Management of Stuttering in Preschoolers

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The material for this chapter has been extracted from Hegde’s presentation on evidence-based therapy at the All India Institute of Speech and Hearing, Mysore. Therefore, I would like to acknowledge Hegde for the information. Some modifications have been incorporated based on the clinical experience at the All India Institute of Speech and Hearing, Mysore.

In the past decades, enormous research on stuttering has provided knowledge base of stuttering. Research on stuttering has indicated that stuttering can be observed and analyzed at various levels. These levels include behavioural, acoustical, physiological, laryngeal, linguistic, genetic, motoric and neurophysiological. Therefore, we have a better understanding of stuttering at these levels of observation. The basic research has advanced in the field of stuttering. However, has this basic research transferred to the treatment of stuttering remains a question. With all this research it was hoped that there would be a break through in the treatment of stuttering which did not take place. True, there was some modified treatments, but not to the extent researchers thought. In the past, treatment research and basic stuttering have often been pursued parallel. In the 1970’s and 1980’s neurophysiological research was dominant. However, the research in this area has faded now. Basic research has helped us to better understand stuttering, but neither its cause nor its treatment.

For the past 50 years stuttering treatment was (a) Van Riper’s fluent stuttering (b) Goldiamond’s fluency shaping that included slow and prolonged speech with or without Delayed auditory feedback in addition to Azrin’s regulated breathing or airflow management. Prolonged speech technique is known to give long-term treatment effects. However, clinicians and clients are increasingly frustrated with prolonged speech treatment. The reasons for this are several. A slower- than-the normal rate is often essential to maintain a stutter-free speech. Stutter-free speech sounds unnatural, which is unacceptable to both the clients and the listeners. Also, when the client slowly increases the speech rate there is a corresponding increase in stuttering. Therefore, prolonged speech technique (especially the programmed) is not the sought technique.
There were effective alternatives, but were ignored as the fluency shaping and regulated breathing approaches were very popular. Looking for alternatives, some have discovered methods that were researched in the 1950s and 1960s, before the advent of fluency shaping (e.g., pause-and-talk and response cost).

Considering the issues and pseud issues in the treatment of stuttering normal sounding fluency was always a goal for persons with stuttering. Past research indicates that fluency is more easily achieved when children were treated compared to adults. Research has also indicated that all persons who stutter, including adults with a long history of stuttering, can gain significant benefits from treatment. Research in child stuttering probed as to whether stuttering was a phase in language development. Results of such research have indicated that probably stuttering is not a phase in language development as in cooing, babbling, first word etc. In early times it was thought that children show increased frequency of stuttering at certain times and therefore there is no need to treat it. Also, in some children stuttering disappears. This was corroborated with Johnson’s famous saying that stuttering arises in the parents ear and not in the child’s mouth. However, the fact that children have more frequency of stuttering at times is no justification for not treating it or withholding treatment. In the 1990’s parents were involved in treatment. However, the recent strategy is to involve children directly in treatment. It is better to treat stuttering as soon as it is diagnosed, no matter how young the child is. Also, don’t consider overblown rates of spontaneous recovery as a guideline for not initiating treatment in children with stuttering. Research has shown that spontaneous recovery is high if the child is allowed to stutter for 4 or more years, which is unacceptable to parents. Therefore, it is advisable not to make individual decisions about treatment need as one can’t predict whether a child is going to spontaneously recover or continue to stutter. Hence there is all justification to treat preschool children with stuttering.

There are several questions on stuttering treatment. First of all is the treatment is socially valid? Is an assessment or treatment procedure socially acceptable? Do parents want treatment for their stuttering preschoolers? Most parents accept treatment unless the professional informs them that treatment is not needed or is not available. Also, all parents accept treatment, even for their youngest children, if competent treatment is offered (Ahlander & Hegde, 2001). Parents also accept such behavioral treatments as time-out and response cost that clinicians tend to reject.

