Parental Involvement in the Treatment of Stuttering

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The most compelling argument for involving parents in therapy must be the statements that adults who stutter have made during their therapy about the role their parents played.

Comments such as:

> "I never speak to my parents now about my stutter and they certainly never discussed it with me when I was a child."
>
> (Gary, aged 28)

It seems that in many cases, "helpful hints" were offered from the family members to "slow down," "relax," "think before you speak," and other advice. Occasionally, there is a memory of being shouted at or of punishment, but generally the consensus is that the subject was "unmentionable."

> "I felt isolated, misunderstood, and frustrated. Stuttering was a bad thing, something to be ashamed of. I was an emotional cripple."
>
> (Tony, aged 32)

One can only guess at the internal distress a child with a stuttering problem must suffer when he or she is aware that something is wrong, is unable to discuss it, and only sees the negative reactions of others to attempts at communication. After all, what better way is there to draw attention to a problem than by pretending to ignore it?

> "This problem is so awful that my parents can't bear to talk to me about it."
>
> (Chris, aged 22)

Early experiences of therapy may reinforce this impression for clients. Often, the child is made conspicuously different by being withdrawn from the classroom to sit outside a medical room or visit a local health or hospital clinic. Memories of therapy vary from breathing exercises, relaxation, and strangely intoned speech techniques to rhymes and singing. Parental involvement was limited to a brief encounter outside the therapy room, some verbal or written instructions, a few therapeutically encouraging words, and "see you next week."

The clear message from our adult clients was that

- *therapy* was not just a waste of time but might have contributed to their lack of self confidence by reinforcing the idea that stuttering was unacceptable, and
- *the conspiracy of silence* damaged trust within the parent–child relationship and contributed to the negative self image surrounding the stutter.

In our opinion, Johnson's (1959) Diagnosogenic Theory was perhaps responsible for professionals' and parents' interpretation that if stuttering was ignored, it would go away. This widely held view has proliferated over the years and, until recently, speech and language therapy students were taught to offer *advice* only to the parents of preschool children. This resulted, in the past, in a situation where young children with incipient stuttering and their parents were given little or no constructive advice on managing the stuttering problem effectively.

Most authorities now favor the *interactionist* model of stuttering development (Conture, 1982; Cooper, 1976; Gregory & Hill, 1984; Rustin, 1987b; Starkweather, 1987; Wall & Myers, 1984). This suggests that there is a genetic or constitutional basis (predisposition) to the problem, with

ABSTRACT: This article presents the view that parental involvement is essential in the effective management of children who stutter. Our assessment procedures provide clinicians with the basis for ensuring full parental participation. Three approaches are proposed that reflect the changes in the type and degree of involvement required and the therapy goals for different age groups. The first approach considers parent–child interaction skills as a basis for facilitating the development of fluency skills in young children. Intensive group therapy programs are then suggested for the age groups 7–14 and 15–18 years, with differing degrees of parental input.

KEY WORDS: stuttering, children, parent interaction, social skills

environmental factors playing an important role in precipitating the emergence of the behavior. The immediate benefit of an interactionist model of stuttering lies in the "hope" it offers to both clinicians and their clients. Although nothing can change the constitutional predisposition, environmental issues can be addressed productively.

Virtually all contributors to our understanding of the nature of stuttering have acknowledged the influence of environmental factors, and an increasing number incorporate these issues in their therapy programs. We see these environmental influences as being the many communication and interpersonal stimuli that children experience. Glasner (1970) emphasized the child's interpersonal relationships in the family as primary in the development of the problem, and even those who have investigated the genetics of stuttering (Kidd, 1983) assume that environmental factors interact with physiological predispositions.

Johnson (1959) hypothesized that stuttering resulted from an interaction between three major variables:

1. the child's degree of disfluency,
2. the child's sensitivity to his own disfluency, and
3. his sensitivity to his listener's evaluation.

Research by Moore and Nystul (1979) examined parent–child attitudes and the communication processes within families with a member who stutters. They reported studies that indicated that the parent–child relationship may show some specific maladjustment from the point of view of the child who stutters, and concluded that "parent attitudes are paramount in constituting the nature of the home environment." Bloodstein (1987) reported that a sizeable proportion of the parents of children who stutter appear to be, in varying degrees, demanding, over anxious, or perfectionist in their child training practices. Competitive pressure for achievement or conformity has been established as a contributing factor to the stuttering behavior. Gregory (1984) stated that "almost all authors writing about stuttering therapy recommend counseling of the parents aimed towards reducing communicative and interpersonal stress." Conture and Caruso (1987) believe "both the child and his or her environment are germane to the problem of stuttering" (p. 88).

