ABSTRACT: The purpose of this article is to describe some of the key principles for forming a strong clinical relationship with adolescents who stutter. Such a relationship provides the foundation for change. In the first section, a structure for understanding adolescence, along with some basic assumptions about the adolescent thought process, is provided. Following this, there are a number of suggestions for different skills to use when communicating with teenagers so as to (a) establish the clinician's credibility as a caring and competent adult and (b) gain insight into the adolescent as a person, and the meaning that he or she attaches to stuttering. The final portion of this article focuses on how the clinician can facilitate two important dimensions of stuttering management: changing cognition and building strong parent–teenager relationships.

KEY WORDS: treatment, teenagers, stuttering

For years, my primary research and clinical interests have been in the area of childhood stuttering. As a doctoral student at Syracuse University in the mid 1980s, I was involved in one of the first large-scale studies of the speech production behaviors of young children who stutter, under the direction of my mentor, Edward G. Conture. That work led to my interest in other phenomena of early stuttering, including various characteristics of parent–child verbal interaction and the role that it might play in early stuttering. Similar to my research path, my clinical work has focused primarily on preschool and school-aged children who stutter and their parents. I have found this work to be professionally and personally rewarding in more ways than I can describe here. Approximately 6 years ago, I entered a rather unsettling period in my life—a time that is familiar to many parents. My oldest child, a girl, became a teenager. For the first 10 or 12 years of her life, it felt as though the two of us were more or less on the same wavelength. As a result of my research and clinical work with young children who stutter and their families, I knew quite a bit about child development and parenting. I felt confident with my own skills as a parent, and for the most part, the positive relationship I had with my daughter was partial evidence to me that I was doing something right. For me, that feeling changed quickly and dramatically when she hit puberty. I am one of those people who deals with the unknown by reading, reading, and then reading some more about whatever area is the source of my anxiety. I am also a relentless conductor of the “informal survey” as a way to obtain insight, opinion, and information about a particular topic or theme. As I struggled to make some sense of my daughter’s world and our radically different relationship, I was also beginning to read more and more in the stuttering literature about teenagers who stutter. My personal journey was spilling over into my professional life. As I continued to read in the three different but related areas of adolescent psychology, parenting, and stuttering treatment for teenagers, I decided that I wanted to spend more time working clinically with this population. I understand my interest in working with teenagers who stutter to be a direct result of my simultaneous desire to help them and to learn from them.

For the past 5 years, the Wendell Johnson Speech and Hearing Clinic at the University of Iowa has offered a week-long residential therapy program for teenagers who stutter. This model is not new in and of itself; there are a number of other successful residential programs for people who stutter around the United States and abroad. However, I think our single focus on teenagers sets us apart somewhat, as do the intervention principles to which we adhere.
We have been fortunate to work with some amazing young people during the past 5 years. We have helped them, but they have helped us just as much. At this point, our program is very much a work in progress. By that, I mean that we have a relatively well-defined structure, but we continue to change various aspects of the program from year to year. We have experimented with various components (e.g., working with a sports psychologist) and evaluated what works best and what needs to be changed. We expect that we will continue in this experimental mode for quite some time, and we rely on direct feedback from the teenagers themselves to assist us in continued refinement of the program.

Now that I have provided some background of where I have been, let me turn to a discussion of what is to come, at least in this article. What appears in the following pages is my attempt to describe what I view to be key principles for establishing an effective clinical relationship with teenagers who stutter. When working with adolescents, forming a strong relationship provides the foundation for change. To set the stage, in the first section, I describe a basic structure for understanding adolescence, along with some basic assumptions about the adolescent thought process. In the second section, there are a number of suggestions for different skills to use when communicating with teenagers so as to (a) establish the clinician’s credibility as a caring and competent adult and (b) gain insight into the adolescent as a person, and the meaning that he or she attaches to stuttering. Finally, the third section focuses on how the clinician can facilitate two important dimensions of stuttering management: changing cognition and building strong parent-teenager relationships.

**UNDERSTANDING ADOLESCENCE**

To work effectively with teenagers, a clinician needs to understand and appreciate the many changes and challenges that define the adolescent years. One of my favorite sources of information about the psychological development of teenagers is *Get Out of My Life, But First Could You Drive Me and Cheryl to the Mall? A Parent’s Guide to the New Teenager* (1991) by Anthony Wolf. In the first chapter, Wolf describes the physical and intellectual transformation that takes place during this period of life. Underlying the changes that teenagers make in the ways they look and think is the “adolescent mandate,” which Wolf describes as the powerful drive to let go of childhood. According to Wolf, this period of turning away from childhood triggers an intense struggle as the adolescent comes to terms with the strong desire to grow up and the simultaneous (and just as strong) wish not to. It is this struggle between the “baby self” and the maturing self, this move toward independence and “a world separate from family and home (that) has always been at the core of adolescence, today and a thousand years ago. It is an inevitable process. More than anything else, it is responsible for most of the behavior that constitutes adolescence” (p. 15). For teenagers who stutter, the adolescent mandate is further complicated by the challenges that come with a persistent stuttering problem.