Second, is there professional validity of stuttering treatment? Do professional accept stuttering treatment methods? Do professionals believe in the early
treatment of stuttering? Unfortunately, many do not believe. Some believe that parents do not accept treatment for their young children (Ahlander & Hegde, 2001). A major hindrance to stuttering treatment is a lack of professional validity of treatment procedures.

Third how long should the treatment last? As long as it takes to (a) eliminate or significantly reduce stuttering and (b) when appropriate, induce natural-sounding speech and maintenance of fluency. Follow-up and booster treatment may stretch clinical management in adults to about 4 years. In children, stuttering may be eliminated in a year’s treatment and a year’s clinical management (follow-up and booster treatment).

Fourth, should the treatment be direct or indirect? It is advisable to treat stuttering directly, as there is no evidence to support fun and frolic activities, concealed treatment, or play (and mess-up) therapy. Strictly parent-oriented indirect treatment (e.g., asking them to relax and slow their speech down) is also ineffective. Behavioral treatments that children enjoy and seek are known to be effective. Counseling either parents or clients themselves cannot eliminate stuttering.

Fifth, what are the various evidence-based treatment methods? Advocated treatments are many, but effective procedures are few. Controlled and replicated evidence supports the following treatment methods:

- Comprehensive fluency shaping
- Prolonged speech
- Pause and talk
- Minimal prolongation plus pause-and-talk
- Fluency reinforcement
- Fluency reinforcement plus corrective feedback
- Response cost

Finally, for whom are these treatment methods applicable? Comprehensive fluency shaping, prolonged speech, pause and talk, and minimal prolongation plus pause-and-talk (experimental) are effective with older children and adults. Fluency reinforcement, fluency reinforcement plus corrective feedback, and response cost are effective in preschoolers and younger children. In the next paragraphs we shall look in to several of these treatment methods applicable to preschoolers.
Fluency Reinforcement for Preschoolers

Treatment options for preschoolers include various packaged programs exist for treating stuttering in preschoolers. But, most of them are not tested. Evidence-based techniques include: the following:

- Fluency reinforcement
- Fluency reinforcement plus corrective feedback
- Response cost

Fluency reinforcement in preschoolers

That stuttering may be eliminated in children by positively reinforcing fluency has been known since the 1970s (e.g., a study by Shaw & Shrum). However, the idea has not been vigorously pursued mostly because of a lack of professional validity. Almost all current treatment procedures offered to preschoolers use positive reinforcement for fluency as their main component (e.g., the Lidcombe program of Onslow and colleagues). There are several steps in fluency reinforcement as follows:

1) **Set the stage for fluency reinforcement**

   Collect toys, picture and storybooks, puzzles, activities (e.g., coloring or drawing), and other stimulus materials.
   Hold sessions for 30 to 40 minutes; if longer, give breaks to the preschooler.
   Seat the child across a small table or, if found necessary, sit along with the child (side-by-side seating).

2) **Select effective reinforcers**

   Prompt and enthusiastic verbal praise is effective with young children.
   If there is no decrease in measured stuttering rate, add additional reinforcers.
   High probability behaviors and tokens are effective additional procedures.
   Add them to verbal praise, which is a constant factor.

3) **Have the parents observe the sessions**

   Ask parents to observe the sessions from the beginning.
   Let them observe through one-way mirrors (not in the treatment room).
Later on, bring parents into the treatment room to eventually train them in fluency reinforcement procedure.

4) **Introduce the treatment procedure**

Describe stuttering and smooth speech for the child.
Model the child’s dysfluent productions.
Reassure the child that he or she can talk smoothly and that you can help.

5) **Begin at the sentence level**

Sit with the child, show storybook pictures or engage the child in planned activities, and talk with the child.
Reinforce all fluent productions while evoking conversational speech from the child.
Initial session or two may involve some practice at the word level, while still evoking phrases or sentences.
With very young children (e.g., 2.6 to 4 year olds), several initial sessions may involve phrases or incomplete sentences.

