A BEHAVIORAL-COGNITIVE THERAPY PROGRAM FOR ADULTS WHO STUTTER: COMPUTERS AND COUNSELING

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This paper evaluates the efficacy of a behavioral-cognitive treatment program for adults who stutter. The program combines a commercially available computer-assisted biofeedback program for the reduction of stuttering and a relapse management program for counseling and attitude change. Four adults who stutter, between the ages of 20 and 25 years, participated in a study with multiple baseline across individuals. The initial treatment was conducted in an intensive time block, followed by extended treatment sessions. Results show that subjects reduced their disfluencies to below 3% stuttered syllables and maintained those changes at the 6 and 12 month follow-up. Measures of attitude changes were also assessed and showed that increases in positive feelings and attitudes were maintained at follow-up.

INTRODUCTION

Over 3 million people in the United States stutter. These people experience a disorder which is characterized by relapsing and recurring episodes of disfluency. The episodic and cyclical nature of stuttering leads to uncertainty. In fact, some clinicians and researchers suggest that stuttering may be a "chronic perseverative syndrome" (Cooper, 1993). People who stutter report uncertainty and a resulting "loss of control" which occurs while speaking specific sounds or words and in specific speaking situations. A number of studies have indicated that the way in which individuals deal with the distress caused by uncertainty can affect both their physical and mental well-being. Researchers and clinicians have reported on how coping with disability affects rehabilitation, adjustment, and quality of life. The uncertainty and potential for relapse necessitates that the treatment of fluency disorders include both behavioral and attitudinal components (Blood, 1993;
The purpose of this paper is to examine the efficacy of a combined behavioral and cognitive treatment package for adults who stutter. The treatment program combines an intensive fluency shaping portion, using a commercially available computer-assisted biofeedback program called CAFET (Goebel, 1988a) with a cognitive program for relapse management.

A clinician's definition of stuttering is extremely important because it provides a basis for the goals of treatment and outcome criteria. The definition of stuttering used in this paper has four factors. The first three factors are from Van Riper and Emerick's (1984) definition of stuttering including: 1) the speech behavior; 2) the emotional upheaval, reflected in physiological stress reactions; and 3) negative attitudes and lifestyle adjustments. The final component concentrates on 4) perceived loss of control. This concept was recently explained by Perkins, Kent, and Curlee (1991) in their article discussing a proposed theory to explain fluency and the production of stuttered and nonstuttered speech disruptions. They defined stuttering as "a disruption of speech experienced by the speaker as loss of control" (p. 734).

Selection of Treatment

The primary goal of this treatment program was to improve the overall communication functioning of the client. This included changes in three broad components of 1) speaking, 2) feeling, and 3) thinking. Specific changes in fluency and the rate of speaking were initially targeted. The criterion of \(<3\%\) stuttered syllables (Caron and Ladouceur, 1989) was established. These behavioral changes were followed by objectives focusing on clients' feelings of avoidance, fear, and negative emotion. Finally, cognitive changes dealing with locus of control, self-control, and self-responsibility were targeted. A brief discussion of each of these three broad categories is included.

Changes in Speech Behavior

The first component of the treatment involved changes in motor speech behavior. This section of the program used a commercially available program called Computer-Aided Fluency Establishment Trainer or CAFET. Goebel (1988a,b) reported on the development of this computer-aided biofeedback device to train and establish fluency for persons who stutter. CAFET includes elements for systematic desensitization and behavioral fluency shaping. The program uses a microcomputer, circuit board, respiratory sensor and a clip-type microphone. The respiratory sensor (chest bellows) is used as a noninvasive measure of airflow worn at a level of the diaphragm. The microphone is worn on the collar and is battery depen-
the computer screen is color-coded in green, purple, red, blue, and white and functions in real-time. A number of different measurements can be obtained which help the client to divide the problem of stuttering into manageable steps.

The following target behaviors and errors were addressed in this part of the therapy.