Let us assume for the purposes of this article that the teenagers we see for stuttering therapy are not coerced or forced by their parents to seek our services (although we realize that this is sometimes the case). Adolescents (and many adults) who stutter often come for therapy with partially formed notions of why they are there and what they want, and almost no idea of who we are and how we might be able to help them. Typically, these clients have vague feelings and ideas about stuttering that have led them to decide that they want to make some kind of change—or at least have led them to *contemplate* some kind of change to which they are not yet ready to commit (Proschaska, DiClemente, & Norcross, 1992). Although adolescents who stutter may believe that they want to make a change in their *speech,* it may be the case that they really want to change the way they *feel* about their speech and themselves, or the way their parents feel and think (and act) about their stuttering.

As clinicians, our first job is to help teenagers to explore the place that stuttering occupies in their lives. What meaning do they attach to their stuttering within the context of their everyday experience and in the present and future goals they set for themselves? It is hoped that this exploration will lead a teenager to understand why he or she has come to see us, and what he or she wants to do in therapy. How do we do this? First and foremost, by listening and talking to the teenager in a way that supports the development of a balanced relationship between ourselves and the adolescent (Blood, 1993). Helping a teenager to explore his or her stuttering and to take responsibility for the decisions made and actions taken to manage it is a process. A relationship based on mutual respect, a clear understanding of roles, and trust facilitates the journey.

**Basic Assumptions**

**They are the center of their universe.** As Wolf (1991) reminded us, adolescence is a time when the teenager’s world is expanding rapidly, at the same time as the relatively small “dailyness” of life receives passionate attention. As the adolescent is struggling to gain independence and experience in the outside world, to be part of a greater whole and to participate in the action that seemingly lurks around every corner, he or she is also intensely self-focused. This duality is important for us to remember. In my experience, many teenagers recognize the egocentricity of their thoughts and actions, but unlike adults, regard it as normal and often humorous. As one teenage girl said to me, “I know there are a lot of awful things happening in the world right now, and I feel really bad about it. But right now, right at this moment, this zit on my chin is bothering me more!”

**Being cool is key.** A big concern for teenagers at this time is the appearance of vulnerability; even though life is changing in important ways, the adolescent strives to appear outwardly immune to the stress that this change invariably brings. Adolescents want to appear cool, calm, and collected. For teenagers who stutter, the social imperative to be cool can be an obstacle to their participation in therapy, or to the transfer and generalization of therapy.
strategies outside of the clinic. For example, a teenage boy in our clinic shared with me that while he felt good about his ability to modify his stuttering behavior in and to some extent outside of the clinic, he had made the decision not to do so while talking with his friends. He explained this decision by telling me that if his friends noticed that he was changing his stuttering, they would know that he was “working on his speech.” More important, however, is the message that doing so sends; that is, working on stuttering indicates that one cares about, or worse for a teenager, is bothered by, stuttering. To directly or indirectly (through action) admit such feelings and concerns to their friends, family, or us is not cool.

Friends are everything; adults are irrelevant. At this time of life, friends are the main way that the teenager gauges his or her success. Most adolescents care very deeply about their friends and what they think of them. Disagreements with friends, or problems that their friends are experiencing, can strongly impact a teenager’s feelings about him- or herself. Alternately, teenagers view adults as occupants of the “old world” of childhood. The adolescent mandate to turn away from childhood requires that teenagers see the adults in their lives as imperfect and foolish. According to Wolf (1991), this is because teenagers believe that to be an adult (which is where they are headed) is to be perfect—something that they fear they will not be able to achieve. So, adolescents are motivated to create a model of adulthood that feels attainable to them from their current vantage point; that model is “adult as jerk” (Wolf, 1991). Our attempts to contradict this view only serve to galvanize the teenager’s belief that we are clueless and inconsequential.

As (adult) clinicians, we will improve our credibility with teenagers who stutter by providing them with a model of adulthood that they can envision themselves attaining and that they respect. Teenagers actually do want to look up to adults, maybe even to us. “What they ideally want to see...are adults who are flawed but who are not thrown by their flaws, and hence are still worthy of respect. Adults who act as if they know everything are hard for teenagers to stomach (Wolf, 1991, p. 39).” What this means for clinicians working with teenagers who stutter is this: The teenager is the expert on his or her own stuttering. As trained clinicians, we know the strategies that can help facilitate fluent speech or “easier” stuttering, but we do not know what is best for the teenager who stutters—only he or she can know that with our guidance.

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**GETTING TO KNOW YOU**

**Establish Roles, Goals, and Responsibilities**

In the beginning of the client–clinician relationship, it is important to agree on what the goals of the relationship are to be (e.g., to get to know each other, to assist the teenager in finding out more about stuttering in general and his or her stuttering in specific, to help the clinician understand the teenager’s stuttering). Once the goals of the relationship are mutually established, the clinician and adolescent should decide who is responsible for what. For example, the goal of getting to know each other assumes a shared responsibility. The goal of teaching the clinician about the teenager’s stuttering is also somewhat shared, but here the client must assume the lion’s share of the responsibility. Assigning responsibility is never clear-cut, but perhaps this is beside the point. The most important aspect of establishing goals and responsibilities is that such a task presents a problem that needs to be solved, and doing so requires discussion and negotiation. This sends a clear message to the teenager that his or her relationship with the clinician is one of mutual dependence; the clinician cannot “fix” the teenager’s stuttering, but neither can the teenager help him or herself alone. Describing the clinician–teenager relationship as similar to that of a coach and athlete is an effective way to help the teenager understand the roles of each.

