

THESE ARE A FEW OF MY FAVORITE THINGS

STRATEGIES FOR SOME CHILDREN AGES 6-8 YEARS

We believe that it is unwise and ineffective to use the same therapy program with all children of a particular age or stage of development of their fluency problem. However, we wanted to share a set of strategies we have tried with success with some children ages 6-8 years. The sequence in which we have done the activities is listed below.

We would suggest a hierarch approach on two levels. First, it is important to begin with single words and gradually build to conversation. Second, it is essential, according to Dean Williams, that success be achieved at each hierarchy level across environments. Dean Williams emphasizes that generalization will not occur unless horizontal hierarchies are used.

Therapy Goals and Procedures

I. BUILDING FLUENCY

Building fluency by producing words with easy onset of phonation and soft, light contact of the articulators. We would ask or instruct the child to "sneak up" on the words as opposed to "pouncing" on them. Concrete descriptive terms would be used by the clinician—such terms as "soft", "easy", "loose", "smooth", "let the air leak out", "let the sound leak out."

The level of communication would be carefully controlled to ensure that the child would meet with a much greater percentage of success than failure.

Procedures

1a. ONE-WORD LEVEL, MODELED ("sneaking" on a word)

1b. ONE-WORD LEVEL, NON-MODELED

2a. SHORT SENTENCES, MODELED

- 2b. SHORT SENTENCES, NON-MODELED. (Let the child make up short sentences from looking at a picture card.)
- 2c. SHORT SENTENCES, NON-MODELED. The child would be asked to look at the picture card, think of what she/he was going to say, then look at the clinician and "pretend you're really telling me." This is an early step towards the conversational level.
- 2d. SHORT SENTENCES, NON-MODELED, PLUS. The task is similar to 2c, but now the clinician makes a short comment in response to what the child has said.
- 2e. SHORT STORY TELLING, NON-MODELED. Using sequence cards, the clinician and the child could take turns telling each step of the story, while "sneaking on our words."
- 2f. SHORT STORY TELLING, NON-MODELED. This task is similar to 2e, with instructions to "Look at the card, think of what to say, then look at me and pretend you're really telling me."
- 2g. SHORT STORY TELLING, NON-MODELED. This task is similar to 2f, but following the completion of the story the clinician would ask the child what he/she thought may have happened next You are making up additional endings to the story. By doing so, speech would be slightly more spontaneous, yet still controlled. The child would be asked to "sneak" on words as he/she talks.

ROLE PLAYING. We have used a minimal amount of role playing. When doing role playing activities, it is important that the child be clear on what his/her dialogue will be. Providing the child with examples of what she/he can say helps the child feel more secure and less uncertain of herself/himself in that situation.

Activities should be structured for fun; however, the purpose underlying the activities would always be stressed. As an example, the clinician might say, "The reason we're doing this is to practice sneaking."

II MODIFICATION OF "HARD TALKING"

This area would be concerned with what the child could do if he/she got "stuck" on a word. We would emphasize "not making a big deal about being stuck." We would stress that the child didn't have to be afraid when he/she was 'stuck'. She/he could tell herself/himself, "I'm stuck; it's not big deal. I'll just let go."

Procedures

- 1a. ONE-WORD LEVEL, MODELED. The clinician would ask the child to "Get stuck just a tiny little bit on a word—on purpose." (This implies no air flow, no phonation, no movement.) "Then, 'let go'. Let the 'air leak out'" "Let the tightness go." We would emphasize "letting go" as opposed to "pushing through" the word. We would tell the child it is easier to let go than to push through a word. We would express this verbally as well as through modeled examples. Do the task on non-feared words to ensure success.
- 1b. ONE-WORD LEVEL, NON-MODELED. Again, the instruction to the child would be: "Get stuck just a little on a word on purpose; then let go."
- 2a. SHORT SENTENCES, MODELED. "Get stuck just a little on a word in a sentence; then let go."
- 2b. SHORT SENTENCES, NON-MODELED. Using picture cards.
- 2c. SHORT SENTENCES, NON-MODELED: The child would be asked to look through simple story picture books and tell short sentences about each page. She/He would be instructed to "get stuck just a little on purpose, and sometimes not on purpose. When you get stuck, tell yourself 'it's no big deal—I'll just let go'"

It is important for the activities in the above level that the clinician be alert to the possibilities of creating tremors, hard blocks or increasing fear in the child. That is why the child is asked to "get stuck just a little..." and this means only mildly, not even moderately, with no associated mannerisms. It also means that the "getting stuck" should be very brief—a second or less in time. Often a child tries too hard to do as asked and problems could arise.

TOUCH-LET GO GAME. The purpose of this game is to reduce/eliminate the panic which often accompanies 'getting stuck' The clinician and the child take turns getting stuck and remaining stuck, briefly, until the other person lightly touches their shoulder. Be cautious to have the child remain stuck for a very, very short time. If

the child remains stuck longer than one second, the feeling of panic or being caught could increase. Watch for signs of the child's eyes widening, holding his/her breath, refusal to do the activity, etc. as cues of fear. If such occur, then omit this section 3, "Touch-let go" from the therapy program. If you do decide to do this section, it might be done as

- 3a. SOUND LEVEL. "Get stuck just a little on a sound. Remain stuck until I touch your shoulder. Then let the air 'leak out' easily."
- 3b. ONE-WORD LEVEL. Similar procedures, using words.
- 3c. SHORT SENTENCE LEVEL. "Get stuck just a little on one word of a sentence. Remain stuck until I touch your shoulder. Then let the air 'leak out'."