**Diaphragmatic Breathing.** The goal of this target behavior was to establish control over the breath stream. When the goal was achieved, a blue line appeared in the goal box on the computer screen indicating successful completion of the trial. An error was recorded when the client demonstrated breath holding. When an error was made, the goal box was cleared of all correct responses and immediate feedback for the trial was obtained.

**Continuous Airflow.** The goal of this target behavior was to eliminate breath holding prior to speech by relaxing the diaphragm. An error was recorded when the client demonstrated breath holding.

**Pre-Voice Exhalation.** The goal of this target behavior was to establish the flow of air before phonation by monitoring the onset of phonation. An error was recorded when the client demonstrated early or late onset of phonation.

**Easy Onset.** The goal of this target behavior was to establish a slow and steady rise in volume. An error was recorded when the client demonstrated hard onset or abrupt changes in volume.

**Initial Prolongation.** The goal of this temporary target behavior was to help learn easy onset (slow rise of volume) and consisted of holding the vowel of the first syllable of the first word of a phrase or breath group. Prolongation longer than .5 sec. was unacceptable. An error was recorded when the client demonstrated a soft onset of volume.

**Continuous Phonation.** The goal of this target behavior was to initiate and maintain vocal fold vibration through a phrase or breath group. An error was recorded when the client demonstrated a speech break.

**Phrasing.** The goal of this target behavior was to help the client use airflow, easy onset, and continuous phonation more efficiently. An error was recorded when the client demonstrated low air.

**Monitored Speech.** The goal of this target behavior was to help the client transfer and maintain the newly acquired speech responses.
Immediate feedback for these target behaviors and errors were provided on the computer screen. For example, the image for maximum chest bel lows movement (a breathing cycle) was seen on the computer screen as a purple line following the contour of a breathing cycle. Clients controlled the breath curve on the screen by using the visual feedback to establish a smooth breathing curve. Another measure that CAFET provides is a measure of slow rise of volume (SRV), also labeled easy onset of volume. Clients were required to prolong the onset of voicing for 3/10ths of a second, without having their volume rise more than 70% during any 1/10th second. They also achieved full volume within 1.2 seconds. This appeared on the screen as a small box of volume increments which dramatically showed the client an abrupt onset of volume in contrast to a slow, steady pattern of volume onset steps as the increases in volume were recorded.

The target behaviors were taught in the following contexts: vowels, single-syllable words, bi-syllable words, short phrases, and conversation. Criterion at each speech level was 20 consecutive error-free cycles during the airflow and timing of onset steps. Criterion levels were reduced to 10 consecutive error-free cycles at the phrase level. The target behaviors had to be mastered in each context before an additional target behavior was introduced.

Changes in Feelings and Attitudes

The second and third components of the program included the use of a relapse management program called POWER²: Dealing with Stuttering (Blood, in press). The program was based on the work of Bandura's self-efficacy model (1969, 1977), Meichenbaum's (1977) cognitive behavior modification approach, and Marlatt and Gordon's (1980) relapse prevention models. The program examines the antecedents and consequences of relapse through the interaction of cognitive factors. For many years, speech language pathologists have recommended that clients become self-reliant, independent and responsible for their stuttering behavior and attitudes. Many therapies recommend clients demonstrate the ability to solve their own problems regarding stuttering. Desensitization, self-esteem, communication, openness about stuttering, coping strategies, and approach-avoidance conflicts have been the backbone of numerous therapies for persons who stutter. This approach was a systematic program for training clients in relapse management. It included phases that taught the client to approach, understand, and solve problems.

POWER²: Dealing with Stuttering (Blood, in press) was designed to work on the attitudes and feelings of adolescents and adults who stutter. The POWER² acronym stands for the six goals for changes in the attitudes and feelings about stuttering including: P(ermision), O wnnership), W(ell-being), E(steem of one's self), R(esilience), and R²(esponsibility). Table 1 provides
Table 1. Summary of the Topics and Activities Included in the Six Different Phases of the POWER® Approach