**Know Your Subject**

Good relationships are established when people have an understanding of each other’s thoughts and attitudes, and also of their everyday life experiences. These experiences are shaped by the culture with which one identifies. Being familiar with contemporary teenage and young adult culture helps the clinician to place the client’s ideas, concerns, and needs in context. So, to work effectively with this population, a clinician needs to understand where teenagers hang out and what they do there. What music, clothes, movies, television shows, computer or video games, activities, and hobbies are popular? What is the typical high school day like? What material is taught in high school courses in English, history, and the social sciences? What political issues seem to resonate with contemporary teenagers?

Clinicians cannot expect to get this information from their teenage clients. Besides reading, it is important to maintain open eyes and ears. Notice what teenagers are wearing—both boys and girls. Visit music stores and take a look at (and listen to) top-selling CDs or listen to the radio and watch MTV from time to time. What people are gracing the covers of the popular teenager magazines, and what are the topics or issues covered by feature articles? People watch: To the extent possible (and appropriate), listen in on conversations between and among teenagers and between teenagers and their parents. Try to remember the “feeling” of being a teenager. Wolf described this feeling as a combination of passion and anticipation that “anything can happen.”

**Talk Less, Listen More, and Avoid Overstatement**

Teenagers react very negatively to adults who monopolize the conversation. Therefore, when talking with teenagers, it is important to talk less and listen more. In addition, it is important to avoid overstatement when trying to make a point with teenagers. As previously discussed, the adolescent mandate creates in the teenager a preconceived notion of adults as flawed; therefore, the teenager’s ultra-sensitive monitoring system looks for examples of things adults say
and do that support this bias or “judgment rule” (i.e., adults are jerks). As an example, my own teenage daughter came home from school appalled at something her physical education teacher told the class. Reportedly, while lecturing them about tardiness and absenteeism, he stated that their future employers would look at their physical education attendance record from high school to decide what kind of employees they would be. Now, there may be some grain of truth in that; however, my daughter and her classmates considered this comment to be totally without merit and from that point on, this particular teacher had no credibility with them, regardless of what he did or said. To be a teenager is to live in an “either–or” world.

Advance, Retreat, Advance

It is often the case that teenage clients cannot or will not give a direct answer to a direct question. This is due to a number of factors, including a general reticence to divulge information, truthfully not knowing the answer, and the amount of time needed to process a response. The amount of processing time required is typically related to the nature of the question itself, and for teenagers who stutter, the real possibility that no one has ever asked them a question about stuttering before. Therefore, when trying to obtain information from teenagers, it is sometimes helpful to use the “advance–retreat–advance” approach. For example, when asking a specific question such as, “What are some of the things you’d like to change about the way you talk?” (advance), the response may be “I don’t know” or “I’m not sure.” At this point, it is helpful to retreat, perhaps making some statements or comments related to either real or hypothetical clients (e.g., “Okay. That’s fine; it’s something to think about. Sometimes kids decide they want to learn how to talk more easily on the phone, etc. Is that true for you?” [advance]). If the response continues to be noncommittal, the clinician should move on to another topic (retreat), but remember to re-ask the question once the adolescent makes a comment that relates to it in any way (e.g., “Hmm. That’s interesting. You said that you feel embarrassed when you stutter in class. That’s understandable. Do you think that you would like to learn how to use easier speech, or change your stuttering in some way when you answer questions in class?” [advance]). The bottom line is that when a teenager’s response to your probes for information yields very little, don’t take this (figurative) “no” for an answer. Retreat and advance, using the teenager’s own comments to form the bridge back to the original question (or a modified version of it). This takes time and patience, but the payoff is well worth it.

Use Humor

Manning (2001) wrote about the importance of using humor in the treatment of stuttering. When working with adolescents who stutter, slowly working humor into the client–clinician interaction can accomplish very important things. First and foremost, it strengthens and deepens the relationship between the clinician and the teenager. As Manning discussed, humor is a shared experience that comes from spontaneity and a developing intimacy. When the teenager and clinician can laugh together, it shows that their relationship is moving beyond the preliminary stages of data gathering, goal setting, and role definition. “Accordingly, until the clinician is calibrated to the client and until some level of intimacy has been established in the therapeutic relationship, humor is not likely to serve a beneficial purpose” (p. 28).

Second, humor provides the clinician with a way to model both insight and perspective taking for the teenager, as these are the pre- or corequisites to expressions of humor. Third, using humor reflects a person’s ability to distance him- or herself from the current situation. One of the objectives of stuttering therapy is to desensitize the individual to various aspects of stuttering. For teenagers, desensitization tasks usually include talking about stuttering in general and the teenager’s stuttering in particular, and producing voluntary or “purposeful” stuttering as a way to increase behavioral awareness and decrease or reduce emotional awareness or reactivity (of stuttering). The adolescent’s ability to use and accept humor when participating in these tasks is evidence of a developing objectivity and insight.

Finally, the use and appreciation of humor is regarded as a mature way to cope with the challenges and stresses of life (Vaillant, 1977). According to Vaillant, because humor requires some degree of objectivity, it “permits one to bear and focus upon what is too terrible to be borne” (p. 386). For that reason, humor allows the teenager to express ideas and feelings about stuttering without discomfort or strong negative emotion. It helps the teenager to distance him- or herself from the behavior and “problem” of stuttering and facilitates a new cognitive set. Subsequently, this new “conceptual shift” (Manning, 2001) promotes the development of objective beliefs and attitudes about stuttering and the meaning that the teenager has assigned to it.

