Helping Adolescents Who Stutter Focus on Fluency

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Perhaps no other time in the life of a person who stutters is more frustrating than adolescence. Van Riper (1971) maintains that problems for youngsters who stutter redouble during adolescence. In discussing the self-concepts of adolescents, Van Riper adds the following:

Adolescents are often the clinician's toughest cases. They cannot bear to confront their stuttering deviancy long enough to do anything about it They resist being singled out They want the security of peer group affiliation with an intensity which is almost overwhelming. (p. 207)

Couture (1982) suggests that the last thing most adolescents want to do is to touch, see, feel, and discuss (with a speech-language pathologist) that which is most trouble especially personal aspects of their fluency and speech production. Experienced speech-language pathologists would agree that many adolescents are sensitive and are among the toughest clinical cases. Like their adolescent peers, students this age who stutter fill their days with a

ABSTRACT: This article recommends that structure and consistency in treating adolescents who stutter are particularly important. The impact of the speech-language pathologist's positive expectations for improvement is recommends that structure and discussed as having a definite influence on the student's attitude and belief that such progress is possible. A comprehensive' program of both cognitive and self-instructional procedures (relaxation, mental imagery, and specific treatment positive self-talk) and behavioral speech treatment strategies is recommended to promote durable results Basic tenets of treatment believed critical when helping adolescent students who stutter are offered.

KEY WORDS: fluency, adolescence, relaxation, imagery, affirmations

number of competing extracurricular activities (e.g., sports, music, camps, special interest groups, etc.). Some students’ schedules realistically do not permit time for speech treatment. Occasionally, adolescents do not show up for their scheduled appointments. Whether the reasons for missing or avoiding therapy are indeed related to competing activities, time constraints, or fears and denial, getting adolescents to commit to the time necessary for treatment is problematic. Manning (1991) proposed that any speech-language pathologist who
is able to convince a teenager who stutters to enroll in treatment should receive a large bonus.

School speech-language pathologists may be unaware of the deep feelings of inadequacy adolescents who stutter may harbor. Some students honestly believe they are unable to do anything about their fears and speech disruptions. Prins (1993) eloquently discusses the sense of futility many adolescents who stutter experience when they anticipate speech failure. Feelings of helplessness result in self doubts in their ability to speak. Often such fears that they will be unable to cope successfully generalize to an overall loss of self-esteem. Such factors should be considered when planning treatment programs.

Helping adolescent students who stutter deal with their fractured fluency and the associated fears and frustrations is especially challenging. Successful therapy requires a solid student-clinician relationship that includes a well-defined treatment plan and a strong, tough-minded speech-language pathologist. In therapy, students will receive instruction on the use of a variety of specific treatment strategies, and they should understand the purpose of each one. After treatment objectives are described and goals are set by both the student and speech-language pathologist, the clinician may frequently need to specify and repeat the purpose of various therapy activities. Experienced speech-language pathologists realize that keeping students focused and on-task session after session is a Herculean task, and they acknowledge that distractions and failures occur often. The speech-language pathologist must consistently coach strategies and encourage the student to try specific again. The student must believe that, despite prodding and pushing to do his or her best, the speech-language pathologist honestly likes and respects him or her as a person. Persistence and a positive perspective are desirable qualities in the student as well as the speech-language pathologist. Ideally, the speech-language pathologist brings a positive and optimistic outlook to therapy. However, for a variety of reasons, the student is less likely to possess these attitudinal attributes when therapy is first initiated. In addition, some students have not become fluent after months or years of previous therapy. Daly (1988) suggested that the attitudes and expectations of the speech-language pathologist are critical to successful treatment outcomes. In addition to being a clear communicator, the speech-language pathologist must believe in the student's capacity to change his or her speech. The clinician must instill hope in the adolescent who stutters. Hope or positive expectation of treatment outcome is important for therapeutic success. Van Riper reminds us that "hope is not evil, however fit is engendered" (1975, p. 475). And, Mowrer (1960) argued years ago that hope is absolutely necessary if any learning is to be accomplished.