Some studies have indicated that parents of children who stutter have less desirable attitudes toward stuttering than parents of children who do not stutter, and often these same parents have less accurate knowledge of the disorder itself (Andrews & Cutler, 1974; Crowe & Cooper, 1977; Langlois, Hanrahan, & Inouye, 1986). Fowlie and Cooper (1978) found that mothers of children who stutter projected undesirable traits onto their children. This indicates that young children who stutter may learn unattractive stereotypes from people within their environment.

Research from the fields of education, learning difficulties, and child development confirm the significance of parental involvement. Bronfenbrenner (1976) suggested the following:

> The family is the most effective and economical system for fostering and sustaining the development of the child....The involvement of the parent as partners in the enterprise provides an ongoing system which can reinforce the effects of the program while it is in operation and help sustain them after the program ends. (p. 23)

Tizard and Mantovani (1981) support this view, stating that "a purely professional service" will benefit only a fraction of the children referred, and by "leaving parents out" may "weaken parents' confidence and ability to act as good parents" (p. 31). This in turn could increase parents' feelings of inadequacy.

White (1979) stated that

> The informal education that families provide for their children makes more of an impact on a child's total development than the formal education system. If a family does its job well, the professional can then provide effective training. If not, there may be little the professional can do to save the child from mediocrity. (p. 4)

The consensus of evidence from national studies in western countries indicates that the home has more influence on a child's learning than the school does (McConkey, 1985).

The child's actions are, to a degree, governed by characteristics of the family's system—he or she may be responding to stresses within the family unit or be contributing to stressing other members within the family system (Minuchin, 1974). The child who stutters lives within a family and is a member of a social system within which he or she learns to adapt, and therefore therapy can be truly effective only if all aspects of the developing problem are accounted for. The benefits of involving parents in therapy include the maintenance of specific skills taught to the child, as well as a greater parental awareness and understanding of the child's problem and the difficulties encountered before, during, and after remediation. Parental involvement also provides a continuity and prolongation of therapeutic benefits for both the child and parents.

With such evidence, why do some clinicians continue to relegate parents to a relatively passive role in therapy? Kiernan (1981) pointed out that despite the clear advantages of parental involvement, occasionally a drawback to their inclusion is that parents themselves may be reluctant to participate because of their own sense of inadequacy in their ability to facilitate change. It is important for them to understand how changing their own behavior can affect how their child behaves.

Speech-language pathologists often report that involving both parents in any therapeutic intervention is not practicable. Many reasons are put forward for this, the most common being the difficulty for both partners in taking time off from work, pressures concerning work, and the need to organize childminding for other siblings. Mittler and Beasley (1982) discussed the importance of professionals sharing their skills with parents, families, and teachers. Clinicians often find this difficult, as perhaps they see themselves as "experts who should know and be able to provide the answers" (p. 30). Further, it tends to be the mother who brings the child to the clinic and, because the majority of speech-language pathologists historically are female, it may be that they feel less confident when dealing with a father.

There are instances, however, where the environmental circumstances make parental involvement difficult (e.g., where English is not spoken by the parents, where the child

is in care, if a parent is too disabled or ill, or within a family where the custody of the child is in dispute). In the very small number of cases where parental involvement is not possible, decisions regarding therapy should be based on the age of the child and a full assessment of his or her level of independence, problem-solving skills, and development of internal locus of control. In our opinion, it is better not to embark on therapy that is unlikely to succeed, as many years of unsuccessful therapy have a debilitating effect on clients who stutter and clinicians alike. We have found that when parents understand the importance of their role, they willingly commit themselves to work in the team for the long-term benefit of their child.

Following the referral to our Centre for Stammering Children, we stipulate that *both* parents (with the exception of single-parent families) attend the consultation interview. This sets the foundation for the long-term working relationship between the parents and clinician.

THE INTERVIEW

Clinicians often feel pressured into commencing therapy before they have an adequate understanding of all the issues concerning a particular family. The core of Rustin's approach (1987b) to the treatment of stuttering lies in the detailed child assessment and parental interview, which provide a comprehensive understanding of the child who stutters within the context of the family. It is the skill of the clinician during this interview that will determine the extent to which parents will be willing to invest their trust and commitment to the therapy process. Conture and Caruso (1987) also state that "what is perhaps more important than the use of prepackaged questions is the clinician's flexibility and creativity during the interview process to generate follow-up questions to probe for further areas of particular concern for a certain family" (p. 90). This parental interview can take 2½–3 hours to complete and provides us with a comprehensive picture of the child's place within the family.

In the interview, we learn about the rules and regulations in the child's life, the parents' attitudes toward child rearing, pertinent issues within the parental relationship, the problem-solving strategies employed, and the place the disfluency problem holds within the family. The interview is structured in such a way that the basic and noncontentious case details are gathered in the early stages of the process, with a gradual move toward more sensitive and emotional material as it progresses.