Writing

Writing is a powerful form of communication and can be especially so if a person has difficulty expressing him- or herself orally. This is certainly true for many adolescents who stutter. In his wonderful memoir, Stuttering: A Life Bound Up in Words, Jezer (1997) described the difference between the way he seemed to others and the way he actually felt as a child and teenager who stuttered. “Shy and quiet, that’s how everyone remembers me. But shy and quiet was how I seemed, not how I felt. I was silent in speech, but loquacious in thought” (p. 26).

This sentiment has been echoed by a number of teenagers who stutter who have shared with me their concern that people (e.g., other kids, their teachers, and even their families, to some extent) “don’t really know me.” They recognize that the primary way that people develop relationships, the way we really get to know one another, is through talking. This is perhaps even more the case with teenagers and young adults in that the developmental challenges of adolescence include the separation from old ties (i.e., parents) and the creation of new attachments (Siegler, 1997).
In order to increase the opportunities that a teenager who stutters has for self-expression, we routinely provide him or her with a variety of different writing projects. These give the teenager a chance to contemplate his or her thoughts and feelings about a particular issue objectively (e.g., how stuttering has affected his or her life) and to develop an opinion. Further, and perhaps more important, writing provides the adolescent who stutters with the time to express these ideas and feelings more fully. Besides providing the clinician with a good deal of information and insight about who the teenager is, the things that teenagers who stutter tell us in their writing serve as a jumping-off point for meaningful discussion.

To begin, there are a number of “paper and pencil” tools available for assessing the perceptions that teenagers and adults have about their stuttering and related issues. For example, we routinely administer the Modified Erickson Scale of Communication Attitudes (S-24; Andrews & Cutler, 1974) and the Iowa Scale of Attitudes Toward Stuttering (Johnson, Darley, & Spriestersbach, 1963), as well as the Self-Ratings of Reactions to Speech Situations (Johnson, Darley, & Spriestersbach, 1963). Two other excellent tools for assessing a teenager’s perceptions of the degree to which he or she avoids or struggles with stuttering, as well as the degree of confidence in different speaking situations, are the Perceptions of Stuttering Inventory (PSI; Woolf, 1967) and the Self-Efficacy for Adolescents Scale (SEA; Manning, 1994, 2001).

In addition to these questionnaires or surveys, we find it extremely helpful to assign a variety of different writing tasks to get to know our teenage clients. One is self-characterization, which is sometimes referred to as a third-person narrative or character sketch. Self-characterization is one of the fundamental techniques of Personal Construct Theory (PCT; Botterill & Cook, 1987; Fransella, 1972; Kelly, 1955; Williams, 1995), which forms the basis for a stuttering therapy approach that focuses on examining and changing the personal dimensions of the disorder. The Botterill and Cook and Williams papers referenced above both provide excellent descriptions of this approach. Briefly, self-characterization requires that the teenager write a character sketch of him- or herself, as if the teenager were the principal character in a play. The teenager is instructed to write the sketch in the third person, as a friend who knows his or her deepest nature, and with whom the teenager has a long-standing and warm relationship, might write it. The following are two examples written by teenage boys who stutter:

Tim is a bright person that is very hard working at everything he does in life. He likes to work at his artwork and is very creative. Tim is a very trusting person, you can tell him anything at all. He will do what it takes to make you happy, and that can be a bit of a pitfall. But I see that Tim is a worrier and worries about everything, even stuff that he cannot control. But he also looks out for the people that need to be looked out for. Tim is a good person, and quite well-rounded in most things. Tim likes to spend his free time reading books and magazines, and is very interested in politics and world studies.

Joe is one of those people who will always follow his dreams. He tries to appreciate the little things in life, because he knows that they could vanish in an instant. He likes to run, and run. Running often puts him in a good mood for the day, it feels good to him. He tries to help his friends whenever he can. Friends are the greatest gift in the world, they are the people he needs in the future. He never lets his stuttering stop him, he will try new things, and meet new people.

Although both of these are relatively short character sketches, they contain much salient information. In the first one, Tim reveals himself to be a sensitive young man who cares about others and sometimes struggles with feelings of anxiety. Although he views his caring nature positively, he also sees that it can be somewhat of a “pitfall” for him (here is a good discussion topic). Tim does not mention his stuttering in his self-characterization, suggesting that he may not consider it to be a “defining” characteristic. In addition, his concern for others suggests that he would benefit from increased volunteer opportunities. This is relevant because altruism, or “constructive and gratifying service to others” (Vaillant, 1977, p. 386), along with humor, is considered a mature coping mechanism. For Tim, it seems that recognizing the difference between “the pitfall” of “doing what it takes to make (others) happy” and helping people in a way that is gratifying to him, is an important distinction to make. As Tim’s clinician, I encouraged him to engage in volunteer work for agencies devoted to poverty relief or human rights, with the idea that his involvement in these altruistic activities would help him to cope with his own problems and issues (stuttering being one).

In the second sketch, Joe presents himself as a positive person who enjoys the simple things in life. His love of physical exercise, particularly running, indicates that he has found a healthy way to “feel good.” For Joe, it seems that a major issue is how to help him manage and cope with his stuttering (which will “never…stop him”) to achieve the dreams he wants to follow.

