The Clinician's Turn: Speech Pathology

EARLY INTERVENTION STRATEGIES FOR DISFLUENCY IN PRE-SCHOOL AGED CHILDREN

Disfluency in young children has been a subject of wide interest and has generated many debates, articles and theses. Clinically we must use those practices which can be adapted to our environment. Our first contributor, Maria Tuchscherer gives us several suggestions which we can use in most clinical settings.

Our second contributor, Rosalee Shenker, besides giving us clinical suggestions, has described her utilization of rigorous research techniques over a long term period to realize goals "to differentiate normal nonfluency from incipient stuttering in young children". We will look forward with interest to the data from this long term study.

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

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Early Intervention of Disfluency in Pre-School Aged Children

From: Maria Tuchscherer, M.S.
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We have probably all seen the two, three or four year old "normally" disfluent child; and probably we were contacted by the parents, who described their child's speech as "stuttering". They may state it as a sudden, overnight occurrence. It may be that perhaps the parent's attention has "suddenly" focused on a gradual breakdown of a child's fluency. Whatever the reason for the overnight change, I think most of us feel immediate intervention is necessary.

During the first visit I observe the parent(s) via a one-way mirror while they are involved in various activities with the child. These activities vary depending on the child's interests and age. I have found, tasks involving manipulation of puzzles, playdough, building toys or drawing, seem to lend a relaxed atmosphere and lessen the direct demand on speech.

Although I have used questionnaires regarding the parents' treatment and reaction to the child's disfluency, first-hand observation tells me a great deal more. One can observe the parent's natural interaction with the child, the nuances of body language in reacting to the disfluency and it allows one to see if the parent is indeed interacting with the child. One mother I observed, did not wait for the child to answer her questions. She didn't realize she was not allowing enough time for the child to reply but answered her own questions. Another mom, rarely looked at her child as she spoke to him, nor did she wait for him to give his own comments - in other words, there was no dialogue - only mom's monologue. This youngster was not quick enough in taking his turn to talk. When the mother did allow a comment he hesitated, repeated sounds or syllables and produced what the mother heard as "stuttering".

A more effective method of observation is using a video which could be replayed so that parents can assist in analysing their behaviours. I point out to parents not to draw

undue attention to the child's disfluency and to caution others, who come in contact with the child to do the same. I have used the film "Stuttering, is it you, is it me...?" to help parents understand the various stages of disfluency and have given literature on normal disfluency to parents to read. For some parents, it seems enough to tell them to "wait it out", don't react to the disfluent times and in most cases parents do just that. Others need regular appointments and more reassurance that the disfluency is a normal phase and that it may fluctuate and eventually fade.

The Stoker Probe Technique for Diagnosis and Treatment of Stuttering in Young Children can also be used to give parents more tangible information of their child's speech development.

When I eventually see the child alone, the parents observe via a one-way mirror. This is done for the purpose, as Cooper (1979) suggests "...rather than present a list of do's and don'ts, give some 'think abouts' i.e. observations the parents should make about their child's speech behaviour rather than suggestions as to what they should or should not do". It appears when parents stop listening for the disfluencies they often report improvement in the child's speech.

The literature is abundant with controversies whether parental attitudes are a significant factor in the etiology and/or maintenance of stuttering-like behaviour and I will not state a case for either. I find one must look at the individual child and his/her parents and deal with them accordingly. If some parents tell their three year old to stop stuttering and it affects the child adversely one counsels them quite differently from those parents who have dealt with the child's disfluency in a silent manner.

In closing I agree with those who opine early intervention is necessary even though the intervention focuses on the parents. They need the assurance that it's okay to be disfluent.

References

1. Films: The Prevention of Stuttering Part I, Danger Signs. Produced by Speech Foundation of America, Memphis Tennessee under the supervision of and narrated by E. Walee, Speech Pathologist, Catholic University of America.

