

THESE ARE A FEW OF MY FAVORITE THINGS

DIRECT INTERVENTION WITH PRESCHOOL CHILDREN: ALTERING THE CHILD'S TALKING BEHAVIORS

Guidelines for Modifying Talking

There are many young children regardless of age whose stuttering severity can be altered very little by the clinician during the evaluation period. It may also be apparent that environmental manipulation and altering of interaction styles will be less effective and that direct altering of the child's talking behavior is needed in addition to reducing communicative pressures. For these children it is likely, too, that the parents and clinician will need to problem solve in nearly every therapy session for strategies that will reduce the severity of the stuttering for a specific child. Three behaviors of the child signal a need for direct intervention: breath-stream mismanagement and/or hard vocal attacks; active attempts to stop stuttering; and active attempts to conceal stuttering.

The clinician devises tasks that are appropriate for a child 2 to 4 years of age in terms of motor coordination, comprehension and conceptualization. We do not focus on stuttering. As much as possible, the clinician models the easier production on single words giving appropriate instructions to start words easily with lips just barely touching.

Very little understanding of what to do can be grasped from verbal directions given to children 2 to 4 years old. Many children do not want to follow your lead, even when playing a Copy Me game. They can be highly independent. At times, clinicians can get a preschool child to say words in unison through a demonstration of Watch My Mouth and instructions to Say It With Me. It is not effective to ask an independent, sensitive child to say it over or easier. Usually they refuse, and refuse to continue working with you. A wiser strategy is to say, Do The Next One Super Easy and model for the child the behavior you want. We comment on how the child can be the boss of his mouth and talk easy. We do NOT ask preschool children to try easy and hard versions of a word. Usually children try too hard to comply and become blocked and frightened when they cannot utter the

word. One difficulty with a young child is that of finding strategies which can be done through game approaches, but enable the clinician to have some control over the kind of talking being done by the child. When a child senses he has a hard time talking, he is more willing to say words or talk in a manner directed by the clinician. When there is even the slightest improvement, the child decides his talking is fixed now and he would rather play freely with the toys. However, the clinician should continue some work in each session on the strategies suggested below to ensure that the more fluent speech continues and that the child comes to perceive himself as enjoying talking and being successful. For any of the suggested strategies, if the child will do them for 3 to 5 minutes, each, the clinician is pleased.

When the program detailed below is recommended, we explain to parents that their child has stuttered too many months and that his pattern of laryngeal closure and breath-stream mismanagement seems too well learned to be reduced or eliminated simply by removing pressures. It is explained that talking is a complex behavior and that their child is not doing certain aspects of the process in a way to facilitate fluent talking. We discuss the talking process with parents and work on specific aspects that the child is mismanaging. It is unlikely that a specific child will be mismanaging all aspects. A summary of the program and some rationale follows:

1. **RATE.** We need to devise games to say words or phrases slowly. Obtain 15-25 words said slowly, if possible. We doubt that the child will detect that the clinician is talking slowly, so the child will need to be asked to talk slower and to have it modeled for him. We do not want to create choppy speech if he talks in phrases and sentences, so it is necessary to link words together. Slower rate reduces the number of repetitions per word and increases the chances of obtaining easier vocal onset.
2. **INTENSITY.** We need to devise a game in which all the players talk softly. Perhaps the child can talk in his typically formulated phrases or sentences, but softly as if what we say is in our little voice vs. our big voice or inside voice vs. outside voice or quiet voice vs. loud voice. Many times when young children try to talk quietly, the only thing they can do is to whisper. At this stage and time such is acceptable. We do not want a loud stage whisper effect since such may increase muscle effort and physical tension in the larynx and diaphragm. If there is laryngeal tension beyond the amount desired, then talking softly and gently and slowly is likely to result in short repeated blockings or hard repetitions rather than hard blockages with the air shut off, and we judge that to be an improvement. If the blockings are short

or if he only repeats, we have observed clinically that the child is less likely to switch words or rearrange his sentences. He is more likely to continue saying the intended word and to be affected less by the stuttering when it occurs. Again, this is judged as progress. We can increase the possibilities of more adequate laryngeal functioning by the words selected for the child to say.