A second writing task involves responding to a structured series of statements, sentence completions, or questions that are designed to uncover the teenager’s level of understanding, thoughts, and feelings across a range of issues related to stuttering. These might include the following:

- How has stuttering affected my life?
- Besides being a person who stutters, I am also a person who….
- How has stuttering been a positive influence in my life?
- What kinds of changes do I think I could make to change the way I talk?
- What makes me most want to change the way I talk?
- How was my family involved in my previous therapy?
- If I could have had it my way, how would I have wanted my family to have been involved in my previous therapy?
- What I want to do in the future is….

As an example, here is the way that 18-year-old Bill answered the first question:

Stuttering has affected my life in many ways. Obviously, it makes it hard to communicate with others. On a more emotional level, I have always struggled with the thought that there is something that I don’t do as well as others. I also
think that it has caused me to take a different perspective on life. I never really had the thought that everything is perfect. On a positive note, my stuttering taught me at a relatively early age that I would have to work harder than everyone else at a lot of things. So, for me, hard work has become a habit. This has taken me a long way and it will continue to help me a great deal.

Further, his completion of the sentence, “Besides being a person who stutters, I am also a person who...” read as follows:

Besides being a person who stutters, I am also a person who does a lot of other things. I play judo. I write computer games. I am a student. I work hard. I do so many things that the label “stutterer” doesn’t apply to me. It is only one aspect of who I am and it doesn’t control my life.

Let me add that Bill exhibited one of the most severe stuttering problems I have ever encountered. When he first came to our clinic, his overall speech rate (with all pauses and disfluencies included) was approximately 50 words per minute. Giving Bill the opportunity to express such complex thoughts and attitudes about his stuttering in writing was an important step in facilitating the development of our relationship. His writing provided me with important insight about the meaning he attached to his stuttering, and helped me to assist him in using a problem-solving approach to set therapy goals.

Finally, it is useful to provide the teenager with ongoing writing assignments over the course of therapy. These can take the form of journals or diaries in which the adolescent “checks in” with both him- or herself and the clinician with regard to specific therapy issues. For example, in our residential therapy program for teenagers, we require that they write in a log at the end of each day. In this daily log, the teenager responds to the following questions: What speech skills or mental skills did I learn today? (more about “mental skills” later); What was easy to do? What was hard? What were my successes? Where do I need to improve? What can I do to improve? How can (clinician’s name) help me to do it? What things did I like? What things didn’t I like? What will I/did I practice tonight? What do I need now? What questions or comments do I have?

Of course, the teenagers in our program vary in the length and detail in which they respond to the questions in their daily logs. What is probably more important is the fact that these daily writing assignments force teenagers to contemplate what they are doing in therapy, evaluate their performance, think about their needs, and make decisions about future directions. In short, journals or diaries can serve to increase the teenager’s responsibility in the therapy process, contributing to a more balanced client–clinician relationship (Blood, 1993).

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COACHING AND COUNSELING

“Mental” Training for Speech Change

Our approach to the treatment of stuttering in teenagers includes a combination of “motor training” and “mental training.” We present the concept of motor training as involving the “mechanics” of speech. Initially, we borrow from Williams’ (1979) “normal talking” approach, in that we discuss the structure and function of the speech mechanism as they relate to the production of both fluent and disfluent speech. Within this context, we stress behavioral awareness, or the awareness of what it physically feels like to produce smooth, fluent speech, as well as to interfere with this process. This skill is taught through a singular and then combined focus on the speech production behaviors of articulator movement (including rate and range of movement and coordinated movements across systems), muscular tension, airflow, and voicing. Once a degree of behavioral awareness has been learned, we introduce the strategies that are available for making changes in speech through both “fluency shaping” and “stuttering modification” approaches to the treatment of stuttering (see Guitar, 1998 for an excellent discussion of these two approaches).

Mental training goes hand in hand with motor training. By mental training, we mean the cognitive strategies that allow easy access to the motor behaviors that have been practiced. These strategies can be different for different teenagers, but most often include developing and choosing to use positive self-talk, imagery, acceptance, and refocus and to trust in one’s abilities. These are all techniques that are used routinely by athletic coaches to help athletes to achieve excellence.

Positive self-talk. Most teenagers and adults who stutter respond to their moments or instances of stuttering with some degree of negative emotional reaction, which can trigger negative “self-talk.” In some ways, self-talk is similar to Beck’s (1995) concept of the automatic thought, which is a stream of barely perceptible thinking that occurs simultaneously with more readily perceived thoughts. Negative self-talk or a negative automatic thought usually reflects a belief about one’s incompetence (e.g., “I can’t talk,” “I’m going to stutter,” “I’m a failure”), or of impending trouble (e.g., “I’ll get fired,” “I won’t be able to do it,” “She’ll think I’m stupid.”). These automatic thoughts then lead to some reaction by the individual. Reactions can be either emotional, behavioral, or physiological. In the case of teenagers who stutter, the reaction to negative thought or self-talk might be increased anxiety (emotional) and/or attempts to avoid anticipated stuttering (behavioral).