Therefore, the speech-language pathologist's belief in the student's potential for improvement must be genuine and unfaultering throughout the student's attempts to change his or her behaviors. The adolescent student may need to change his or her respiratory, phonatory, and intra-oral breath pressure responses when speaking. Changing any habitual behavioral pattern is difficult; changing the behavioral components of a stuttering speech pattern is particularly difficult. Equally important, and possibly more difficult, are the changes the student may need to make regarding his or her attitudes, belief system, and the emotional components of the fluency problem.
The speech-language pathologist's positive expectations for improved performance will help the student believe such progress is possible. The school speech-language pathologist must provide hope repeatedly for the student during inevitable periods of doubt or reduced motivation. Many adolescents drop out of therapy, miss sessions, or attend begrudgingly. Other disfluent students often "downplay" the effects of their stuttering on their communication and social interactions. Some adolescent students display mood swings, whereas others are argumentative or sullen-possibly as a result of their stuttering. Mood swings and strong reactions to failure make speech therapy less than a steady course of action. Student rationalizations for poor attendance or for not practicing are common.

Some of the most frequent rationalizations heard from students were: "My speech doesn't bother me. Really, my disfluencies are no big deal. OK, an inconvenience maybe, but a serious problem-NO!" Van Riper (1975) and Couture (1982) both make a strong case for the argument that often such negative or seemingly disinterested students are testing the speech-language pathologist. They are testing to determine whether the speech-language pathologist is committed to his or her belief about the importance and necessity of therapy. Adolescents who stutter challenge and test to determine if the clinician possesses a sound knowledge base and is, in fact, clinically competent in applying the relevant theories and facts with regard to stuttering therapy.

Speech-language pathologists must realize that although student doubts about the efficacy of therapy are common, they typically occur simultaneously with a strong desire for help. For some stuttering students, adolescence may be the first time they have a choice regarding whether or not to remain in therapy. Besides not wanting to be considered different from their peers by being pulled out of class for treatment, adolescents may challenge the speech-language pathologist by posing many questions regarding qualifications, treatment efficacy, and clinical expertise. Some students may question the specific procedures or the length of the proposed plan of treatment. More probable, and perhaps more important for this age group, is a more basic question-adolescents, perhaps more than younger or older clients, want to know if their speech-language pathologist is someone they can trust.

**THERAPY PROCEDURES FOR ADOLESCENTS WHO STUTTER**

**Rationale**

Years ago, the authors believed that many adolescent and adult individuals who stuttered could achieve "normal fluency." After more than 45 combined years of clinical experience with clients who stutter (including the last 14 in private practice with moderately severe and severe cases), the authors have modified their beliefs and clinical philosophies. Clinical data indicate that permanent normal fluency for many adults with chronic stuttering may be the exception rather than the rule.

Fortunately, a much more optimistic picture is painted for the prognosis of very young children who stutter. Couture(1982) reminds us that the age of the stuttering is more important than the age of the child. The shorter the time stuttering has existed, the better.
Most authorities (e.g., Meyers & Woodford, 1992; Ramig, 1993) agree that the earlier young children who stutter are treated, the better the prognosis.

Adolescence represents that in-between age when the individual is not an adult and yet not a child. Clear efficacy of treatment data for adolescent youngsters who stutter do not currently exist. Treatment outcome studies for adolescents are rare, thus a reality-based prognosis for adolescents who stutter is not clear. The paucity of treatment outcome studies on adolescents who stutter must be rectified. Both within-subject case study reports and group analyses on treatment efficacy for adolescents who stutter are needed.

Uncertain outcome data for this group is not the only ambiguous factor. This "in-between age" also is a period of relative disorganization. Many concomitant external and internal pressures (e.g., dating, scholastic performance, peer-group identification) are associated with this transitional period. Adolescent students often perceive relapses and minor setbacks in therapy to be catastrophic. In addition to students' frustrations following fluency breakdowns, experiences like not making the tennis team or the cheerleading squad sometimes trigger a setback. Additionally, breaking up with a boyfriend or girlfriend occasionally seems to cause an increase in disfluencies. Basically, any emotional crisis resulting in a loss of self-esteem may provoke insecurities and negatively affect fluency skills. Unfortunately, such emotional upheavals are common in adolescence and the speech-language pathologist needs to be aware of such events as they may affect the student's mood, motivation, and performance in treatment.