THE CHILD ASSESSMENT AND INTERVIEW

The information gathered during the assessment and interview allows the clinician to analyze the nature of the presenting fluency problem, investigate linguistic functioning, and explore the child's understanding of the problem and the effect it has on his or her life. Once the child and parental assessments are completed, the clinician is in a position to answer some fundamental questions about the child, the family, and the particular speech disfluency problem. A profile of strengths and weaknesses can be drawn up that covers the cognitive, linguistic, social, emotional, and neurophysiological components of the child's stuttering. On the basis of this individual profile, we begin to formulate treatment goals that are tailored to individual needs.

THE THERAPEUTIC PHASES

Stuttering as a disorder of communication has phases in its development and the structure of the child assessment and the parental interview must account for these changes and vary accordingly. Broadly speaking, we separate the phases in terms of age range rather than stuttering severity. These age ranges should account for the developmental changes in stuttering and locus of control, and the degree and type of parental involvement.

Phase One: 2–6 years

Within this age band, although there may be a wide variety of types and severity of stuttering, it is our opinion that for many of the children referred early, intervention may prevent the development of a chronic long-term problem. It is becoming a real possibility, with a detailed assessment and case history, to make a differential diagnosis between normal fluency failure and those children who are at risk of developing the true syndrome of stuttering. Strategies for intervention are based on the findings and, without exception, involve both parents (unless a one parent family) as an integral part of the process.

Parental interview. In the parental interview, the parents are invited to describe the child's fluency problem in their own words. It may be that the stutter is the main issue for some, whereas for others it is only one of a long list of behavioral, social, and emotional concerns. Even at this early descriptive stage, we learn a great deal about the family system from the ways in which the parents express their concerns and the examples they offer of their child's specific difficulties. Although frequently the onset of stuttering is not clearly tied to one event, during the course of the interview, it often becomes clear that the onset can be linked to one or more major events. Although the stuttering cannot be attributed directly to any one event, we do feel there may be a cumulative effect that may trigger the emergence of a fluency problem.

Specific questions are posed about the child's developmental history. Here we look for any evidence of uneven development and related concerns. We question the parents about the child's current behavior in different contexts and look for variability in reported fluency. Rustin's interview procedure (1987a) has been amended recently to include items of particular relevance to this age group (Rustin, Botterill, & Kelman, in press). These would include sleeping habit and bedtime routines, as well as issues related to feeding, coping with temper tantrums, and behavior problems.

A considerable part of the interview is spent gathering information about family dynamics, child care arrangements, and social contacts. We inquire about other developmental and psychological problems in the family history as well as try to build a picture of the current circumstances of the family unit. We also note significant developmental difficulties experienced by the parents and the extended family. We inquire about the physical environment, the type of housing, and any additional pressures (e.g., social, financial) on the family at this time. We ask about the child's progress in nursery or school and his or her attitude toward its appropriateness.

Child assessment schedule. In the child assessment, we are seeking information about the observed stuttering behavior, the associated linguistic functioning, and the patterns of interaction between each parent and the child. A routine schedule of informal and formal tests (Rustin, Botterill, & Kelman, in press) is administered and a sample of the child's spontaneous speech is audiotaped for analysis. The formal tests may include The British Picture Vocabulary Scale (Dunn, Dunn, Whetton, & Pintillie, 1982), Word Finding Vocabulary Scale (Renfrew, 1977), and Clinical Evaluation of Language Fundamentals–Revised (Semel, Wiig, & Secord, 1987).

Each parent is videotaped playing with the child and a 5-minute sample of this is used to assess the patterns of interaction. A short interview with the child asks questions about siblings, parents, caregivers, the things he or she likes and dislikes about the environment, and his or her perception of his or her speech difficulties. These questions should be attempted with even the youngest children as it is essential for the clinician to have some understanding of the child's level of awareness of his or her speech difficulty.

Often, it is assumed, particularly by parents, that the child is unaware, but it has been our experience that this generally is not the case. Some preschool children are very clear about the difficulties they experience, precipitating the very changes in parental attitude that may prevent the "conspiracy of silence" from developing. One 4½-year-old girl, when asked to tell us about her talking, replied, "Oh it's so *hard* sometimes; the words won't come out." Her reply to the question, "If I could make magic and change one thing for you, what would it be?" was very clear; she wanted us to "make her voice better."

Where appropriate, the discussion continues as young children usually can describe what they do to help themselves and whether what teachers or parents do either helps or disturbs the fluency. The child is asked to describe the situations when the stuttering becomes worse, and when he or she is more fluent; examples of typical contexts are sought. The clinician will want to know how well the child understands what happens at the moment of the disfluency. Conture (1982) posits that the more objective the child is about the actual stuttering behavior, the better the prognosis. How does the child envisage his or her life without a stutter, and are there any advantages in continuing this behavior? It would be important to know of any situations the child feels able to avoid because of his or her stutter (e.g., reading aloud in class).