We work with teenagers to identify the negative self-talk and automatic thoughts they entertain regarding their speech and stuttering. Beck (1995) provided an excellent description of how to help people to become aware of and explore their automatic thoughts, as well as how to assist them in questioning these thoughts. An intermediate step is to discuss the possibility of choosing to use positive self-talk once the negative thoughts and self-talk have been brought to the teenager’s awareness. Although it seems as though negative automatic self-talk really does just “happen,” it is also the case that the adolescent can choose to use that thought as a cue for positive self-talk. Most teenagers will need to develop their own positive comments—the ones that have the most meaning for them. Some favorites include “You can do it,” “It’ll be okay,” “Go for it!”, and so forth.
**Imagery.** Imagery is the process by which a person uses imagination to "train" neural pathways that have been established in the brain and body. It provides a way to mentally practice performance, using visual, kinesthetic, and emotional images. In stuttering therapy, we teach teenagers that motor training by repeatedly practicing speech modification strategies over time is what lays down the "new" neural pathway or changes the "old" one. The new pathway leads to spontaneous or controlled fluency or "easier" stuttering, whereas the old pathway resulted in stuttered disruptions while speaking. Through imagery, the adolescent can use his or her imagination to practice performance resulting from the newly learned pathway in "imagined" scenarios or situations. Many of the teenagers we see have had previous experience with imagery or visualization through their involvement with school sports.

For teenagers who stutter, the development of an imagery audiotape is a good way to facilitate this mental practice. With the help of the clinician, the teenager decides what purpose the tape will serve; that is, are there specific speech skills that he or she wants to practice? Practicing through imagery can help to break down complex skills or slow down behavior (such as speaking) so that one can isolate and experience the correct production of a particular strategy or skill and troubleshoot problem areas. Are there upcoming events for which the adolescent would like to prepare? Imagery can help the teenager to mentally practice smooth, flowing speech in particular situations, and can also be used to rehearse coping techniques; that is, to prepare and practice responses to stuttering and typically difficult talking situations where stuttering occurs. In this case, imagery can help the adolescent to reduce any perceived threat and to practice distancing. Finally, some teenagers decide to develop tapes as a way to practice general stress management techniques, to "psych" themselves prior to a particular event, or to maintain motivation.

During one of our residential programs, a group of teenagers jointly produced an imagery tape that featured a situation in which they all experienced anxiety and increased stuttering—walking into the school cafeteria at lunch time and sitting at a table with students other than their best friends or the "usual crowd." The script started in the early morning when they first opened their eyes and took them through the steps of getting ready for school, getting there, going to classes, and finally ending up approaching and entering the cafeteria at lunch time. Each teenager provided examples of positive self-talk and affirmation to include, such as "You're feeling strong," and "You can talk smoothly."

**Acceptance and refocus.** Accepting behavior or performance without judgment or evaluation and then immediately refocusing to the task at hand is a common tool used by athletes to "stay in the game." This concept is also salient for the teenager who stutters. If a basketball player misses a free throw, or if a runner knocks over a hurdle, he or she knows to acknowledge and accept the action, but to refocus on the performance and avoid negative evaluation. This is because to evaluate or to judge a behavior as a mistake usually leads to negative self-talk and automatic thoughts. For athletes, these negative cognitions can be a distraction to the keen focus that is needed for optimum performance. The same can be said for teenagers who stutter: If they respond to their stuttering with negative emotion and self-talk, it is unlikely that they will be able to focus on what they are doing at the present time while talking. Paying attention to negative thoughts is likely to shift the focus from attending to the present to feeling anxious anticipation about the near future (the next few minutes, or the rest of the conversation). That being said, we spend a fair amount of time helping the teenager who stutters to respond to moments or instances of stuttering by mentally acknowledging (I stuttered), accepting (That's okay), and refocusing (Attend to what I am doing).

**Trust your abilities.** One of the skills that separates elite athletes from the rest is the ability to "let go" and believe or trust that they can perform. This is also an important concept for teenagers who stutter. That is, trust allows the motor skills that the teenager has acquired and practiced (and then practiced some more) to surface. Similar to using positive self-talk, trusting oneself is a choice. A key point is that trust alone will not yield a successful performance. This is sometimes difficult for the adolescent to grasp because many teenagers who stutter (and adults, too) believe that their stuttering is functionally related to the amount of confidence they feel in a particular moment or situation. In addition, many teenagers have had therapy experiences that emphasized the need for a high level of monitoring and attending to speech. These teenagers often develop the belief that for them, talking more easily will always involve focus and attention; in other words, they will always have to "work at it."

Again, using concepts and analogies from sports and athletic training is very helpful here. Most teenagers understand that a star basketball player does not achieve a high level of performance merely by having a positive attitude or confidence in his or her abilities. In the same way, there are times when even the most skilled athlete performs poorly or "chokes" during an event or a game. So, technical expertise alone might increase the probability of a good performance, but it does not ensure it. Rather, trust or confidence together with hours of daily practice and training yields the most consistently strong performance. Many athletes report that they "let go" or "tune out" when they are in a game with their team or in a competitive event. Some describe this as being "in a zone." The point is that once a teenager who stutters has shown skill in making speech changes across a variety of contexts and has engaged in practice of these skills, it is time to "let go" and allow these skills to surface. As the saying goes, just do it.

**Cognitive Restructuring**

Throughout therapy with teenagers who stutter, we are engaged in different levels of cognitive restructuring. Cognitive restructuring is based on the "cognitive model," which considers a person's perception of him- or herself, others, and the world, as the major influence on emotions and behavior (Beck, 1995). The way a person perceives a particular situation, rather than the situation itself,
determines how he or she feels (Beck, 1964). Very often, of course, perception and reality are not the same, which leads to a dilemma in that the cognitive model suggests that perception is probably more important than reality in determining mood and behavior.