2. The Stocker Probe Technique for Diagnosis and Treatment of Stuttering in Young Children, Stocker, Beatrice, Modern Education Corporation.Tulsa, Oklahoma.

3. Cooper, E.B. Understanding Stuttering: Information for Parents. National Easter Seal Society for Crippled Children and Adults, Chicago 1979.

December 29, 1983.

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Early Intervention Strategies for Disfluency in Pre-School Aged Children

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The recent literature suggests a trend toward early intervention for disfluencies in pre-school children. In fact, programs developed by Ryan (1974), Cooper (1976), Hill and Gregory (1980), and Costello (1983) encourage the use of fluency facilitating procedures such as modeling, gradual increase in length and complexity of utterance, and fluency-initiated gestures for children as young as four.

I have recently established a clinical facility housed in McGill University's School of Human Communication Disorders. My goals are to differentiate normal non-fluency from incipient stuttering in young children and to

develop specific procedures for the prevention and/or management of early disfluency.

Children are initially screened on the basis of parental responses to a case history form which incorporates aspects of physiological, social, language and speech development relevant to disfluency. Parents are subsequently asked to bring to the initial interview a recording of a spontaneous, representative verbal interaction with their child. The tape is assessed for type and frequency of disfluency. In a case of normal nonfluency, parents are given general information about language and fluency development and are provided with a forum to express and discuss their concerns about stuttering with other parents. These parents are followed monthly by telephone until disfluency is no longer a concern.

A child is considered at risk if three or more danger signs exist. These include part-word repetitions of two or more units per repetition on 2% or more of words uttered, substitution of the "schwa" for appropriate vowels in syllable repetitions, vocal tension, prolongation lasting longer than one second, increase in loudness, pitch change, evidence of struggle or avoidance and family history of stuttering. When a child is considered to be at risk, a clinical evaluation of language and speech competency is performed and the child's speech is observed under varying conditions, which might alter fluency. Of particular interest are observations of how speech is affected by linguistic complexity, semantic organization, stresses to fluency imposed by the examiner such as loss of attention, disagreement, asking for repetition and faster response, and interrupting. Measurements include rate, type and percentage of disfluency. Following this assessment the parents and clinician jointly decide upon an appropriate intervention strategy.

Clinical intervention may be 1) Indirect; where steps are taken at home by parents to alter their linguistic and communicative interactions with their child and 2) Direct clinical intervention, utilizing a fluency facilitating procedure. To alter environmental variables which might be contributing to disfluency, parents are initially asked to focus on a situation in which disfluency is most severe, attempt to provide smooth speech patterns for the child to model, alter listening skills on this occasion, and in some instances decrease their own speaking rate. Parents are taught to 'probe' the situation being monitored and to maintain a record keeping task which depicts progress.

If the child's more severe disfluency patterns have not been altered in three months, clinical intervention may be recommended. The majority of children seen to date present disfluency secondary to delayed language, and have responded well to small group therapy utilizing fluency enhancing procedures which include gradually increasing length and complexity of utterance. Language development procedures consistent with the goals of stuttering therapy and appropriate to the child's needs may be incorporated. In most instances parents are asked to observe therapy, becoming active participants, and gradually assume the clinician's role.

In order to form an empirical data base, each child who has been assessed for disfluency is matched to a normal speaking child of the same age, sex and language level, and followed by telephone and questionnaire survey until age six. It is hoped that in this way, long term data relevant to normal variations in fluency and the effects of language development on stuttering can be gathered. I am encouraged and optimistic that the combination of this type of research with earlier and more active intervention may facilitate greater reduction and recovery from stuttering in young children.

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Cooper, E.B. Personalized Fluency Control Therapy: An Integrated Behaviour and Relationship Therapy for Stutterers. Austin, Texas: Learning Concepts, 1976.

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December 7, 1983.

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Issue Name	Copy Deadline
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March	February 17
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October-November	October 13
December	November 17

Generally, each issue is in the mail approximately six weeks after its deadline.

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