Finally, it is necessary for the older child to ascertain the child's ability to monitor his or her speech (e.g., can he, on instruction, achieve fluency without modification of his speech behavior, or can fluency only be achieved with some modification or change in speech production?). The clinician here is aiming to find the method that will be the least disruptive and allow the child's own natural fluency to predominate where possible. The child who can learn for him or herself the most effective way of controlling his or her speech is more likely to attain eventual fluency (Sheehan & Martyn, 1967). The child's own opinions would be invited throughout this experimentation with fluency to discover which methods he or she found most comfortable.

Treatment. As we have described above, the type and degree of parental involvement is dictated by the phase the child has reached in the development of the stuttering problem. It is clear from the literature that many writers are confident that early intervention is successful. Prins and Ingham (1983) exhort us to expect a rapid generalized improvement in fluency when things that provoke communication uncertainty in the child's home environment are altered. Bloodstein (1987), in his review of the literature, reported that successes in therapy with young children who stutter are common, and there appears to be a widely held belief among clinical workers that the disorder usually is more easily treated in early childhood. Riley and Riley (1983) state that a delay in initiating treatment is serious because treatment is simpler, briefer, and more effective with preschool children than with school-age children.

We would postulate that clinicians would undertake the management of preschool children who stutter only if they knew what to do. The literature is largely in agreement that parental counseling is an important component of intervention (Cooper & Cooper, 1985; Riley & Riley, 1983; Starkweather, 1987). The literature also clearly describes the areas that should be considered when counseling parents and shows how parents can make changes. In his description of the Demands and Capacities Model, Starkweather (1987) includes parents and siblings under the category of *demands*. Clinicians may well know *what* to advise parents in the content of counseling, but there continues to be a shortfall regarding advice on *how* to effect change in parents' management of the child (i.e., *the method of counseling).*

Intervention procedure. The goals of intervention within this age group are to:

1. Identify those aspects of parent–child interaction that could be identified as facilitating fluency.
2. Identify those aspects of parent–child interactions that may be increasing the external demands on the child's fluency skills.
3. Enable the parents to identify for themselves relevant aspects in their interaction with their child and, through videotape recordings, further develop those skills in (1) above and modify those of (2). (Rustin, 1991)

For families where there are signs of early stuttering and/or there are other predisposing factors, a more directive

approach is required. At this stage, we are interested in the nature of the interaction between the parents and their child. In order to look at this aspect more fully, a task called *talking time* is set for the parents to complete at home before their next appointment. The task is negotiated with each parent who makes an individual commitment to spend 3, 4, or 5 minutes 4, 5, or 6 times per week playing with their child. They are instructed that talking time is their task and they will have to ask their child to help them with it, and should negotiate with the child a time that is mutually convenient. At the appointed time, the parent should ask the child to choose a toy to play with (cars, Lego, dollhouse), but not reading material or TV. The parent and the child then go into a room, close the door and, once settled, time the task and encourage the child to talk by joining in the activity. The parent should not make any demands or comments on the child's speech but should listen carefully to *what* is being said, not *how* it is said. When the time is completed, the parent should thank the child for helping them with their homework and record in a notebook that the task has been completed, making a few comments on how they felt about doing it (Rustin, 1987a).

Parents are reminded that the time limit is important and should not be exceeded because it is the quality of time that is important rather than the quantity. The next appointment is made for the following week. This exercise provides a routine framework for making changes in the future and ensures the commitment of both parents to therapy and also their willingness and ability to undertake tasks as instructed by the clinician. Any problems completing the task should be discussed with the parents and child. Should the parents continue to be unsuccessful in completing the task, their ability to participate in therapy would be questioned and they would be encouraged to return to therapy when they are more able to offer a firm commitment.

The following therapy procedures (Botterill, Kelman, & Rustin, 1991) require the parents to be active and willing participants in exploring alternative ways of managing the disfluent child to assist the development of fluency. At the beginning of every session, each parent is videotaped separately conducting a talking time session with their child for 5 minutes. This provides a basis for assessing the parent–child interactions; from this, treatment steps may be planned systematically. The discourse is analyzed in terms of verbal content and context, and a note is made of the nonverbal behavior of the parent and child. The focus is mainly on the *parent's* verbal and nonverbal behavior, as research has shown that the model the parent provides for the child will directly influence the levels of fluency. Newman and Smit (1989) suggest that some children as young as 4 years of age are able to adjust one aspect of their speech when the speech of their conversational partner changes. The clinician should detect all the fluency-disrupting factors in the interaction, the most prevalent of which are as follows:

