Early Childhood Stuttering Therapy: A Practical Approach
(1.5-hour version)

J. Scott Yaruss, Ph.D., CCC-SLP, BRS-FD, ASHA Fellow

speech@yaruss.com / www.Yaruss.com
www.StutteringTherapyResources.com

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Overview

Part I: Stuttering 101

I. The Clinical Process for Preschool Children Who Stutter
   A. Initial Contact or Referral
   B. Diagnostic Evaluation
   C. Parent-Focused Treatment (if necessary)
   D. Re-evaluation / Follow-up

II. A Clinical Process Flowchart

III. Where Do Preschool Children Who Stutter Come From?
   A. All Clients Come From Somewhere
      1. Typically, we “inherit” our school-age clients from other clinicians…We inherit their evaluation data, treatment goals, activities, knowledge about stuttering (or lack thereof), and baggage – and this can affect their readiness to participate in treatment.
      2. For preschoolers, the situation is different…WE are often the first SLPs to see them. Still, preschoolers (and their families) are not without baggage of their own
B. What Has the CHILD Experienced?

1. We have traditionally assumed that preschool children are fairly oblivious to their stuttering.
   a) One prominent theory warned of significant consequences if the child became aware.
   b) Many clinicians have tried to prevent children from becoming aware by avoiding the word “stuttering” and using exclusively indirect treatment.

2. Recent research has shown that even very young children are already aware of their stuttering.
   a) And, there is very little evidence that purely indirect treatment works!

C. What has the parent experienced?

1. The most common advice parents receive from others is to not draw attention to stuttering.
2. What does this lead to? In a word? Fear!
   a) Fear that she might have accidentally done something wrong that caused the stuttering.
   b) Fear that she might make the problem worse by drawing attention to it or that she might make the wrong decision about the child’s treatment.
3. And, she has other fears too… “big fears” about the child’s future.

D. What Does This Mean for Us?

1. Rather than postponing an evaluation, fearing that we might “create awareness,” we can (and should) get involved so we can be sure that the child gets the help he needs and so we can address the parents’ fears!
2. Rather than using solely indirect approaches that have questionable validity, we can use more direct approaches that have proven efficacy!
3. Recognizing the reality of the child’s awareness and the parents’ fears frees us to do our jobs!

Part II: Getting Ready for Treatment

I. What is the purpose of the diagnostic evaluation? To determine whether the child is at risk for continuing to stutter and, therefore, whether he needs treatment!

II. Where Do We Start?

A. Our recommendation is based on the child’s risk for continuing to stutter, so…we need to determine his risk for continuing to stutter!
   1. If he is at risk for continuing to stutter, then he is definitely in need of treatment.
   2. If he is not at risk, then perhaps treatment can wait.

B. Unfortunately, there is no single factor that necessarily differentiates children who will continue to stutter from those who will recover.
   1. What we can do is assess risk factors…

C. Some risk factors are related to the causes of stuttering.
1. Stuttering arises due to an interaction among several factors that are affected by both the child’s genes and the child’s environment. An interaction among these factors contributes to the likelihood that the child will produce speech disfluencies and react to them.
   a) Language Skills for formulating messages
   b) Motor Skills for producing rapid and precise speech
   c) Temperament for reacting to/regulating disruptions

2. What are we looking for in the child?
   a) A mismatch between Language Skills and Motor Skills (any type of mismatch)
      (1) Advanced language skills & typical/lower motor skills
      (2) Advanced motor skills & typical/lower language skills
      (3) And...anything in between.
      If you see a mismatch in the child’s language and motor skills, this counts as a risk factor.
   b) A sensitive or highly reactive Temperament. If the child is reactive or has difficulty regulating emotions, this counts as a risk factor.

D. Stuttering Is Genetic
1. Stuttering runs in families – if you have one person in a family who stutters, chances are 60-70% that you will find another person in the family who also stutters.
   a) If the child has a positive family history of stuttering, this counts as a risk factor!
2. Girls are more likely to recover than boys.
   a) If the child is a boy, he is more likely to continue stuttering and this counts as a risk factor!