6) **Systematically reinforce fluency**

Children (and adults) who stutter have plenty of fluent speech that may be positively reinforced.
Preschoolers and younger school-age children react positively to fluency reinforcement.
All fluent utterances, whether a word, a phrase, or a sentence are positively reinforced with verbal praise.

7) **Use a variety of verbal praise**

Enthusiastically and promptly praise the child with a variety of statements:
- “Excellent! I like your smooth speech!”
- “Very good! That was smooth speech!”
- “Your speech is so smooth!”
- “You are working hard! Your speech is nice!”
- “That was smooth speech!”
- “That was wonderful! You said it smoothly!”
- “You said it nicely!”
8) Ignore stuttering

Do not react to stuttering in any manner.
Do not stop the child, do not give corrective feedback.
Stuttering is technically an extinction course.
When the child stutters, model the same production fluently.
Reinforce the fluent production that typically follows.

9) Progression of treatment

Move from phrases/sentences to continuous speech.
Move from sentences to continuous speech.
Move from continuous speech to narrative speech.
Move from narrative speech to more spontaneous conversational speech.

10) Reinforce fluency in continuous speech

Evoke continuous speech with the selected stimulus materials (e.g., story books with large pictures).
Prompt the child to produce more continuous speech (e.g., "Say it in longer sentences," "Tell me more about this picture," "Tell me everything happening in this picture," "Tell what you are doing now" etc.).
Model continuous productions.
Instruct the child to talk in longer sentences.
Model longer productions.
Reinforce imitated productions.
Withdraw modeling, evoke productions.
Reinforce spontaneous, longer productions.

11) Reinforce fluency in narrative speech

Tell or read aloud a short story that is appropriate to the child.
Ask the child to retell the story in smooth speech.
Reinforce smooth speech on a variable schedule.
Prompt the story elements when the child is unsure.

12) Reinforce fluency in conversational speech

Note that you may reinforce fluency in conversational speech before you reinforce fluency in narrative speech.
Engage the child in typical conversations.
Ask questions about the child’s family, friends, school, teachers, hobbies, activities, sports or games of interest.
Reinforce fluent productions on a variable schedule.

13) **Use objective criteria to move from one level to the other**

At each level of training (e.g., sentences, continuous speech, narrative speech, and conversational speech) use an objective performance criterion. We use 5% or less dysfluency rate at a given level, sustained over three sessions, to move to the next level. Most preschoolers attain less than 1% dysfluency rate in treatment sessions.

14) **Record the frequency of stuttering in each session**

Use a prepared recording sheet.
Minimally, record the frequency of stuttering and percent dysfluency rate for each session.
Optionally, record the frequency of specific types of dysfluencies and then calculate the percent dysfluency, and rate of speech.

15) **Periodically probe the stuttering rate**

A *probe* is a measure of target skills without the treatment procedures.
Engage the child in conversational speech; tape record the speech sample.
Do not model, prompt, or reinforce fluent speech; keep the conversational natural and typical.
Record the rate of stuttering or dysfluencies.

16) **Before dismissal, make sure the parents can reinforce fluency at home**

Train parents in fluency reinforcement.
Have them conduct sessions in front of you.
Fine-tune their skills in evoking, modeling, and reinforcing fluent productions.
Train them in ignoring stuttering (a task that is difficult for many).
17) **Use an objective dismissal criterion**

We use a criterion of less than 5% dysfluency rate (preferably less than 1%) in conversational speech sustained across 3 sessions to dismiss the child (or an adult) from therapy.
Adopt your own criterion and adhere to it.
We prefer the less-than-5% criterion because it allows a “cushion” for eventual increase in the natural environment.
We want them to sustain less than 5% dysfluency rate over time and across situations.