- *Rapid rate of parental speech.* The clinician needs to assess whether the parent's rate of speech is placing undue pressure on the child, which may result in an increase in disfluency (Meyers & Freeman, 1985b; Starkweather, Aronson, & Amster, 1987; Stephenson-Opsal & Bernstein Ratner, 1988).
- *Poor listening and turn-taking (interruptions).* The clinician should note the number of interruptions and their effect on the child's level of fluency (Meyers & Freeman, 1985a). Poor parental listening skills disrupt the discourse with inappropriate interruptions that take no account of the child's contribution to the interaction.
- *Parental questions.* Adults frequently resort to repeated questioning in an attempt to stimulate conversation. It is *commenting* that encourages verbal exchange, whereas questions may put pressure on the child (Wood, Wood, Griffiths, & Howarth, 1986). Parents also often fail to wait for the child's reply before presenting them with a further question.
- *Adult response-time latency.* If a parent pauses before responding to the child's utterance (increases the response-latency time), the child will be more likely to allow time before responding, thereby increasing the likelihood of fluency (Meyers, 1990).
- *Syntactic and semantic complexity of parent's speech.* A high level of complexity in parental language is more likely to increase the level of disfluency (Haynes & Hood, 1978). Parents frequently discuss events that are unrelated to the current activity. Therapy is directed to the use of an appropriate level of language and should be related to the current activity.
- *Directiveness.* Training parents in nondirective play sessions with stuttering children helps to increase fluency (Andronico & Blake, 1971).
- *Nonverbal behavior.* A child may pick up nonverbal signals from the parents that indicate negative attitudes. These may stem from anxiety, poor rapport, impatience, or lack of experience playing with their child (Rustin, Botterill, & Kelman, in press).

The clinician will view the recordings with the parents and encourage them to make comments about their behavior. It is important to emphasize that the purpose of the exercise is to make some changes in the interpersonal communications that may assist the child in becoming more fluent. The clinician should make positive statements about the interaction and guide the parents toward *one* fluency disrupter that either they have identified or would be tackled relatively easily. The parents are then videotaped again individually trying out the new behavior in a further play session with the child. This change is then targeted for the *talking time homework* sessions until the next appointment. This procedure is repeated for each therapy session in order to monitor, encourage, and reinforce their efforts; to reinstruct or redirect where appropriate; and to identify other fluency disrupters for targeting.

Six 1-hour weekly sessions are arranged followed by a 4-week consolidation period, during which time the parents continue their talking time with the targeted behaviors and send in homework sheets to the clinician (e.g., Appendix A). The clinician would reply to the parents, encouraging and advising as appropriate. At the follow-up session, if

there is an increase in fluency, the parents are encouraged to continue to monitor and practice with their child, returning homework sheets weekly for 6 weeks. The family will then attend review appointments at three monthly intervals for up to 3 years.

In our experience, the majority of families have not needed further intervention. However, in the event that the stuttering remains resistant to the modifications made to the child's speaking environment, it would become necessary to employ direct speech modification techniques. The clinician should first establish an easier fluent speech pattern by trying a variety of approaches (e.g., easy onsets, slow rate, flowing the words). We take a cognitive behavioral approach (Rustin, 1984) to the problem, which requires that the child is involved in a process of discovery and that a common language is developed for describing the difficulties in talking and the strategies that alleviate them. The chosen approach is then modeled and practiced in structured activities that reduce the linguistic and semantic complexity, usually beginning with one word utterances or short phrases of 2–3 words. The baseline fluency should be established firmly before increasing, in easy stages, the linguistic complexity of the tasks.

Where coexisting linguistic difficulties have been identified, steps are taken to incorporate strategies to remediate these within the newly established framework of talking times. The parents are again the agents of change, providing the environment necessary to establish the desired behaviors. Long-term measures of treatment efficacy are clearly important in supporting our approach to therapy. At this early stage, it is not possible to offer firm data, however, the clinical impression to date confirms that one-third of the children have achieved normal fluency levels, one-third will continue to be monitored but have made good progress, and the final one-third are likely to be offered direct, intensive group therapy with their parents in the future.

Phase Two: 7–14 years

During this phase, the research evidence (Andrews et al., 1983) would suggest that there is still a possibility of remission. However, the child in this age group who is stuttering is likely to be developing a self-image associated with stuttering, experiencing communication failure, and developing productive and unproductive strategies for overcoming the problem. The child also is still dependent on the family for his or her resources and development.

Parental interview. A detailed description of this procedure can be found in Rustin's (1987a) work. The form and structure of the interview is similar to that previously described for the 2- to 6-year-olds. The variation that occurs relates to the issues of particular relevance to this group. These would include more specific detail relating to the type of school and the child's progress and attitude towards his or her peer and social relationships, the emergence of antisocial behaviors, discipline, and developing sexual awareness. As described previously, other issues are explored as they seem pertinent to each individual family.

Child assessment. This assessment also is described in detail in Rustin's (1987a) work. It is more formal and structured than the assessment for younger children and includes an audiotaped speech sample of a variety of speech tasks that increase in complexity, allowing quantitative and qualitative evaluation. The clinician will use an interview format, again adapted for age, to explore the child's attitudes to school, home, teachers, parents, and friends. This also offers an opportunity to note the child's overt anxiety level, reaction to questioning, state of body tension, spontaneity of talk, emotional expressiveness, attention span/distractibility, gross activity level, and any evident mannerisms.