Beck (1995) provided an extremely useful structure for helping clients to identify and restructure their perceptions so as to (a) bring them closer to the reality of a particular situation and therefore (b) foster emotions and behaviors that are more relevant to that reality.

Beck (1995) described the relationship between five levels of belief, thought, emotion, and behavior. These levels include core beliefs, intermediate beliefs (i.e., attitudes, rules, and assumptions), automatic thoughts, emotions, and behavior. Briefly, core beliefs represent those fundamental beliefs that begin to develop in early childhood as “the way things are” regarding self, others, and the world. These core beliefs are usually deeply ingrained and unquestioned; they are frequently not articulated because in many ways they represent more of an unspoken but very strong “feeling” that is difficult to put into words. These core beliefs can be both positive (“I’m lovable”) and negative (“I’m not worthy”), and yield intermediate beliefs from which attitudes, rules, and assumptions arise. For example, because of his experience with stuttering and his own and the environment’s perceived reaction to it, a particular teenager who stutters may have developed the core belief that he is “incompetent.” This core belief might then lead to the following:

- **Attitude:** Being incompetent is the worst thing in the world.
- **Rule:** I must work hard not to be incompetent (i.e., to not stutter).
- **Assumption:** If I work hard to not be incompetent (i.e., to not stutter), I will be happy (not stuttering = happiness).

According to Beck (1995), such intermediate beliefs influence our view of a particular situation or event and lead to automatic thoughts. Automatic thoughts reflect a “stream of thinking” that occurs simultaneously with more readily apparent or perceived thoughts (Beck, 1964). This coexisting thought stream is not abnormal; we all experience it. However, for the most part, we are unaware of our automatic thoughts. This is because they tend to be fleeting and can take a verbal or visual form (i.e., they can be images). They are not filtered by rational thought, nor are they developed through problem solving and sound judgment. Because of their fleeting and deeply ingrained nature, and because they are barely perceptible, automatic thoughts are generally accepted as true; we don’t reflect on their validity.

Some examples of automatic thoughts that might be specific to intermediate beliefs possessed by teenagers who stutter include the following:

- **She thinks I’m stupid.**
- **They’ll laugh at me.**

Finally, these and other automatic thoughts trigger emotions, which eventually lead to behavior. Emotions can include panic, fear, embarrassment, guilt, sadness, tension, anxiety, and so forth. For the most part, people can be aware of the emotions associated with automatic thoughts, but as discussed previously, may not be aware on a conscious level of the thoughts that elicited them. Williams (1979) alluded to this when he stated that people who stutter exist in a present time that is “filled with emotional awareness and is a vacuum of behavioral awareness...(they) attend to their feelings (i.e., emotions) and are only vaguely aware of what they are doing” (p. 245). Using the cognitive model, then, teenagers (and adults) who stutter can be considered to be acutely aware and perhaps overly focused on the emotional responses that are triggered by automatic thoughts and core and intermediate beliefs—three phenomena of which they are barely aware. The circle is complete when these emotions, which the teenager interprets as some internal cue signaling “stuttering,” lead him or her to modify speech behavior in an attempt to keep from stuttering (Williams, 1979). For most teenagers and adults who stutter, these behavioral patterns manifest as the physical tension, avoidance, and struggle behavior that constitutes advanced stuttering. These may include excessive laryngeal tension, inappropriate cessation of airflow and/or voicing during speech, the use of multiple interjections prior to specific sounds or words, and so forth.

When we focus on cognitive restructuring in teenagers who stutter, we initially focus on the relationship between automatic thoughts, emotions, and behaviors. In some cases, we may need to help the teenagers to identify and reevaluate related core and intermediate beliefs in order for long-term change to occur; usually, however, we can facilitate a good deal of positive change through a focus on the interdependence of automatic thought, emotion, and behavior as it relates to the teenager’s stuttering.

Beck (1995) described a number of activities designed to help with the identification of automatic thoughts and the emotions and behaviors that might be tied to them. One way to start is by observing an “affect shift” within the session. Such quick shifts or changes in affect can include nonverbal behaviors such as changes in facial expression or posture shifts, as well as verbal cues such as pitch, tone, or volume changes. When these shifts are observed, the clinician asks, “What was going through your mind just then?” Once these thoughts are elicited and identified, the clinician can then help the adolescent to attach emotions to them, and, ultimately, behavior. For example, if the teenager becomes aware of thinking that he “can’t do it” when ordering in a restaurant, he can then focus on tying an emotion to that thought. Perhaps the emotion is fear or embarrassment. At this point, through a combination of identifying thought–emotion relationships and training in the behavioral awareness of speech production (i.e., what he or she “is doing” when talking), the teenager may come to recognize that the “I can’t do it” thought can trigger the
cessation of airflow at the level of the larynx, as well as the cessation of articulator movement.

The process of identifying relationships between thoughts, emotions, and behaviors helps the adolescent to view speaking and stuttering more objectively as a behavior, as opposed to something that “just happens” (Williams, 1979). This process is very helpful in desensitizing the teenager toward the emotional issues associated with stuttering in general, and his stuttering in particular. Once the adolescent and the clinician explore the relationship between automatic thoughts, emotions, and behaviors, work to “restructure” these automatic thoughts can begin.