Furthermore, clinical experience and recent data suggest that clients who suffer from allergies or asthma seem to experience more frequent setbacks or relapses. Parents of younger children who stutter as well as adolescents themselves inquire about the possible relationship between increased disfluencies and allergies or asthma. The co-occurrence of these illnesses with stuttering is quite apparent in the authors' clinical practice. Other investigators (e.g., Bloodstein, 1987; Fosnot, 1993) also report an increased awareness of this intriguing relationship. Although ear infections are less common during adolescence than earlier, they too may set off increased disfluencies. This would strongly suggest that school-based speech-language pathologists should be alert to such factors affecting students' health, energy level, fluctuating concentration, or ability to focus. Just as serious athletes strive to "play through their pain" when they are injured, adolescents with fluency disorders must be encouraged to "practice through the pain" of health-related problems and periodic illnesses as well as through life's ups and downs.

Given the multitude of potential emotional or physiological variables that may affect an individual's speech performance, keeping the student engaged in the ongoing treatment process often is difficult. Active participation in therapy is enhanced when student interest is peaked and when an understanding of procedures is heightened. Confusion and uncertainty regarding fluency disruptions are common reactions of adolescent students. Therefore, it is essential that the speech-language pathologist relate therapy concepts to ideas and examples that are meaningful and age-appropriate to the student. Analogies often are useful for increasing the student's interest and understanding
Procedures

Two analogies that have been used successfully over the years with adolescent students are offered. First, an analogy used in counseling and motor-speech training with adolescents pertains to driving a car. Most adolescents are highly interested in driving. Therefore, miles per hour (mph) are equated to different speech rates. Insurance companies report more accidents when drivers exceed the speed limit. In addition, when rain or icy conditions exist, speeds slower than the posted limits are recommended. Therefore, students are taught to adjust their speaking rate when fluency is tenuous; that is, at times when they are anxious, tired, stressed, or perhaps coming down with a cold or the flu. Extra vigilance in monitoring their rate also is recommended whenever clients sense images or feelings telling them they are going to fail. Because moments of stuttering are more likely to occur under such conditions, the authors firmly believe that speech-language clinicians should help students prepare mentally as well as physically. As will be shown later under the cognitive and self-instructional strategies phase of therapy, the authors concur with Olympians like Margaret Groos (marathoner and winner of the 1988 U.S. trials) who commented, "If you haven't done your mental homework in training, then you don't have anything to fall back on" (in Ungerleider & Golding, 1992, p. 29). Mental training is considered imperative for sustained improvement.

A second popular analogy that has been instructive and meaningful to many adolescents deals with sports. Students seem to understand descriptions of being "on" or "in the groove" during various athletic events such as basketball, tennis, golf, bowling, or skiing. Similarly, having "off days" or "choking up" also are concepts they understand readily. One particular book, The Mental Athlete, by Porter and Foster (1986), is recommended to adolescent students because the authors cogently report how athletes handle pressure, stress, choking-up, and the fear of failure. Adolescent students confide that they fear speaking failures and choking up too. Thus, sports examples have been exceedingly helpful with members of this age group who need guidance in dealing with their stress and fears associated with speaking.

Interestingly, serious athletes have known about the benefits of relaxation and mental imagery practice for years. Waitley (1984) reported that Russian athletes he interviewed confided that as much as 60% of their training program was devoted to mind training. Other researchers (e.g., Ungerleider & Golding, 1992) reported that 85% of the Olympic athletes they studied at the 1988 Olympics in Seoul, South Korea, practiced mentally as well as physically. Ungerleider and Golding maintain that "mental practice may facilitate a `set' to perform that actually results in improved performance" (p. 18). They add that many coaches and sports medicine personnel now advocate relaxation exercises, mental practice strategies, and visualization techniques for athletes as part of their training.