Questions relating to the child's knowledge of his or her stuttering will give us an idea of the child's perception of his or her communication difficulties. Where the child is aware of the problem and realizes the significance of the interview, the discussion is extended to enable the clinician to estimate his or her understanding of the difficulties and his or her willingness to participate in therapy. The British Picture Vocabulary Scale (Dunn, Dunn, Whetton, & Pintillie, 1982) is administered routinely as a screening test to indicate the appropriateness of further linguistic assessments. Tests such as the Test of Word Finding (German, 1986) and the Fullerton Test of Adolescent Language (Thorum, 1986) also may be administered to shed light on coexisting linguistic difficulties. These detailed findings will make it possible to make recommendations for treatment.

Treatment. In the past, treatment for this group of children has been based on an *individual* model of service delivery. The clinician worked with the child and it was the child who was responsible for effecting and maintaining his or her fluency. The therapy model we advocate is based on the assumption that intervention with individuals who influence the communication environment of the child who stutters is the critical component in the treatment of children who stutter. Mallard (1991) is equally committed to this view and states that we must involve the people responsible for the child's communication environment from the beginning of therapy if the child is going to use what is learned in a meaningful way. Involvement does not mean talking with the parents infrequently about what is happening in therapy. Involvement means working with the parents, child, and teacher as a unit so that reasonable decisions can be made to help the child when problems occur. This therapy approach is described as *systemic* (Andrews & Andrews, 1990). It contrasts with the individual model of service delivery in that:

- The *interactive* system is the child and a circumscribed group of people who interact with the child, have influence on the child, and are concerned about the problem.
- Change is expected in the individual *and* the interactive systems.
- Change occurs in the natural environment.
- The primary intervention is with the interactive system.

Intensive treatment with active parental involvement. The therapy offered on our intensive courses has evolved over the years through a process of evaluation of the effects of intensive therapy and experimentation with new

treatment components. Intensive treatment courses offer adequate time to establish a consistent level of speech control and the opportunity to carry out treatment in a social context. Parents are crucial to the therapy process and children are accepted on the course only if both parents (unless a one parent family) agree to attend each day with their children. This level of involvement not only contributes to the process of establishing fluency but is vital in the transfer and maintenance components of therapy.

The goals of intervention within this age group are to:

- Increase an understanding of the nature of stuttering for both the children and their parents.
- Identify the positive changes that can be made by both the children and their parents.
- Practice changes in patterns of communication within a secure framework.
- Offer effective follow-up schedules following the intensive course.

Child program. There are two principle components that are considered prerequisites for the development of fluency skills in social settings.

- *Social and relaxation skills training.* Social skills training (Rustin, 1984; Rustin & Kuhr, 1989) is an integral part of the intensive course. The problems range from inappropriate eye contact during conversation to a serious lack of specific skills (making friends, assertive behaviors, negotiating skills, etc.). The particular areas with which we are concerned are observation, listening, turn-taking, reinforcing, and problem-solving skills. Role play affords us the opportunity to teach individual skills that may be missing or poorly developed in the individual's repertoire (Cartledge & Fellowes-Millburn, 1980). Our approach is focused on specific social situations that cause particular problems for the child.

  A very common source of difficulty for the young child is coping with teasing from other children. This problem-oriented approach to skills training captures the child's imagination and, coupled with the use of role-play and problem-solving exercises, provides opportunities to practice and explore alternative strategies in the controlled intensive course setting. Spivack and Shure (1974) discussed the use of such cognitive problem-solving skills among young children and concluded that those who are good problem solvers show higher levels of social adjustment when dealing with conflict situations. In our experience, direct training in problem-solving skills is extremely useful to children who stutter and may account for a great deal of their continuing fluency outside of the therapy context (Rustin, 1984).

  Relaxation training also is a feature of the course. Many children become very tense when anticipating a speech act. High levels of muscle tension contribute to stuttering behaviors and we therefore aim to help the children understand the difference between relaxation and tension through games. For example, in Tin Soldiers and Rag Dolls, members of the group are instructed to march around the room keeping their bodies stiff and straight just like tin soldiers (or robots). They are then instructed to walk around like limp floppy rag dolls and finally end up in a crumpled heap on the floor. Music can be helpful (Rustin & Kuhr, 1989). As the children become more proficient in relaxation, we encourage them to use this process as a coping mechanism when stuttering is particularly marked.

- *Fluency control techniques.* The aim of many treatment programs is to facilitate the acquisition of specific motor speech skills that allow clients who stutter to speak at a slower rate, with an easy onset and more continuous airflow, while blending sequential sounds smoothly together. In teaching speech control to the children, we emphasize the various factors that facilitate fluent speech rather than adhere rigidly to a particular technique. The advantage here over more prescriptive approaches is greater flexibility, which allows the individual child to concentrate on those features of control that genuinely aid his or her fluency. The speech control is introduced to the child using cognitive problem-solving skills. The child examines what goes wrong with his or her speech and what he or she can do to help him or herself.