Throughout these activities it is important to tell the child that she/he did not get scared and that because she/he "was very calm, it was easy to let go."

It might be possible to teach a child to "get stuck on a sound and let go" when the sound is prolonged. Note that this task differs from 1a under II in that the sound now has phonation (if it is a voiced sound) and airflow, but NO MOVEMENT.

- 4a. ONE-WORD LEVEL, MODELED. The clinician could model a voiced prolonged sound and the "let go" and complete the word. E.g., 'mmmmmmmmmmmm'. The child would be told that "when we get stuck on a sound in this way, we can do the same thing as before—just let go and finish the word." We would stress that the child did not have to start the word over as 'mmmmm, man' but could simply finish the word the first time, e.g. 'mmmmman' Provide the child with modeled examples to be certain the child understands. You might have the child do the task in unison with you once or twice.
- 4b. ONE-WORD LEVEL, NON-MODELED. Similar procedures.

We would devote the first portion of the session to a variety of "sneaking" activities, and the second portion to "getting stuck and letting go" activities.

III BUILDING SELF-CONFIDENCE

Whenever introducing something new or when changing to another activity within the session, the clinician would be sure to provide the child with clear explanations. Examples would be modeled, and done in unison if necessary, to ensure the child's understanding. The child would be encouraged to let the clinician know if she/he were not sure about what to do. The purpose would be to decrease the child's uncertainty and fear of making a mistake.

We would provide a very accepting and comfortable atmosphere. At every available opportunity, we would express the notion that "it's O.K. to make mistakes. We all make mistakes. It's no big deal to make mistakes." This would be stressed in relation to both speech and non-speech activities. Since we often work 45 minutes with a child, we plan a 'break time' with play activities being structured to encourage cooperative effort that then competition. Games played in a non-competitive way allow for a relaxed attitude about "winning" or "losing." The clinician would verbalize the notion that "It's O.K. to lose; sometimes we win, sometimes we lose. It really doesn't matter." We feel if the clinician is openly accepting of failure and mistakes, the child may be more willing to accept them as well. "Pouncing" on a word or "getting stuck" on a word would be likened to making a mistake. We would emphasize that "it's OK to get stuck", "there is nothing to be afraid of because you know what to do." The "secret of letting go is not to be afraid; the secret is to be calm." Another point which could be stressed with the child is the notion that "she/he is the boss of her/his mouth—she/he is the one making talking easy." The purpose here is to emphasize the part the child is playing in making talking easy. We would reinforce a lot, but not blame for errors. Our goal would be to increase the child's confidence in her/his own ability to generate 'easy speech' E.g., "You really know how to speak." We do not see a need to use the term "stuttering" in the sessions since it is not descriptive of behavior.

DESCRIPTIVE OF STUTTERING BEHAVIOR OF 2 CHILDREN ON WHICH THIS PROGRAM WAS EMPLOYED

Child #1: 1) tightness in the laryngeal area to the degree that sound and air are completely stopped, sometimes for a duration of 5 seconds; 2) "holding back" or trying-not-to-stutter behavior. He would begin to repeat the initial sound of the word, then stop himself as if sensing the repetitions would continue, and finally pushes out the word with force and loudness increase; 3) deliberate efforts to talk slower; 4) forced repetitions accompanied by tension and vocal fry; 5) pitch rise at the end of some sentences and running out of breath before finishing the sentence; 6) silent blocks and silent pauses; 7) lip and jaw tension and occasional torso tension with some down and forward head movements. He sometimes becomes frustrated with the effort of talking and stops talking; he did not like to recite memory work in school; he stated that talking is "hard work" and he know in some sense that he cannot get words started. He was observed twice to kick his leg in the act of completing a stuttered word. Age: 7 yrs. 0 mos.

Child #2: 1) tight contacts of the articulators on the initial sound of words beginning with plosives; 2) strategy of initiating phonation with a prolonged "M" before saying the actual word, no matter what sound the word started with; 3) posturing of the articulators, particulator of the lips prior to initiating air flow and phonation; posture was held fixedly; 4) squeezed eyes shut tightly with head jerking downward on most severe stutterings; 5) audible inhalations of air prior to a stuttered word on occasion; 6) pounding with fist or hand in the act of saying a word; parents reported she had pounded 10-15 times before the word was uttered; 7) combination of schwa vowel (as perceived by listener's ear) and pausing prior to uttering the word; 8) repetition pattern was predominantly 3-4 per word, fast rate, uneven rhythm. Six repetitions occurred on some words. Typically the tight, fast repetitions were unvoiced when the actual word began with a voiced sound– p-p-p-p-baby or t-t-t-t-dog.

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