Coaches and sports medicine experts profess that practice for increasing the student's interest and understanding does not make perfect, but practice does makes permanent. What these experts and others (e.g., Suinn, 1985) maintain is that physical and mental practice will make perfect only if one is practicing the correct response. The authors concur and teach the same motto to adolescents who stutter. Regular mental practice and repeated motoric practice are both necessary for fluency improvement. Thus, the use of relaxation and mental imagery (visualization) of future fluent utterances and speaking situations as well as actual structured
speech practice are taught and encouraged. Clinical observations and enthusiastic feedback from successful fluency students strongly suggest that unless mental practice is combined with repeated speech exercises, lasting changes in fluency skills are highly unlikely. In addition, fostering an attitude of doing their best, rather than of being perfectly fluent, reinforces realistic perceptions of progress made during treatment.

The concepts discussed above provide the student with a clear yet comprehensive framework that outlines the work that will be necessary for successful therapy. The two analogies presented above correspond well to the two major components that constitute the primary treatment activities described below.

**Phase I. Speech treatment strategies.** This article is written with the premise that sufficient information is available to instruct, model, and teach adolescent students who stutter either fluency target skills (Cooper & Cooper, 1985; Daly, 1988, 1992; Shames & Florance, 1980; Webster, 1979, 1991) or stuttering modification strategies (Daly, 1984; Gregory & Hill, 1984; Peters & Guitar, 1990; Van Riper, 1973). Inasmuch as many speech treatment programs have been described expertly in this forum, as well as elsewhere in the literature, they will not be reiterated here. Whether computers, delayed auditory feedback machines, vocal feedback devices, or structured therapy materials are employed, the focus of direct speech help herein centers around changing what the stuttering students do to adjust their intra-oral breath pressures as they produce the necessary air, voice, and movement patterns.

Speech-language pathologists must not only provide students with adequate speech strategies effecting positive change, but also with the mental stamina to persevere during those times when failure seems imminent. Speech-language pathologists also must help students stay focused on the goals and specific tasks being practiced and offer immediate positive reinforcement for improved responses.

In virtually every one of his writings on therapy, Van Riper (1971, 1973, 1975) repeatedly reminds clinicians that individuals who stutter must change their attitudes and perceptions as well as their stuttering behaviors. In discussing the self-concepts of adolescents and adults who stutter, Van Riper argues convincingly that "any therapist must deal with more than the stutterer's speech" (1971, p. 200). A specific treatment program for helping stuttering adolescents and adults modify their voicing and breath pressure parameters has been designed (see Daly, 1988). Following the establishment of fluency skills, the second phase of treatment focuses on (a) guided relaxation exercises, (b) mental imagery and visualization activities, and (c) affirmation training and positive self-talk strategies to help students see themselves speaking more fluently in the future. This cognitive and self-instructional phase is critical for sustained progress.

**Phase 2. Cognitive and self-instructional strategies** Comments and complaints about relapses from students who had been discharged earlier from therapy as "successful" led to an appreciation of Lazarus' (1971) comment that "behavioral methods alone are often insufficient to produce durable results" (p. 173). Bandura (1977) also maintained that many students need cognitive therapy to help mediate the behavior change that occurs when successful performance leads to a sense of mastery. His self-efficacy theory has much to
offer speech-language pathologists who perhaps were trained in strictly behaviorally oriented therapy programs.

Follow-up studies (Daly & Darnton, 1976) with adolescent students who stutter revealed that "too many of our clients get fluent in their mouths but not in their heads" (Daly, 1988, p. 34). This realization led to the study and utilization of strategies that encouraged students' mental changes as well as their behavioral changes. Durable change occurred more readily when adolescents began to see themselves and hear themselves as different-as more fluent and more in control than previously. Maltz (1960) argued long ago that "before a person can change he must somehow see himself in a new role" (p. 29). Therapy was modified to incorporate cognitive strategies that allowed for and encouraged students to "see themselves" in new roles (i.e., more relaxed, more fluent, more in control). These perceptual changes occurred slowly over time and group therapy seemed to facilitate students' thinking positively. Comments from students were taken most seriously as various techniques were explored. The most successful students encouraged continued use of the procedures described below. They maintained that the relaxation, mental imagery, affirmation training, and positive self-talk strategies were as important in helping them achieve and maintain high levels of fluency as the direct speech therapy techniques used initially in treatment. Each strategy is described separately.