<table>
<thead>
<tr>
<th>Phase</th>
<th>Topics and Activities</th>
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<tbody>
<tr>
<td>PERMISSION</td>
<td>Permission to stutter or not to stutter is discussed. Clients discuss stuttering, awareness of stuttering, general communication skills, and learn problem solving techniques.</td>
</tr>
<tr>
<td>OWNERSHIP</td>
<td>Ownership of the problem of stuttering is discussed. Short-term and long-term goals for changes in speaking, feeling, and thinking are addressed. Facts about stuttering are learned.</td>
</tr>
<tr>
<td>WELL-BEING</td>
<td>This component of the therapy deals with social support systems, barriers to successful transfer to outside the clinic, impact of daily hassles, and annoyances on stuttering.</td>
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<tr>
<td>ESTEEM OF ONE'S SELF</td>
<td>Discussions focus on assertiveness in speaking and interpersonal situations. Perceptions about “self-talk” and changes to enhance positive feelings and thoughts about self and stuttering are examined.</td>
</tr>
<tr>
<td>RESILIENCE</td>
<td>This part of the therapy deals with the “hardiness” component. Dialogues about “bouncing back” after stuttering episodes, relapse control, and perfect fluency are conducted.</td>
</tr>
<tr>
<td>RESPONSIBILITY</td>
<td>The issues of self-control, self-responsibility, and the effects of one’s beliefs on therapy outcomes are discussed. Activities include different communication models, “perfect speakers,” relaxation exercises, and coping styles.</td>
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a summary of some of the activities that were covered under each area of the POWER® therapy approach. Relapse control activities consisted of discussing stuttering, the impact of stuttering on client’s lives, ways to deal and cope with the challenges of stuttering, and the concept of resilience or “hardiness”. The therapy consisted of asking the client to generate responses to a series of questions about awareness of the problem, problem solving techniques, self-esteem issues related to relapse, perceived control issues, social support factors in maintaining fluency, and general well-being topics. All of these “therapy questions and discussions” helped the client deal with stuttering. These components of the treatment also helped to reinforce the fluency and speech changes. A short summary of some of the counseling skills used during the management of feelings and attitudes with adults who stutter is included in Appendix A.

METHOD

Subjects

Four males with a history of stuttering since childhood served as subjects for this study. Subject 1 (S1) was 21 years old, and had been enrolled in therapy for 12 years. Subject 2 (S2) was 20 years old with a history of fluency
therapy for 8 years in public schools. Subject 3 (S3) was also 20 years old with a history of speech therapy for 10 years. Subject 4 (S4) was 25 years old and had been enrolled in 9 years of therapy for his stuttering.

Baseline, post-intensive treatment session, and post-extended treatment sessions measures are reported in Table 2.

Assessment of Stuttering

Like the disorder of stuttering itself, the task of assessment is a multifaceted one. The speech motor behavior must be assessed. In addition, the feelings and attitudes of the client must also be evaluated. The measures used for baseline, post-intensive treatment sessions, post-extended treatment sessions and follow-up are briefly discussed here because of the emphasis of this article on treatment. Many of these measures were used in a previous study with adolescents who stutter (Blood, in press) and can be found in greater detail in that article.

The assessment of speech behavior included four variables:

1. Percentage of stuttered syllables per minute (%SS) were obtained.
2. Rate of speaking in syllables per minute (SPM), was calculated from

