The Clinician's Turn: Speech Pathology

"Dysfluency Groups With School-Aged Children"

If one were to judge our therapy programs for the dysfluent school-aged child by the large number of requests for contributors and the paucity of replies on this topic, we should be understandably depressed. However, our Manitoba contributor answers our concern with a very positive note - preventative programs and improved intervention strategies have diminished the need for speech pathology for the dysfluent.

Questions about specific issues should be addressed to the authors. Comments on this or previous topics, or suggestions for future topics should be sent to the coordinator:

Angela M. Murphy
34 Weir Crescent
Saskatoon, Sask.
S7H 3A9

From: Pauline Dunstan, Speech Therapist
Child Development Centre
1685 Grant Street
Nanaimo, B.C.

One of the problems of therapy with school-age dysfluent children seems to be insufficient carry-over of fluency from one-to-one therapy to home and school settings. This difference in performance is probably due largely to the low-pressure level of individual therapy, where the child knows he will not be interrupted or lose his listener's attention. Also, a reduction in propositional value results from his knowing that he is talking 'for speech therapy's sake'. A method of overcoming these draw-backs would be to conduct group therapy, where peer interaction would make the situation more realistic (and enjoyable) and heighten propositional value of communication. It would also improve motivation, while increased understanding might result from parents meeting stuttering children other than their own, and their parents.

Some time ago, when working in the school district, I formed a group of three boys, 7, 8 and 9 years old, and these advantages were very apparent. The boys had received at least three months of individual therapy, with little consistent progress being shown. After a two month period of group treatment all three had made notable gains in fluency and general social and communication skills, as indicated by pre- and post-therapy assessments and reports from teachers and parents. Follow-up showed that these gains were maintained and the boys required no further therapy.

Parental involvement was considered extremely important in the facilitation of carry-over. Goals and methods were discussed with them prior to the course, and they met as a group with the therapist halfway through and at the end to question, comment and review changes. One parent was invited to attend each therapy session. They were expected to participate in various ways, e.g. note and comment on stuttering behaviour or fluency to the students, conduct portions of the session under the direction of the therapist, or take students on out-of-office assignments. Siblings were welcome to participate. In addition, children carried notebooks

in which home assignments were set, requiring some form of written feedback as to whether homework had been done. Assignments such as demonstrating to parents and using in conversation techniques learned during lessons, making telephone calls to other group members, and spoken requests when shopping, varied depending on the stage in the course.

An attempt was made to involve the student's respective schools by informing teachers of the group before it commenced, and contacting them halfway through and finally for mutual feedback. One assignment involved the teacher and one the principal.

Sessions were held in the therapist's office twice weekly after school for approximately one hour. The course lasted 17 sessions. Each one consisted of three parts, with varying times being allocated.

Students were introduced to various techniques which had been found to promote fluency (syllable-timed speech, cancellation and negative practice were used) and practised these in activities of gradually decreasing structure and increasing propositionality (e.g. guessing what someone in a picture is saying, co-operative drawing and leggo construction projects where students take turns to contribute and verbalize, using a portable intercom and describing an area in or around the building which the rest of the group could not see.)

A short discussion was held each session on topics such as learning new skills and changing old habits, how stuttering differs from "normal" speech and coping with situations which the children described as difficult.

Most sessions ended with a practical component such as running errands requiring speech, planning and presenting a puppet show to families and staff.

Due to a change in age and nature of caseload I have not had an opportunity to repeat this format, but results of the experimental group supported my view of group therapy, with attention to family involvement and transfer of fluency, as the preferred treatment method for the majority of dysfluent children. I also feel that conducting therapy for a specified period helps to keep motivation and enthusiasm high on the part of students, parents and therapist.

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From: Chuck Dunham
Child Guidance Clinic
700 Elgin Avenue
Winnipeg, Manitoba

For about eight years I operated a program of group therapy for stutterers around the 14 to 16 year old age range in the Child Guidance Clinic of Greater Winnipeg. Clients for the group were attained by referral from Clinicians working out of the Clinic in the schools of the Greater Winnipeg area. The group met only once a week for one hour sessions so it was considered desirable that the students in it also receive therapy from the Clinicians in their home schools. One of the primary purposes of the group, therefore, was to provide peer group support for its members to work on their speech.

The form of group therapy used in this treatment program revolved around a series of assignments given to the students to do during the week between sessions. The result was that the content of most of the one hour sessions involved first discussing the results of assignments that the group members had been working on. Second, a new set of assignments would be given and usually discussed at some length, and finally, if time permitted, there would be a "free-for-all" discussion of whatever topics anyone wanted to talk about, during which they were supposed to begin

their assignments if at all possible.

The assignments used for this group therapy during the first 10 or 12 weeks were aimed at achieving a better understanding of each student's stuttering through exploration of it. Each week they would be asked to identify and collect examples to discuss a certain characteristic of their stuttering. After having explored their stuttering, the students were started on a series of assignments to modify it. The overall pattern of therapy used followed generally but not exactly the model described by Van Riper in his book The Treatment of Stuttering (Prentice-Hall, 1973) from about page 200 of the book onward. The end desired result of therapy was that each stutterer should have a much better understanding of his problem, and should be able to approach feared words with a strategy for modifying and controlling his stuttering.

Over the years that the group was run I found it unnecessary for all its members to be at about the same stage of therapy at the same time. In any case it proved impractical. New students joined the group as each year progressed while others dropped out. It seemed to work out alright for different students to be doing different assignments at different stages of therapy. Students who had attended the group for a while were interested in discussing their past assignments with newer members who were just coming to those assignments.

One of the biggest problems of the group approach was inconsistent attendance, and I believe this was largely due to transportation problems. Most students had to arrange their own transportation to and from the sessions in the Child Guidance Clinic. Many of them lived rather far away, and had to travel on city transit buses. That can be a rather slow and tiresome way to travel to and from a one hour therapy session.

The above described group therapy program is not operating any more. The last year or two that I ran the group the numbers of students attending it became too small to justify continuing. I don't think there are as many adolescent stutterers in Winnipeg now as there were ten years ago. Our field's best work regarding the problem of stuttering lies in the area of prevention. Probably second best is our therapy for stuttering when it first begins. I believe that over the last decade the steadily increasing number of Speech Clinicians in the Winnipeg schools has brought about a steady decrease in the number of school age stutterers. If that belief is correct, it is very good news.

Reference:

Van Riper, C. The Treatment of Stuttering, Prentice-Hall, 1973.

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