighten the client's awareness of his speech fluency. Make the client's speech fluency (i.e., and only then, disfluency) the object of study.

- *Develop or improve use of fluency facilitating techniques during instances of stuttering.

- *Address thoughts, feelings, and attitudes directly.

- *Transfer fluency facilitating techniques to extraclinical settings.

- (2) Develop Resistance to Potential Fluency Disrupters**

- *Introduce direct fluency challenge.

- *Revisit and advance toward the top rung of communication hierarchies.

- *Prepare for relapse: Relapse Happens!

- (3) Establish or Maintain Positive Thoughts and Feelings About Communication and Oneself as a Communicator**

- *Treat teasing and relapse as probabilities rather than possibilities. Empower clients with constructive strategies to withstand the potential ill effects of teasing and/or relapse.

- *Help clients maintain positive thinking about communication and themselves as communicators.

- *Talk with clients in positive ways. Help clients understand how they speak, think, and feel about themselves.

- (4) Maintain the Fluency-Inducing Effects of Treatment**

- *Help the client become his own clinician.

- *Decrease the frequency of scheduled treatment.

- *Maintain regular maintenance checks of decreasing frequency for at least two years post-treatment.

- *Institute regular, client-initiated benchmarking.

- *Deliberately revisit the past.

- *Reexamine the client's personal construct. Be sure the changes are integrated into the client's personal construct.

- *Integrate treatment changes with the communication system.

- *Respect the primary role of the conversational partners and help support their needs.

SELECTED TEXTS RELATED TO FLUENCY DISORDERS

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