- 3. PHONATORY REQUIREMENTS.** We need to be concerned with the effect of voiceless and voiced sounds, and with laryngeal functioning for onset and termination of voicing within words. Many children demonstrate more severe stuttering whenever they say a word that begins with a vowel or diphthong. Sometimes they cannot initiate words beginning with stops: for example, KKEY or PPUPPY. We have to experiment more with words to be certain of clinical

hunches, but based on experience, we expect a child to be more fluent on words beginning with voiced continuants. Examples include such words as MAMA, WAGON, perhaps even RABBIT or ZIPPER. A child is expected to have more difficulty on words beginning with voiceless continuants such as FFIVE or Some since there is a shift from voiceless F to voiced I and from voiceless S to voiced O. We do not think it wise to tell a child that he has a hard time saying words beginning with the letter F or S or K, etc. It is acceptable to tell him if he seems concerned that some words may be easier to say and that we will help him change his talking on the harder words.

- 4. BREATHING AND BREATH STREAM MANAGEMENT.** Taking a deep breath and holding it, shutting off air in the throat or mouth, gasping, speaking without sufficient breath or talking in long run-on sentences are some of the behaviors we have observed. It may be difficult for children to control the breath stream. We devise games in which he can experience relaxed breathing and a return to normal breathing patterns. To begin with, we try activities that do not require talking. For example, the parent, the child and the clinician can lie on their backs on the floor just relaxing, certainly not resting for sleep. We can look at the ceiling and just breathe in and out easily with no forcing, no altering of the normal pattern. When we are relaxed, we can exhale the air gently just the tiniest amount, by turn.

The clinical models for the child and the parent. The clinician can take a turn, then the parent, then the child. Then we can take turns at being a little wind and make an **Aooooooo** sound. If the child is willing, the clinician can say a number or a word, then the child, etc. with one word floating out per exhaled breath at the start. We can aim for phrases and short sentences later. A similarly effective strategy for keeping air stream and phonation continuous involves a game in which the child and the parent move turtles slowly over a road. The road can be drawn on brown paper and needs to have a hill so that we can demonstrate sliding easily down the hill and moving slowly on the road. We can slide a sound or a word said in slow motion. The idea is to make all the sounds in the word slightly more slowly. It is incorrect to stretch the first sound of the vowel of the word only.

5. **EFFORT AND MUSCLE TENSION.** Sometimes a child seems to be forcing words out. His abdomen and chest are very rigid or tensed. He will not know what to do if he is directed to relax. It can be effective with some children for the clinician to briefly rub their tummy very, very lightly and say **Keep Your Tummy Soft** as you rub.
6. **RHYTHM.** If he likes singing, we can sing with real words or silly syllables. Try clapping hands to get a timing effect without singing, or beating on a plastic bowl with wooden spoons in lieu of a drum as we say phrases. It is important to use a variety of rhythmic times rather than just one. We can play drums with syllables as **WAH** wah-wah and perhaps the first **WAH** can be stressed slightly more. We do not advocate using a metronome. We want him to move his body.
7. **ATTITUDE.** It is important for the child to hear us say, when it is appropriate to the situation, that we learn to talk and when we learn we sometimes make mistakes. **It's no big deal. We can fix mistakes. And, a mistake is not BAD.** This implies that the parents and the clinician need to remove as much as possible the value words from their verbal interaction and their thinking when with the child. We need to omit words such as **right, wrong, good, bad, nice** and instead, praise for ideas he has to share and for interesting, colorful pictures he drew. He also needs to feel that we believe he won't always talk hard and that we can help him change his talking. Perhaps none of the above ideas will work as effectively as we wish. Then we will continue to problem-solve **TOGETHER** for other strategies.

In today's culture, many families try to be open in respect to feelings and in other areas of living. Yet, they have been advised to ignore stuttering and avoid dealing

verbally with the fact that it occurs. Parents notice bruises, dirty hands and torn clothing. A child may expect a parent to notice when he has difficulty talking. And they may expect the parent to help him to talk. After all, parents bandage cuts, attend to stomachaches, repair bicycles. Why don't they get his talking fixed? Children cry, act out and verbally acknowledge their concern. Direct quotes from children include: You be the Indian Chief who doesn't like the way I talk. I have trouble with my h-h-h. The doctor forgot to check my words. There is no need to ignore disfluencies that are of concern to a child. A parent can calmly comment, **Yes, sometimes it may be harder to talk. But it won't always be. There are people who know how to help you talk.** Clinicians and parents can intervene to reduce fluency disruptors, to build fluency skills and to alter stuttering behavior in preschool children.

Source: Judith Eckardt, SLP, Board Recognized Fluency Specialist, USA, 1/04