The parent program. During the first week, the parent group sessions include a carefully prepared series of discussion topics and exercises (Rustin, 1987a). We let the parents experience the games and exercises we routinely use in treatment, including direct instruction in speech modification techniques, systematic muscle relaxation (Mitchell, 1988), and cognitive problem-solving techniques. Each day, homework tasks are set, which are discussed at the group meeting the following day. It is our intention that the parent groups should generate a variety of viewpoints about the problem of stuttering and its management within the family setting.

This exchange of ideas may initiate productive changes within each family without the need for explicit professional intervention. At certain points, the group discusses topics without professionals being involved because we feel this is an important step toward using the power of the group to create informal contacts between parents that can last well beyond the courses themselves.

During the second week of the course, family sessions are conducted that provide an opportunity to tackle issues that are specific to each family unit. Every family member over 4 years of age is invited to the session, including grandparents if they have a role within the household. The purpose of this meeting is to set up systems of communication between the family members that acknowledge the roles they play in the maintenance of the stuttering problem. These family sessions also are conducted by the family at home each week following the course when further problems and solutions are discussed. The family thus acquires new skills in negotiating conflicts that will persist beyond the timescale of the intensive courses.

The implicit aim of this method of working is to shift the responsibility for treatment from the professional clinician to the family unit. We aim to transfer the clinical skills of fluency control to the parents and their child in order that treatment gains are maintained after the course. Parents and children are recalled for follow-up sessions at 6 weeks, 3 months, 6 months, and 1 year. The long-term results of a study into the efficacy of this therapeutic approach are being processed currently. We are anticipating publication of the positive results in the near future. The overall clinical impression is that parents and children consistently benefit from their joint venture following this treatment approach.

Phase Three: 15—18

The stuttering problem in this group is probably now fully developed. Adolescence is a transitional period from childhood to adulthood, which brings together the demands and pressures of rapid physiological development and concomitant emotional, psychological, and cognitive changes. By virtue of the problem of stuttering itself, there are inevitable issues involving communication relationships and self-image that are of concern to the young adult who stutters and may affect his or her effective transition into adulthood (Rustin, Cook, & Spence, in press). Parental involvement at this stage becomes highly relevant in terms of encouraging independence, understanding locus of control, supporting the vacillations that occur in self-image, and coming to terms with their own role change at this important stage.

Parental involvement with the adolescent. As children reach the nexus between childhood and adulthood, the role of parents changes. If we accept the notion of adolescence as the transitional period from childhood to adulthood, which brings with it the demands and pressures of relatively rapid physiological development and concomitant emotional, psychological, and cognitive changes, it is clear that the assessment of an individual who is entering this phase is a highly complex, challenging task. Our aim is to encourage a partnership that will assist in the development of independence, growth of decision making, and ability to negotiate areas of disagreement.

Other authority figures (teachers, relatives, etc.) also loom large in the life of the adolescent client. In many cases, adolescents are endeavoring to establish their own autonomy in a reasonable way, but in some cases there is a rejection of, or rebelliousness toward, every person seen as an authority figure—including the clinician. Although the main focus of therapy is the client, the parents' role within the partnership is still of critical importance, particularly with the child who has not achieved sufficient independence to be fully responsible for making his or her own decisions.

Parental interview. The same structured interview is used as described above, but emphasis is put on understanding the parents' attitude towards this transitional phase. It is important that clinicians recognize and respect the legitimate concerns of the parents within the context of "the adolescent phase." The issues are very wide ranging and the clinician will need a basic knowledge of the theory of adolescence to support him or her in working with parents. There are, for example, enormous variations in the physical development and cognitive growth within this age group, and this should be reflected within any therapy program.

The interview will investigate the parents' strategies for facilitating the growth of independence and problem solving, as well as their changing approaches to discipline and concerns over friendships, sexual development, and morals. Issues relating to school work, exams, and future career prospects also should be taken into account. It is particularly relevant to discover the "function" the stutter may be serving for the individual within the family system. It may be that the stutter becomes a convenient diversion from the trials of adolescence; the parents may inadvertently collude in order to maintain the status quo.

Adolescent assessment and interview. A standard speech assessment that gives us a qualitative and quantitative analysis of the stutter is administered as well as the British Picture Vocabulary Scale (Dunn, Dunn, Whetton, & Pintillie, 1982) and the Test of Word Finding (German, 1986). It is important to listen to and understand the problem from the adolescent's point of view. Our extensive interview format (Rustin, Cook, & Spence, in press) probes school life, their performance and career plans, and their feelings about teachers and peers. Home life is explored, including relationships with siblings and parents and their reactions to the stuttering, as well as their social life and interests within and outside the home. Particular time is spent asking questions about their speech. We need to understand their personal theories about their stuttering, its variations and contexts, and any control strategies they have developed, as well as their expectations of therapy.