E. What about the Environment?
1. The field once believed that the environment caused stuttering, but we now know that is not true.
2. Still, the environment does play a role
   a) An advanced communication model does not cause stuttering, but it can make it harder for the child to communicate successfully.
      (1) Children are more likely to stutter on longer, more complicated utterances (adult language model)
      (2) Severity is related to dyadic speaking rate (the difference between the parent’s and child’s rate)
   b) Strong reactions to stuttering by parents do not cause stuttering, but it may convey that stuttering should be feared

F. Most Children Recover…But Not All (Approximately 75% of children who stutter recover!)
1. Most do so within the first 6 to 12 months. After that, even though some can recover 2, 3, or even 4 years post-onset, the chances of recovery diminish.
2. The longer the child stutters (i.e., the greater the time since the onset of stuttering), the less likely he is to completely recover.
   3. Longer time since onset counts as a risk factor. (Longer than what? The field does not agree.)
G. Summary of Risk Factors
   1. Positive family history of stuttering
   2. Time since onset > X months (Exactly how long is still under debate – I use 6 months)
   3. Child has language / motor mismatch.
   4. Child has concomitant speech/language disorders (Indicates a fragile language or motor systems.)
   5. Child is highly reactive to mistakes or disfluencies (Esp. if the child is concerned about stuttering)
   6. Parental reactions are negative or fearful

H. Again, notice what’s missing…
   1. I did not mention the frequency of speech disfluencies exhibited by the child.
   2. Frequency tell us relatively little about whether the child is likely to recover from stuttering
      a) Some children who stutter severely can still make a complete recovery, while others who stutter mildly may still be at risk for chronic stuttering!
      b) “Initial severity does not predict chronicity.”

I. A Final Word on Risk Factors
   1. Remember that these risk factors are not definite determiners of who will continue to stutter (or who will need treatment) they are simply predictions based on presumed likelihood. (Even children with family history can recover!)
   2. By considering these factors, we can make a reasonable prediction about whether the child is likely to recover on his own; if he is not, we can feel more confident recommending treatment.

J. Summary of the Diagnostic Evaluation
   1. The purpose of the evaluation is to determine whether the child needs treatment, based on his presumed risk for continuing to stutter.
   2. The more at risk the child is, the more likely he is to need treatment!
   3. This does not mean that everybody receives the same treatment – we can scale our treatment based on the perceived level of risk!

Part III: A Family-Focused Treatment Approach for Preschool Children Who Stutter

I. What’s the Primary GOAL of Treatment for Preschool Children?
   A. To Help Them Speak More Fluently! (i.e., to eliminate the stuttering)
   B. How Do We Do That? “There’s more than one way… …to skin a cat”

II. Treating Preschool Children Who Stutter – the OLD Way
   A. Historically, treatment for preschoolers has been indirect, based on the (incorrect) diagnosogenic theory
   B. No instructions were provided to the child about how to modify his speech or improve his fluency
      1. In fact, no mention of speech was made at all, for fear that the child would “get worse” or “become aware of his stuttering”
      2. This is old news! Times have changed!
III. Treating Preschool Children Who Stutter – Some NEW Ways

A. Over the past 15 to 20 years, researchers and clinicians have moved toward providing direct treatment for preschool stuttering

1. Direct treatment of speech fluency through:
   a) Establishment of fluency-facilitating environment
   b) Direct discussion of stuttering to ensure healthy, appropriate communication attitudes
   c) Modification to the child’s speech to enhance fluency

2. Operant correction of stuttered speech and praise for fluent speech (e.g., Lidcombe program)

B. This workshop presents the Family-Focused Treatment approach

1. For young children who stutter, the first goal of therapy is to improve their fluency

2. Still, our therapy is not focused entirely or exclusively on fluency
   a) We also work to ensure that children develop effective communication skills
   b) And, all along the way, we want to ensure that children develop appropriate attitudes toward their speaking and stuttering