Relaxation - The doubting attitudes and negative self-talk many adolescent students demonstrate definitely interfere with establishing a new perspective about themselves as more fluent speakers. Benson's (1976) book, The Relaxation Response, is believed to be one of the more clearly written and easily understood explanations of relaxation techniques for adolescents. Many students purchase their own copy for future reference. Benson includes written scripts on relaxation that students may read aloud or record for future listening. He also cites research studies that extol the benefits of repeated listening to relaxation exercises. Repeated listening promotes a deepening of the relaxation response and enhances clearer mental images of desired future outcomes. Daly's (1988) program also provides a written relaxation script and audio cassettes with recorded relaxation exercises. Students report that repeated listenings to the tapes are exceedingly helpful.

Mental imagery - Many psychologists have written about the "self-fulfilling prophesy" where focusing on mistakes, inadequacies, and possible failures in the future actually contributes to those possibilities. The renowned psychologist Arnold Lazarus (1984) asserts that "if you assume that things will go wrong, you may inadvertently aid and abet the negative outcome" (p. 70). He emphasizes that if a person wishes to accomplish something in reality, he must first picture himself achieving it in his imagination. Following relaxation training, students are asked to begin imagining seeing themselves speaking fluently in school, when giving a report, or when talking over the telephone. Students are counseled that many of these tasks are difficult now, but they are encouraged and instructed to mentally rehearse future speaking outcomes. Repeated practice of "pre-playing" future successes usually enhances a student's ability to clearly image.
Waitley (1984) reports that a primary characteristic of highly successful athletes, scientists, and business executives was an ability to mentally rehearse events before they happened. The goal of mental rehearsal is to assist the adolescent student, through repeated practice of visualization and mental imagery, to perceive his or her future speaking experiences differently, that is, with more confidence and more fluency.

**Affirmation training and positive self-talk** - Affirmation training is a goal-setting activity. Affirmations are statements of truth written in positive language in the first person, present tense. They are statements that are not true now, but rather something the person wishes to be true in the future. The objective is to convince the subconscious mind that the statements are true now.

Adolescent students are assisted in writing simple positive statements on 3" x 5" cards. They are instructed to read the cards aloud into a mirror with enthusiasm several times a day. A solid rationale for practicing affirmations is provided by Meichenbaum and Cameron (1974), who were among the first researchers who reported good results by helping students modify what they say to themselves. Helmstetter (1986) also provides specific instructions and guidance for helping individuals change negative images through positive self-talk. Some examples of affirmations employed with adolescent fluency students include the following:

"I am positive and confident. I know that I can handle any speaking situation by remaining in control of my speech."

"My voice sounds strong, clear, and confident. I enjoy hearing the sound of my voice as I say `Hello' when answering the phone."

"Using easy pressure or smooth starts on the first words of my sentences helps me. The more I practice the smooth starts, the more fluency I have. Using smooth starts is smart!"

Initially, only a few affirmations are provided for each student. Subsequently, students are asked to write their own. Adolescents frequently rewrite or change the wording of their affirmations after they have practiced them for a week or so. They add new statements as they think of new situations. The goal is to read the statements aloud whenever they can throughout the day.

Neurolinguistic researchers, such as Robbins (1986), maintain that changes in behavior occur more readily when people change the way they communicate to themselves. Repeating positive, success-oriented statements increases positive expectations of future improvement and strengthens the students' belief in their own abilities.