Summary. At the end of the interview, the clinician summarizes the information gathered at the interview and makes decisions regarding the appropriate intervention strategy for that particular individual. These are then discussed fully with the parents and adolescent. Care is taken to explain that there is no cure for the problem nor one prescribed route to fluency, but a joint exploration of alternatives to enable the client who stutters and the family to take charge of the problem. Flexibility is demanded throughout therapy to take care of the needs of the individual, whether in group or individual therapy.

Therapy. The goals of intervention for this age group are to:

- Increase understanding of the nature of stammering and its development.
- Increase awareness of the antecedents and consequences of stuttering.
- Develop alternative and more effective strategies for dealing with stuttering.
- Improve communication skills.
- Design effective follow-up schedules following intervention.

A combination of both intensive group and individual sessions are commonly seen as the most effective management strategy for this age group. Parents and teachers will

need to participate actively with different aspects of the problem. In contrast to the younger child, they will only be involved on an ad hoc basis as the adolescent is more able to make decisions for him or herself and needs encouragement to become more independent preparing for separation from the family.

The 2-week intensive program. Fluency control, relaxation, and social skills are taught in a similar way to the 7- to 14-year-olds but are adapted to meet the more sophisticated needs of the adolescent who stutters. Clients develop their own fluency control strategies and a personal communication plan that, following sufficient practical experience, they adjust for their own needs. At this stage, the degree to which they use fluency control becomes their choice (Rustin, Cook, & Spence, in press).

All aspects implicitly involve the clients in having a full understanding of the underlying rationale and an active role in designing their own individual program. Ideas and terminology from the group are used to generate group strategies and targets. It is our view that part of the process of dealing with transfer and maintenance is in both the client's and parents' understanding that *fluency* is not necessarily the answer to the problems of adolescence. This allows all concerned to look at the wider issues involved in an atmosphere of shared understanding, which in turn helps the stutterer take responsibility for his or her fluency.

The social skills aspect of therapy is emphasized as the underpinning of all other communication skills. Particular attention is paid to seven specific areas of skills training: observation, listening, turn-taking, negotiation, relaxation, praise and reinforcement, and problem solving. Considerable time is spent in developing these skills to meet the needs of the individual within the group through skill training exercises, role play, and role rehearsal (Rustin & Kuhr, 1989).

Individual therapy. The skills taught on the course require follow-up therapy if transfer and maintenance are to be achieved. In order to monitor progress as well as to identify and tackle new problems, individual sessions are scheduled following the course. Family sessions will be arranged to open up lines of communication that will enable the family members to negotiate issues more effectively (Rustin, 1987a). It is at this stage that the parents may be helped to assist in their child's growth of independence. Clinicians will need to inform teachers of the nature of the intensive course and discuss their concerns about dealing with an individual who stutters.

The client and teacher will be brought together to negotiate management of the stutter in the classroom and any issues where "antisocial behavior" may have become confused with stuttering will be addressed and dealt with. It is clearly important that the teacher be given a theoretical understanding of the nature and development of stuttering in order to maximize the individual's chance of developing more successful communication skills. All our intervention procedures require a commitment from parents, as well as the child or adolescent who stutters, to complete homework tasks because these are the stepping stones to long-term follow-up and maintenance.

CONCLUSION

The role of parents can no longer be denied; without the involvement of parents, clinicians become powerless to help the child beyond the confines of the clinic room. It is parents who enable their child to develop fluency and communication skills and thus take ownership of their child's progress. Once clinicians have overcome their initial fears of working with families, they will find it more interesting, challenging, rewarding, and fun.

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APPENDIX A

Assessment and Therapy Program for Disfluent Children: Task Sheet

Family name: E. First name(s): W.
Address: London E15

Date	*Task(s)*	*Description of what happened*	*Comments or feelings*
1-12-94	Increase eye-contact opportunities. Reduce rate.	Play acted. I was talking "cat" and W. was "catwoman."	W. talking fine. Lot of eye contact. Went well.
1-13-94	Even balance in conversation. Comment rather than question.	Planes. Was Budgie the Rocket. W. was Pippa the plane flying about in the sky.	It went OK, even though I kept a steady pace. W. still shouting. Lots of eye contact.
1-14-94	" "	Toy figures. I was Prince Eric. W. was Ariel the Mermaid.	Enjoyed activity but W. still shouting. Perhaps I'm talking too low? Good eye contact.
1-17-94	" "	Toy figures. Batman and Catwoman.	Less eye contact. Fun game. Fluency good but shouting is irritating.
1-19-94	Think about my irritation with W's shouting. Less active game.	Drawing a story.	Less eye contact. Good talking more relaxed. No shouting. Very happy.