According to Beck (1995), questioning is a good way to help the teenager to evaluate both the validity and the usefulness of these automatic thoughts. For example, the teenager who identifies “I can’t do it” or “She (or he) thinks I’m stupid” as two frequent automatic thoughts might consider the following:

- What evidence do I have to either support or refute this idea?
- What is the worst thing that could happen if this were true?
- What is the best thing that could happen?
- What is the most realistic outcome?
- What is the effect of my believing this thought?
- What could be the effect of changing my thinking?
- What should I do about it?
- What would I tell a friend if he or she had the same thought?

Once teenagers have worked through the process of identifying and restructuring their automatic thoughts, and of contemplating the relationship between these thoughts and their emotions and behaviors, we ask them to keep a journal or diary as a way to record automatic thoughts that surround specific situations or events. In addition, we instruct them to make a note of the observed outcome of that same situation or event, and then to assess how valid and useful the thought or thoughts were.

Parents

Last, but not least, we come to the issue of parents. For many teenagers, stuttering has played a prominent role in the relationship they have with their parents. For example, it is not uncommon for the parents of children and adolescents who stutter to view these children as less mature, less socially competent, and, in general, more fragile and needy than children who are normally disfluent. Perhaps these perceptions and assumptions have led the parents to be more involved and overprotective than they might have been otherwise.

The teenager’s stuttering behavior may be of little significance for the teenager at a particular point in time. Instead, the teenager may be more interested in having more open and meaningful discussions with his or her parents about stuttering, or for parents to be more accepting of stuttering. Often there is confusion about who is responsible for seeking therapy or for making sure that the adolescent is an active participant in stuttering therapy. In many ways, this scenario is no different from similar issues surrounding school performance, grades, and so forth:

- Should the parents be involved in making sure their child does homework, studies for exams, finishes projects, and so forth, or should the lion’s share of responsibility lie with the teenager? What should be done when things fall through the cracks (as they almost always do at one point or another)?
- Who should pick up the pieces when a teenager forgets an appointment or fails to complete an important task—the child or his or her parents? Again, the teenage years are a time of transition between childhood and adulthood, and often changing roles and responsibilities are unclear and may take a relatively long time to develop.

We counsel teenagers in our program to take the initiative in conveying to their parents not just general information about stuttering, but also their own thoughts, feelings, and impressions about their speech and related issues. Many times, adolescents provide a whole list of things that their parents do that annoy them. For example, they may say that they feel angry when a parent finishes a word or sentence for them, or that it bothers them when their parents seem impatient. Some adolescents resent it when their parents remind them to attend to their speech; they find it absolutely unacceptable. On the other hand, these same teenagers may express frustration at their perception that their parents never talk to them about stuttering. They want a specific type of interaction, and their parents are not providing it. This, of course, can be a frequent stalemate in any kind of relationship. One party wants something that the other isn’t providing, but neither one is able or willing to inform the other.

As part of our program, we help teenagers to sort this out and then develop ways to communicate their thoughts, desires, and needs to their parents in a direct, nonconfrontational manner (no small feat!). We don’t leave any of this to chance. Our expectation is that the teenager will do this as an important part of his or her therapy, and we do all sorts of things to help the adolescent to manage this in a comfortable way. Sometimes, we develop scripts; sometimes, we role play. Once the teenager feels ready to talk with parents, we schedule a meeting that includes the teenager, parent(s), and clinician. The teenager basically develops the agenda and runs the meeting. We take a back seat and step in if and when there is a breakdown in communication between the child and his or her parents, or if things get too heated.

As an example, let’s consider what went on when Ted met with his parents:

Ted was an 18-year-old high school senior who had come for our week-long summer program. As part of his therapy, he decided the kind of conversation he wanted to have with his parents and how he would begin. We worked on content and form in our sessions. At the end of the week, Ted’s parents came to pick him up at the dorm, and the four of us sat down to talk about the format of the week and what Ted had accomplished. Ted was an active participant in this discussion, explaining and showing his parents examples of strategies that he had explored and intended to practice. Toward the end, Ted started to talk about what he wanted his parents to do to:
“support me as I work on my speech.” He talked about listening to what he said, not how he said it, and that he wanted his parents to know that he was “so much more than my stuttering.” He also gave them specific suggestions for how they might respond or react to his stuttering; for example, “Please don’t look away; I’ll get it out soon” and “Don’t look like you feel disappointed in me,” at which he mimicked the facial expression he had seen that sent him that message.

Over the course of numerous discussions we had had with Ted, he had developed an appreciation for the fact that his parents probably did a lot of what they did because they loved him and were concerned for his well-being. Even so, they needed to realize that stuttering was his. It was something he did, and something that only he could change. Although they could support him, Ted told his parents that the most important thing they could do for him was to “be mom and dad.” Ted decided that he needed to tell his parents all of this, and he did. At that moment, there was a palpable reduction in tension in the room, and Ted’s mom literally let out a sigh of relief. Ted asked his parents if they would love him any more if he didn’t stutter. At first, they appeared somewhat surprised by the question, but it took them no time to answer. By asking this, Ted helped his parents to reaffirm to themselves that they loved him unconditionally.

The moral of this story is that teenagers who stutter need to recognize that they have a responsibility to tell their parents “where they’re at” in terms of their stuttering. What are their concerns? What would they like to do, if anything? How can their parents help them? If this information does not come from the teenager, then the parents are likely to develop a plan of action that may miss the mark entirely and may create conflict in the parent–teenager relationship. When teenagers acknowledge their parents’ concern, express their own point of view, and ask for what they want, the stress that the child’s stuttering can place on the family is diminished.

REFERENCES


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