18) **Follow-up the child**

A 6-month follow up is essential. However, Hegde (2007) considers that two-year-follow-up is essential for most children (longer in the case of adults).
A follow-up is essentially a probe.
Record a naturalistic conversational speech sample to measure the stuttering rate.
If the rate is close to 5% or exceeds it, offer booster treatment.
Give the same treatment or a new treatment that is known to be effective; schedule another follow-up.

**Fluency Reinforcement Plus Corrective Feedback for Preschoolers (The second option for preschoolers)**

The second option is to add corrective feedback for stuttering while maintaining positive reinforcement for fluent productions. Addition of corrective feedback for stuttering may enhance the treatment effects. In this procedure, the clinician reacts to both fluent and dysfluent productions.

**The role of corrective feedback:** Although fluency reinforcement may be used exclusively, corrective feedback should not be used exclusively; there is no strong evidence that mere corrective feedback will eliminate stuttering. Corrective feedback should always be combined with fluency reinforcement. The child should receive more positive reinforcement than corrective feedback. Use the following steps in fluency reinforcement plus corrective feedback:
1) **Maintain fluency reinforcement**

Use all the suggestions and guidelines offered under *fluency reinforcement*.
Introduce the treatment.
Use toys, activities, storybooks and other materials to evoke speech.
Select effective reinforcers.
Begin treatment at the phrase/sentence level.

2) **Reinforce fluent productions**

Enthusiastically and promptly praise the child with a variety of statements:
- “Excellent! I like your smooth speech!”
- “Very good! That was smooth speech!”
- “Your speech is so smooth!”
- “You are working hard! Your speech is nice!”
- “That was smooth speech!”
- “That was wonderful! You said it smoothly!”
- “You said it nicely!”

3) **Offer corrective feedback for stuttering**

Offer corrective feedback at the earliest sign of a stutter (e.g., twitching of the lips, tension in the face, shoulder, or chest, irregular breathing, any facial feature associated with stuttering).
Do not let the stuttering run its course; stop it by immediate corrective feedback.

4) **Vary corrective feedback**

Promptly offer one of several forms of corrective feedback at the earliest sign of stuttering. Say:
- “Stop! That was bumpy!”
- “Oh no! You didn’t say it smoothly!”
- “That was bumpy!”
- “Stop! You are having trouble saying it”
- “No, that was not smooth!”
5) Progression of treatment

Move from phrases/sentences to continuous speech.
Move from continuous speech to narrative speech.
Move from narrative speech to more spontaneous conversational speech.

6) Use objective criteria to move from one level to the other

At each level of training (e.g., sentences, continuous speech, narrative speech, and conversational speech) use an objective performance criterion. We use 5% or less dysfluency rate at a given level, sustained over three sessions, to move to the next level. Most preschoolers attain less than 1% dysfluency rate in treatment sessions.

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Engage the child in conversational speech; tape record the speech sample.
Do not model, prompt, or reinforce fluent speech; keep the conversational natural and typical.
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9) Before dismissal, make sure the parents can reinforce fluency at home

Train parents in fluency reinforcement.
Have hem conduct sessions in front of you.
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If the rate is close to 5% or exceeds it, offer booster treatment.
Give the same treatment or a new treatment that is known to be effective; schedule another follow-up.

**Response Cost for Preschoolers**

Response cost is an attractive alternative to fluency shaping. It is effective with young children for whom fluency shaping is not a good option. It does not affect the speech rate and speech naturalness. It is easily administered; clinicians are readily trained in its use. Parents accept it and therefore it has high social validity. Early research studies in the late 60s and 70s, demonstrated the effectiveness of response cost (RC). But those studies were limited as well as experimental, with few participants and little or no follow-up. There is a need to explore the immediate and long-term effects of this attractive procedure. At California State University-Fresno, the RC research program is run within a preschool format (Hegde, 2007). The author wanted to experimentally demonstrate that:

- Early treatment of stuttering is effective
- Stuttering in preschoolers may be pretty much eliminated
- Response cost will induce fluency without slower speech
- Fluent speech generated by response cost will sound natural
- Early treatment results in better maintenance of natural-sounding fluency
Furthermore, he wanted to clinically demonstrate that parents accept and seek treatment for their preschool-age children who stutter. The RC research preschool was conducted as follows:

- Sessions were held twice weekly, two hours each (1 to 3 pm)
- Six (6) children are seen each semester; 38 children treated so far
- All children come to the clinic and leave the clinic at the same time
- Children are between 2.6 to 5 years
- Individual RC therapy is offered to each child for 30 to 40 minutes
- The children are engaged in group interaction when not in individual sessions

The preschool is set-up as an experimental study on the effects of RC. Hegde used a modified ABAB design (AaBaAaB) in which:

- A= initial baseline
- a= 3-min probe at the beginning of each session
- B= RC treatment
- a= A 3-min probe at the end of each session
- A= Natural withdrawal of treatment during semester breaks or other holidays (Thanksgiving, Christmas, and spring breaks)
- a= A 5-min probe before treatment reinstatement
- B= Reinstatement of RC treatment

The experimental design can rule-out such extraneous variables as maturation, spontaneous recovery (a main concern in treating young children), parental influence, and so forth as the potential cause of the effects seen in the study. The design helps demonstrate the effects of RC by showing that during the course of the treatment, there was no spontaneous recovery. It does by showing (a) a stable initial baserate of stuttering, (b) that in the initial stages of treatment, stuttering rate was higher in the first and the last 3 min probes (the small a conditions) than during treatment, and (c) that when the treatment was withdrawn, stuttering rate went up, but when the treatment was reinstated, the rate went down; these changes rule-out spontaneous recovery during the course of the study.

Three graduate students (clinicians) administer treatment in individual sessions as a part of their clinical practicum. Two paid undergraduate students (assistants) conduct the group interactions. At the beginning, all six children are in a 10-minute warm-up group interaction; forming a circle, they greet each other and sing an attendance song. At the end, all six children gather again to listen to a story, tell about the prize they got in individual treatment, and say good-bye to
each other and to the clinicians and assistants. At any one time, three children may be in individual therapy, and three in group interactions. Various group interactions include:

- Reading aloud children’s stories and asking questions about the stories.
- Painting, coloring, and making craft and art projects.
- Outdoor activities involving playing or planting seeds in small containers.
- Putting puzzles together.
- Talking about birthday parties, festivals just celebrated, vacations taken, and so forth.
- And such other activities.

The two undergrad assistants socially reinforced fluent productions on a variable schedule; they praise the children for their “smooth speech”. Each time a child stutters, an assistant may say “Oh! That was bumpy! Say it again smoothly”. On occasion, the assistants fluently model the child’s stuttered production; the child then imitates the assistant’s fluent production. No response cost procedure is used during the group interactions.

**The response cost treatment**

- During the first individual session, introduce the treatment procedure to the child.
- Show a box of goodies (a collection of small gift items) to the child and ask the child to select a gift he or she will “buy” at the end of the session
- Have the child describe the procedure to make sure the child understands the procedure

**Administration of response cost: Token award**

During the individual response cost therapy the clinician uses toys, storybooks, puzzles, selected games, activities, and so forth to evoke speech from the child. For every fluent production (a word, a phrase, or a sentence), the clinician places a token in the child’s container. The clinician also praises the child for smooth speech as she places the token in the child’s cup (e.g., Says, “That was smooth speech! Here is a token for you”).

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Administration of response cost: Token withdrawal

When the child stutters, the clinician says something like “Oh no! That was bumpy! I am taking a token back!” and removes a token from the child’s cup and places the removed token in her own cup. He fluently models the child’s stuttered production for the child to imitate and awards a token to the child if the imitated production is fluent.

Variation and progression

Initially, withdraw a token with announcement (“That was bumpy, I am taking a token back”). Later, take a token back without announcement. While showing pictures and evoking controlled responses, interject brief conversational episodes.