As they begin to report successful speaking situations in individual and group therapy sessions, students are reinforced verbally. Writing down their successes also reinforces successful experiences. Not surprisingly, many adolescents find it difficult to recognize their fluency successes as important. Van Riper (1971) reminds speech-language pathologists that
students who stutter "minimize their successes and maximize their failures" (p. 203). Lazarus and Fay (1975) believe that clients must write down their successes. In their book, I Can If I Want To, they flatly predict, "no notebook, no change." Each student is encouraged to keep a success journal and to write down his or her expected and unexpected successes. Numerous adolescent students report that reading their entries aloud periodically, especially when having self-doubts or feelings of negativity, has been exceedingly helpful.

Regular practice and rehearsal of the cognitive and self-instructional strategies are necessary to change the negative or pessimistic attitudes possessed by many adolescent students who stutter. Clinicians are encouraged to give sincere, positive reinforcement when students report that their visual images are becoming clearer, and whenever they demonstrate increased use of positive self-talk. The authors' findings are in accord with those of Meichenbaum and Cameron (1974), who maintain that teaching and reinforcing positive self-talk behaviors leads to greater treatment efficacy, more generalization, and longer persistence of treatment effects. The importance of repetition and persistence in using and reinforcing the cognitive strategies cannot be overstated.

When practicing speech techniques and cognitive strategies, students are encouraged to strive to do their best, rather than trying to be perfect or the best. Shared goal-setting between the adolescent student and clinician is preferred. Frequently, restating the purpose and rationale for various therapy procedures also is particularly powerful. The speech-language pathologist's commitment to being positive, patient, and persistent with adolescent students with fluency disorders is critical for maintaining therapeutic trust.

SUMMARY AND CLINICAL IMPLICATIONS

Adolescence is a challenging period of development during which most individuals struggle to establish their own individuality as well as relate to their peer group. This period generally is associated with considerable confusion, fears, and denial for most students. Adolescence is particularly unsettling for students who stutter. Therefore, structure and consistency in treatment are of paramount importance during this period of development. With this in mind, five basic tenets of treatment for adolescent students are offered.

First, the school speech-language pathologist should be optimistic and enthusiastic with every adolescent student who stutters. It is imperative that the speech-language pathologist believe in the student's capacity to change and it is essential that this belief be conveyed to and fostered in the student. Confidence in the speech-language pathologist, the specific treatment strategies, and in him or herself are critical to the therapeutic outcome for each student.

Second, a well-defined course of action must be established to provide the student with a series of concrete, realistic goals. The procedures selected must be explained thoroughly to the student. Student awareness and understanding of the relationship between the various treatment activities and the goals enhances success. The authors' experiences mirror those of Lazarus (1971), who warned that if procedures do not make sense to the student, therapeutic
impasse is likely to occur. The rationale for most treatment procedures can be understood and appreciated by adolescent students, especially when related to concepts they already grasp and in which they have a particular interest. Several attempts to explain procedures, often with different examples or analogies, may be necessary.

Third, the authors contend that the frequency of treatment warrants serious consideration. Relapses and feelings of frustration from students suggest that treatment once a week is unrealistic for many adolescent students who stutter to comprehend the benefits of therapy. Adolescents who received therapy three times a week for the first 2 weeks, and then therapy twice a week for the next several weeks typically performed better. Frequent treatment initially serves to motivate students by demonstrating progress early in the therapy and to promote the development of a trusting relationship.

Fourth, a combination of both behavioral and cognitive treatment strategies most likely is necessary for successful treatment outcome. Clinical experience with scores of adolescents over the last decade indicates that repeated and consistent use of cognitive and self-instructional procedures augments the progress achieved using behavioral speech treatment strategies. A concatenation of the various procedures is strongly recommended.

Fifth, the speech-language pathologist plays many roles when working with adolescents who stutter. Sometimes empathic listening or counseling may be appropriate to help students focus on the multifaceted aspects of their problem. Decisions about whether a directive or a more supportive role is needed when dealing with predictable or unforeseen problems such as relapse must be made. At other times, the challenging, prodding, and encouraging guidance similar to that of an athletic coach may be necessary to realize results. Central to each of these roles and to each of the aforementioned beliefs is the speech-language pathologist's sensitivity and awareness as to when to be patient, persistent, or positive with the adolescent who stutters.

REFERENCES


