

Description of the School-Age Therapy Process

Early Sessions: Learning about Speech and Stuttering

During initial therapy sessions, activities focus on giving students the opportunity to discuss, learn about, and demystify stuttering (Dell, 1993; Murphy, 1999). We gain insight into children's

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perceptions about the nature of stuttering, as well as their feelings and beliefs regarding their own particular speech difficulties.

Early sessions incorporate activities that present information about stuttering, explore student attitudes, and assess situational variables that may affect speech fluency. These activities set the stage for therapy

by giving students a preliminary understanding of stuttering and establishing an attitude of openness and acceptance toward it. They also help to identify cognitive, affective, linguistic, and/or social factors that may be influencing a child's stuttering (Healey, 2004; Reardon-Reeves & Yaruss, 2004). These types of activities are revisited regularly as children move through treatment.

Initial discussions should address the fact that that speech therapy will involve making noticeable changes in how students talk. Students should understand that, although their new speech skills will help them to speak more freely, the speech changes will feel and sound somewhat different from what they are accustomed to (Reardon-Reeves & Yaruss, 2004).

The anatomy of the speech system and the physical processes involved in speaking (respiration, phonation, and articulation) are also discussed during early therapy sessions. Age-appropriate explanations are provided as children examine their own speech system and how it works (Chmela & Reardon, 2001; Conture, 1990; Ramig & Dodge, 2005). In addition, students identify and explore how different speech sounds are produced.

Stuttering Modification Strategies

1. **Catching the Stutter**
 2. **Relaxing the Stutter**
 3. **Slide**
 4. **Easy Stuttering**
 5. **Cancellation**
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After basic knowledge of the speech process is established, students learn to examine and modify their stuttering. This involves identifying stuttered speech (Catching the Stutter), changing levels of tension as they purposefully stutter (Relaxing the Stutter), and learning ways to reduce tension and modify real moments of stuttering (Slide, Easy Stuttering, and Cancellation). Teaching these skills in the early stages of treatment sends a clear message to students. That is: *They can directly address, work with, and change their stuttering.*

Stuttering modification skills are typically taught before fluency-enhancing strategies. One reason for this is that we want to show students that they can manage their unwanted stuttering behavior. We want to help students *move toward* the thing that's been causing problems. This runs counter to a person's natural tendency to move away from, avoid, or hide their stuttering. Avoiding and hiding the stuttering tends to make it worse, whereas *facing the stuttering directly* tends to decrease its potency and power.

Another reason for teaching stuttering modification skills first is that, even though fluency techniques can improve students' fluency to a great degree, there will be times when stuttering occurs. It is essential that children have the ability to directly modify this stuttered speech.

A final reason why we teach stuttering modification strategies first is that students may transfer these techniques into daily life sooner than their fluency-enhancing skills. This allows students to experience the benefits of therapy right away.

Fluency-Enhancing Strategies

1. **Relaxed Breath**
 2. **Slow Stretched Speech**
 3. **Smooth Movement**
 4. **Easy Voice**
 5. **Light Contact**
 6. **Stretched Speech**
 7. **Linked Relaxation Rhythm**
 8. **Extra Intonation**
 9. **Nearly Natural Speech**
 10. **Natural Speech**
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Fluency-enhancing strategies are introduced after students have demonstrated proficiency with the stuttering modification skills.

When necessary, diaphragmatic breathing (Relaxed Breath) is taught first in order to promote beneficial breathing patterns and provide a foundation for other fluency skills. Then a slow, prolonged speech pattern is introduced (Slow Stretched Speech). This provides “a container” within which additional fluency skills are integrated and practiced.

Next, students are taught specific strategies for producing various classes of speech sounds in an easy, relaxed manner (Smooth Movement, Easy Voice, and Light Contact). Then students’ speech rate is increased, while still maintaining a prolonged and physically grounded modification (Stretched Speech).

Students then learn to produce connected speech with relaxed and rhythmic continuous phonation (Linked Relaxation Rhythm). This speech pattern is subsequently normalized somewhat by adding extra inflection and vocal variation (Extra Intonation).

Next, students’ speech rate is increased once again, and more normal inflectional patterns are adopted (Nearly Natural Speech). Finally, a natural-sounding speech pattern is produced as all the fluency-enhancing strategies are integrated with a high level of sophistication (Natural Speech).

It should be noted that all of the slower unusual sounding fluency-enhancing strategies *are only used in the therapy room or during home practice*. Students don't transfer these skills to outside

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settings until they have been shaped into natural sounding speech.

Furthermore, as students move through the progression of fluency-enhancing speech patterns, they continually review and integrate their stuttering modification strategies.

Ultimately, students will make the various strategies their own by spontaneously adjusting them in ways that "feel right in their bodies."

Whether they are learning stuttering modification or fluency-enhancing skills, it is extremely important that children understand *why* they are doing *what* they are doing. This will improve skill development and deepen their investment in the therapy process (Reardon-Reeves & Yaruss, 2004).

Final Sessions:

Carry-Over with Appropriate Expectations

Students use these stuttering modification and fluency-enhancing skills during structured activities that gradually increase length of utterance and linguistic complexity.

When children demonstrate success with the strategies at the conversational speech level, a systematic process of carry-over is initiated. We help students create hierarchies of increasingly difficult speech situations, and then provide support as they transfer what they have learned into home, school, and community settings. Initially, it is important to choose a limited number of specific situations in which the skills will be used (e.g., with particular people, in particular places, and/or at particular times).

Parents, other family members, teachers, and the children themselves must have realistic expectations about what happens at the end of therapy. While students should certainly continue to practice their skills in order to keep them fresh and accessible, they are not expected to use them all the time.

The goal is to become an effective communicator who can manage both stuttered and fluent speech.

In addition, students should understand that their strategies won't always work. They should be reminded that *because they are human*, even the strongest, most well-developed speech skills will break down under certain circumstances. Thus, the issue is not whether their speech skills will always work. The issue is how

students can best manage the times when they don't.

Indeed, the goal is *not* 100% successful implementation of the speech strategies. The goal is to become an effective communicator who can manage both stuttered and fluent speech. The goal is to develop a variety of strong and flexible skills that substantially increase one's ability to speak freely.

When parents, teachers, and students have realistic expectations, they are much less likely to become frustrated by the inevitable ups and downs that are associated with transferring new skills into daily life. Therefore, it is essential that we appropriately educate them about what to expect at the end of treatment.