3. Fortunately, we have several effective tools to help us accomplish these broad goals!

IV. A Family-Focused Treatment Approach for Preschool Children Who Stutter (from Yaruss, Coleman, & Hammer, 2006)
Part IIIa: Parent-Focused Treatment

I. Treatment Goal #1: Educate the Parents
   A. Goal: Parents will (continue to) receive provide information and support as they learn about stuttering and how they can help their child.
   B. Procedure: The parents and clinician will...
      1. continue discussions started at the initial contact or diagnostic evaluation so the parents will have a greater understanding of stuttering.
      2. discuss information as needed so the parents are ready to assume the role of “home clinician.”
         a) Remember that counseling ≠ informing, so watch out for too much informing
         b) We do need to provide information, but don’t bowl them over with too many facts and try not to be too directive in treatment

II. Treatment Goal #2: Identify Fluency Stressors
   A. Goal: The parents will identify factors (fluency stressors) that make it more difficult for their child to maintain fluency.
   B. Procedure: The parents will...
      1. Learn about the “bucket analogy” so they can understand the role of stressors.
      2. Complete “stressor inventories” so they will see what “adds water to the bucket”
   C. The Bucket Analogy helps parents understand that many factors affect stuttering and that we cannot distinguish the influence of individual factors once they are in the bucket.
   D. The Stressor Inventories help parents identify factors that might add water to the child’s bucket (see back of handout for stressor inventories)

III. Treatment Goal #3: Introduce the Concept of a “Fluency-Facilitating Environment”
   A. Goal: Parents will understand the value of making changes in their own communication style (a “fluency-facilitating environment”) to help their child speak more fluently.
   B. Procedure: Parents and clinicians will...
      1. Review “stressor inventories” and bucket analogy to see what stressors can be diminished.
      2. Consider changes to the parents’ communication style that may enhance the child’s fluency.
   C. Parents can change their speech patterns to help the child achieve more fluent speech, e.g.:
      1. Slower speaking rate (not too slow!)
      2. Easier interaction style (increased pausing both within and between utterances)
      3. Less hurried daily pace / lifestyle (be careful with this one)
         (Less hectic scheduling of daily life activities; one-on-one time with the child)
IV. Treatment Goal #4: Teach the Parents to Provide a “Fluency-Facilitating Environment”

A. Goal: Parents will learn how to provide a fluency-facilitating environment for their child.

B. Procedure: The clinician will...
   1. Model communication changes for the parents
   2. Give parents the opportunity to practice, both in the therapy room and outside the therapy room.

C. Examples of Communication Modifications
   1. Reducing parents’ speaking rates slightly (i.e., using an “Easy Talking” model)
   2. Reducing time pressures (also called “delaying response” or, simply, “pausing”)
   3. Reducing demand for talking (if demand is high)
   4. Modifying questioning (if and only if necessary)
   5. Providing a supportive environment for both fluent and stuttered communication

V. How Can We Help Parents Do All These Things?? (and do them consistently)

A. “Parent-Child Training Program” -- A 6-to-8 session treatment program in which we address the 4 key goals presented thus far.
   1. 2 to 4 parent-only sessions for counseling and education (expanding upon the process started at the initial contact and covering Goals 1 and 2).
   2. 3 parent-child sessions when parents learn and practice fluency-facilitating communication modifications (covering Goals 3 and 4).
   3. 1 to 2 review and problem-solving sessions where the need for further treatment is assessed.

Part Illb: Focusing on Parent and Child Acceptance

I. Is It REALLY Okay To Talk About Stuttering ?!?

A. YES! Talking about stuttering (in a supportive way) will not make stuttering worse.

   One treatment approach (the Lidcombe Programme) even teaches parents to point out disfluencies in a child’s speech and ask them to say the words again smoothly, without “bumps.”

B. It’s even okay to say the “S” word: “Always use the proper name for things. Fear of a name increases fear of the thing itself.”