Progression across response complexity

As with other procedures, advance the child from isolated sentence level to more continuous speech. From continuous speech, advance the child to narrative speech. From narrative speech, advance the child to conversational speech. Remember, continuous and narrative modes can be trained in any sequence.

Trouble shooting

Occasionally a child may react emotionally to the first token withdrawal and refuse cooperation. The child may stop talking, fight tears, leave the seat, or ask for Mommy. Showing signs of disappointment is natural and the clinician needs to do nothing. Serious emotional reactions need to be handled promptly and sensitively.

Reverse the Roles

*Role reversal* is invariably effective in completely eliminating the children’s unfavorable reactions to the initial token withdrawal. The clinician plays the child’s role, and asks the child to give and take tokens for smooth and bumpy speech (and produces many bumps). Children gleefully withdraw tokens from the clinician! When the treatment is resumed, children have no problem with token withdrawal.
Token bankruptcy

Another potential problem to be handled is token bankruptcy—the child who is left with no tokens, which means no gift at the end of the session. That, of course, can’t happen; the clinician should avoid token bankruptcy at all cost. Token bankruptcy means no reinforcement for fluency and the child will react explosively.

Handling token bankruptcy

Clinicians monitor the number of tokens the child has at any moment. When the child’s token collection is precariously low, the clinician can
- award two tokens for fluent and longer productions
- more frequently model fluent productions
- extend the session by a minute or two so the session ends with surplus tokens for the child.

Parent training

Train the parents in the administration of response cost at home. Train them only when the effects the natural withdrawal has been established. Do not monitor parent training in any systematic manner.

Results of the RC in one child (1.9 year old girl) is shown in the graph below:

![Graph showing results of RC](image)

A1=Initial baseline, B1= Treatment using Response Cost Procedure, A2= Treatment withdrawal period, B2= Reinstatement of Response Cost Treatment.
A1 = 3 sessions, B1 = 9 sessions, A2 = 6 days, B2 = 8 sessions

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Results indicated that stuttering rates were reasonably stable during the initial base rates. Stuttering rates during the first and the last 3-min probes in each session were higher compared to the rate during treatment—meaning that stuttering rate was lower when RC was in effect and higher when RC was absent just before and just after treatment. Stuttering reduced below 5% after treatment. Stuttering rates substantially increased after a break of one week. Stuttering rate decreased substantially when the RC was reinstated.

Social validity of treatment outcomes

During the follow-up, ask the following questions to the parents.

- Do you still consider your child to be a stutterer?
- Do you think your child's fluency is as good as any other child?
- Do you think your child needs further treatment?

Pause and Talk for Older Children and Adult

Earlier it was called time out. Hegde (2007) prefers to call it pause-and-talk (P&T) to time-out (TO) because (a) TO is much misunderstood and misused in educational settings, (b) TO is thought of as undesirable, and (c) TO has questionable professional validity (professionals reject them). However, TO has good social validity (clients and their family members accept it).

TO was initially researched in the late 1960s (Haroldson, Martin, & Starr, 1968). James had published several studies from 1976 to 1981. Early studies had shown that TO is invariably effective in eliminating stuttering while not affecting the speech prosody. However, there is limited follow-up. More recent studies include those by Hegde & Parson (1989), Carter-Wagner & Hegde, 1998) Ahlander and Hegde (2000), and Onslow, Packman, Stocker, van Dorn, & Siegel (1997). These and other studies, totaling more than 20 studies with about 150 individuals who stutter, have shown that P&T is effective with older children and adults. It does not affect speech prosody. Also, it may promote better maintenance than fluency shaping (limited data). It does not require constant monitoring of speech production. It may offer a more permanent treatment (need more evidence). Ahlander evaluated the relative effects of P&T and RC within an alternating treatments design in older children (10 to about 16 years of age). Both the procedures were equally effective, although P&T was slightly more effective than RC. Although known to be effective, clinicians neither recommend nor practice P&T. Clinicians in the U.S. and most European countries believe that P&T, being
an *operant punishment procedure*, is unacceptable to society. But their belief is unfounded; it may be an excuse for not having been trained in the use of P&T.