II. Treatment Goal #5: Talk to the Child about Talking

A. Goal: Parents will create an environment where stuttering is viewed in a straight-forward, matter-of-fact manner, so it is nothing to fear.

B. Procedure: The clinician help parents learn to...
   1. Model appropriate attitudes toward the child’s speaking abilities and stuttering behaviors
   2. Respond to stuttering in a supportive manner
   3. Talk directly to children about stuttering
III. Treatment Goal #6: Addressing More “Big Fears”

A. Goal: Parents will develop the tools they need to help their children overcome their own fears and concerns about stuttering.

B. Procedure: The clinician will...
   1. Listen to the parents’ concerns about how they should respond to their children’s fears.
   2. Give parents concrete suggestions about what they can say when their children express their fears.

Part IIIc: Child-Focused Treatment

I. First, Decide If It’s Necessary

A. For many children, this is all you need to do.
   1. 67% of the children in the Yaruss et al. (2006) study recovered completely following just the 6- to 8-session parent-child training program. (This included the parent-focused treatment AND the attitudinal work described thus far.)
   2. The remaining 33% needed additional treatment. (Some just a few sessions; some more.)

B. So, the next step is to determine whether additional treatment is needed.

C. The Key Decision...How long should I try this before “giving up” and trying something else?
   1. I rarely stay only with parent-focused aspects of treatment for more than 3 months (6 sessions, every other week).
   2. If the child isn’t better by then, move on!

D. Child-Focused Treatment: Improving Fluency Directly
   1. If the child continues to stutter following the use of the parent-focused treatment (and attitudinal work), then it is time to begin direct child-focused treatment.
   2. At this point, the goal of treatment is actually the same as it is for older children who stutter
      a) To improve the child’s fluency through direct modification of the child’s communication skills
      b) To ensure that the child develops and maintains healthy, appropriate communication attitudes

II. Treatment Goal #7: Prepare the Foundation

A. Goal: The child will learn about speaking and stuttering so he will be prepared to make changes in his speech.

B. Procedure: The child will learn more about...
   2. What stuttering is and what happens when people stutter.
   3. Differences in speech production.
III. Getting Ready to Use Techniques
A. Now that we’ve laid the foundation, we’re ready to introduce techniques for enhancing fluency.
B. The problem is… the child is still very young!
   1. There are a lot of different techniques and we don’t want to confuse him with too much to do.
   2. So, we need to think carefully about which techniques we’ll use, why we’ll use them, and how much we’ll expect the child to do.
C. Most (all?) techniques for enhancing fluency involve changes to two parameters: timing & tension.

IV. Treatment Goal #8: Making Changes to Speech Timing
A. Goal: The child will demonstrate the ability to reduce his speaking rate to enhance his fluency.
B. Procedure: The child will:
   1. Learn the difference between “too fast,” “too slow,” and “just right” speaking rate.
   2. Practice using a speaking rate that is “just right” (i.e., slightly slower than his habitual rate).

V. Treatment Goal #9: Making Changes to Speech Tension
A. Goal: The child will demonstrate the ability to reduce physical tension in his speech mechanism in order to enhance his fluency.
B. Procedure: The child will:
   1. Learn the difference between “too tense,” “too loose,” and “just right.”
   2. Practice using physical tension that is “just right” (i.e., slightly less tense than normal).

VI. Treatment Goal #10: Ensuring Healthy Attitudes
A. Goal: The child will (continue to) discuss stuttering in an open, matter-of-fact manner that reflects acceptance rather than fear.
B. Procedure: Even while talking about ways to enhance the child’s fluency, the clinician will keep the child’s and parent’s focus on successful communication as the primary outcome of therapy.