In a study on the social and professional validity of P&T in an investigation on the relative effects of response cost and time-out, Ahlander & Hegde found that in the opinion of clinicians, parents of children who stutter reject the method. Parents themselves, however, had no problem accepting the technique as treatment for their children’s stuttering. Essentially, the technique had social validity, but not professional validity.

**Best possible candidates for P & T**

- P&T is perhaps most effective with older children and adults.
- It may be difficult, though not impossible, to apply to young children (perhaps below 6 years of age).
- Generally speaking, older students and adults stop talking when the clinician says so; very young children fail to stop, so RC is better suited for them.

**Parents training to administer P&T**

- Parents may be trained to administer P&T effectively (Carter-Wagner & Hegde, 1989).
- P&T is as effective, or may be slightly more effective than RC in treating older children.
- RC is not the best treatment option for adults; P&T is a better option for them.

**What is pause-and-talk?**

It includes both social reinforcement for talking fluently and sudden withdrawal of that reinforcement for stuttering. Contingent on each instance of stuttering or dysfluency, it imposes a 5-sec duration of no talking, hence a period of no social reinforcement. Client is socially reinforced as long as the speech is fluent.

**Nature of reinforcement:** Fluent talking receives the usual social reinforcement, which is the clinician’s attentive listening, smile and other approving facial expressions, verbal expression of approval, and continued opportunity for self-expression for the client. Being able to talk may be the ultimate reinforcer in this procedure.
The nature of corrective feedback: Time-out is a period of no reinforcement. Reinforcement is withdrawn when a dysfluency is imminent, when it is in progression, or when it just occurred. Reinforcement withdrawal takes place when the clinician says, “Stop” and avoids eye contact. The client should cease talking for the method to work.

Administration of P&T: Gather the usual stimulus materials. Instruct the child about the procedure. Begin with conversational speech, evoked through storybooks, toys, activities, and so forth. The speech the child produces may be words, phrases, or sentences; accept all fluent productions. Reinforce fluent productions. Maintain eye contact with the client. Pay keen attention to what the client says. Maintain a pleasant facial expression. Make comments typical of everyday conversation (express agreement, nod your head, say “Yes” or “No” as found appropriate, etc.). Ask questions, prompt details or additional information, suggest topics of conversation, and use all devices to keep the client talking. Minimize your own (extended) talk.

Withdraw reinforcement for dysfluencies: Watch the client’s face carefully to detect even the earliest sign of a stutter. Say, “Stop” as soon as you see the sign of a stutter; make sure the client stops talking. Terminate the eye contact as you say “Stop”. Look at your watch to count 5 sec (never longer). Maintain a neutral facial expression and remain still for the 5 sec duration. Reestablish the eye contact at the end of the duration. Say something to, or gesture the client to, resume talking.

Do not misuse the procedure
- Never impose time-out for fluent productions.
- Do not be slow to recognize dysfluent productions; by the time you impose time-out, a fluent production may be in progress.
- Do not continue to pay attention when a dysfluent production is in progress.
- Do not ask the client to speak slowly, use gentle onset, or use airflow management.

Objectively evaluate the progress: Tape-record each session to later analyze dysfluent and fluent productions. Keep a tally of time-out periods to make a quick assessment of the number of dysfluent productions. If fluency does not begin to increase in two or three sessions, assess your skill in administering the procedure. Consider alternatives (RC or fluency shaping) if the method proves ineffective.
To conclude, use evidence-based therapies so that you are more answerable to the client and his/her family. Always maintain therapy record. Santosh will provide with a sample of record maintenance that can be followed with all clients with stuttering.

References