VII. Summary of Family-Focused Treatment
A. The Family-Focused Treatment Approach help preschool children achieve and maintain normal speech fluency. Treatment involves parent-focused and child-focused that are designed to:
   1. Help parents make communication modifications to indirectly facilitate children’s fluent speech
   2. Help parents and children develop and maintain healthy, appropriate communication attitudes
   3. Help children make communication modifications to directly improve their speech fluency

VIII. Summary
A. The primary goal is to help preschool children eliminate their stuttering.
   1. Although more needs to be done, there is at least preliminary evidence that this approach is effective
B. In addition to addressing fluency, treatment should ensure that the child develops appropriate communication attitudes so he does not struggle with his speech (and, in case he does continue stuttering and needs more advanced treatment)
Key Stuttering Organizations and Resources

I. Stuttering Foundation of America (SFA) - www.stutteringhelp.org -- (800) 992-9392
   A. Publishes many helpful booklets and videotapes for clinicians, people who stutter, and their families
   B. Provides numerous CE workshops for SLPs

II. National Stuttering Association (NSA) - www.WeStutter.org -- (800) We Stutter (937 8888)
   A. Supports more than 80 local chapters for adults, as well as several new chapters for children and families.
   B. Provides CE workshops for SLPs as well as workshops for people who stutter and their families
   C. Hosts an annual conference with 3-day youth program

III. Friends: Association for Young People Who Stutter - www.friendswhostutter.org
   A. Hosts an annual conference bringing together people who stutter from around the country

IV. SAY: The Stuttering Association for the Young – www.SAY.org
   A. A non-profit organization that empowers young people who stutter and inspires the world to treat them with compassion and respect, so they can achieve their dreams.

V. American Board on Fluency and Fluency Disorders - www.StutteringSpecialists.org
   A. Certifies specialists in fluency disorders; provides information to consumers and professionals

VI. The Stuttering Home Page (http://www.stutteringhomepage.com)
   A. Contains a tremendous amount of helpful information about stuttering, including essays about stuttering, course syllabi, and links to other stuttering pages

Some Helpful Resources and References

(This is just a selection. There are many resources available to help clinicians improve their confidence in helping people who stutter)

Selected Author References

Factors Potentially Associated with Childhood Stuttering

- Negative Reactions to Stuttering
- Fast-Paced, Demanding Questioning
- Frequent Interruptions
- Competition for Talking Time
- Rapid Rate of Conversation

- Unrealistic Demands
- Major Life Changes
- Family / Sibling Conflicts
- Traumatic Events (?)
- Fast-Paced / Unpredictable Lifestyle

- Genetic Predisposition to Stutter
- Language / Motor Mismatch
- Highly Reactive Temperament
- Concomitant Speech/Language Disorder

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Personal, Interpersonal, and Communicative Stressor Inventory

Child's Name: ___________________________ Date__________________

Person Completing Form: _______________ Relationship to Child _______________

When a child stutters, parents often ask why their child is experiencing difficulties with talking. There is no single answer to this question. There are, however, a number of different factors that may be involved. These factors (or stressors) can come both from within the child and from within the child’s environment. Developing a better understanding of these stressors can help parents and speech-language pathologists better understand a child’s stuttering, and this can enhance success in therapy.

Please check the items that apply to your child and your child’s environment. Remember, these factors do not cause stuttering—they simply contribute to your child’s overall communication environment.

POSSIBLE STRESSORS WITHIN THE CHILD

_____ Is sensitive (reacts strongly to life experiences) or has an “intense” personality.

_____ Tends to be a perfectionist or becomes easily frustrated or upset.

_____ Is highly competitive with others.

_____ Demonstrates performance anxiety or fears about speaking.

_____ Becomes more disfluent when tired or ill.

_____ Exhibits other speech and language or communication difficulties.

_____ Has family members or other relatives who have stuttered or who currently stutter.

(Note: This item refers to the fact that stuttering runs in families, due to genetic factors)

POSSIBLE STRESSORS WITHIN THE ENVIRONMENT

_____ Experiences hectic daily routines at home or in other settings.

_____ Faces intense sibling rivalry or competition for talking time.

_____ Has limited opportunities for free time or quiet time.

_____ Shares communication environment with others who talk fast or interrupt frequently.

_____ Has experienced stressful life situations (e.g., divorce, death, etc.).

_____ Experiences high expectations imposed by others (e.g., family members, teachers, etc.)