<table>
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<tr>
<th>Table 2. Overview of Treatment Protocol and Schedule</th>
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<tbody>
<tr>
<td><strong>Introductory Session</strong></td>
</tr>
<tr>
<td>1. Agreed upon perceptions of problem and treatment, hierarchy for treatment and deterrents to recovery discussed.</td>
</tr>
<tr>
<td>2. Outline typical treatment sessions and anticipated time line.</td>
</tr>
<tr>
<td><strong>Assessment Session</strong></td>
</tr>
<tr>
<td>1. Evaluate speaking, thinking, and feeling aspects of disorder.</td>
</tr>
<tr>
<td><strong>Baseline Sessions</strong></td>
</tr>
<tr>
<td>1. Ten to 15 minutes of videotaped conversations with clinician.</td>
</tr>
<tr>
<td>2. Data on percentage of stuttered syllables and rate of speech.</td>
</tr>
<tr>
<td><strong>Intensive Treatment Sessions (42–60 hours)</strong></td>
</tr>
<tr>
<td>1. Rapid changes in speech disfluencies and/or rate through intensive treatment using a commercially available computer-assisted biofeedback program.</td>
</tr>
<tr>
<td><strong>Extended Treatment Sessions (51–64 hours)</strong></td>
</tr>
<tr>
<td>1. Introduction of POWER² program for relapse management, counseling, and changing attitudes about stuttering and role of active collaboration by the client.</td>
</tr>
<tr>
<td>3. Agreed upon termination of treatment with check-up visits.</td>
</tr>
<tr>
<td><strong>Follow-up Sessions</strong></td>
</tr>
<tr>
<td>1. Clients return at 6 and 12 month intervals after the termination of the extended treatment sessions and complete all the assessment measures.</td>
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</table>
3 minute samples by dividing the number of syllables spoken by the total number of minutes.

3. **Stuttering Severity Instrument-SSI** (Riley, 1980). The SSI evaluates stuttering frequency, duration, and physical concomitant. Total scores were calculated. Percentiles and severity ratings were obtained.

4. Five, 61 second **Diagnostic probes** using the computer-assisted biofeedback equipment as recommended in the protocol for the CAFET program.

The feelings components were evaluated by two self-administered scales.

1. **Personal Report of Communication Apprehension-PRCA** (McCroskey, 1978). This was a standardized, self-administered 25 item scale which measured the clients' fear, anxiety, or apprehension (real or anticipated) about speaking to another individual or individuals. Low communication apprehension was defined as scores below 58, while high communication apprehension was defined as scores above 88 according to the guidelines by McCroskey (1978). The mean score for subjects is 73 with a standard deviation of 13.

2. **Assertiveness Scale** (Rathus, 1973). This 30 item self-report scale assessed assertiveness or social boldness. Subjects endorsed scores from +3 (very descriptive of me) to −3 (extremely nondescriptive). During reliability checks, score ranged from +60 to −70.

Finally, the thinking component evaluation included two self-administered scales.

1. **Self Efficacy Scale for Adult Stutterers-SESAS** (Ornstein and Manning, 1985). This scale is based on the work of Bandura (1969, 1977) and was developed to estimate a client's confidence for their likelihood of establishing and maintaining fluency in a variety of situations. Subjects were asked to complete 40 items dealing with their confidence in 1) approaching a situation and 2) maintaining a self-defined "level of fluency" in a situation. Subjects rate their approach and performance from 10 (quite certain) to 100 (very certain) decile scale. An overall average score can be obtained.

2. **Erickson S-24 Scale** (Erickson, 1969; Andrews and Cutler, 1974). The modified Erickson Scale is a 24 item self-report scale that assesses the client's attitudes and feelings about stuttering.

**Experimental Design**

A single subject multiple baseline across subjects design (Hegde, 1994) was used to determine the efficacy of the treatment on the clients' rate and disfluencies. An excellent review of the advantages and uses of single-subject
designs in clinical practice can be found in an article by Williams (1993). In this type of clinical study, the treatment is administered to S1 after a stabilized baseline has been observed. During this time, S's 2, 3, and 4 are held in continued baseline. The design shows the effectiveness of the treatment as long as the measured behaviors do not change during the baseline sessions. Baseline data stabilized after 5 sessions for S1, at which time the treatment was begun. Treatment for S2 started after 10 sessions. Treatment for S3 started after 12 sessions and treatment for S4 started after 15 sessions. S3 and S4 had indicated that they could not start the intensive treatment sessions for at least 2 months after the diagnostic testing. They indicated a willingness to come to the clinic three times a week to provide ten minute speech samples.

In addition to the control of the multiple baseline design, baseline, post-intensive treatment, post-extended treatment, 6 and 12 month follow-up data were compared.

Course of Treatment

The treatment program was divided into baseline, intensive treatment, extended treatment, and follow-up sessions. Table 2 provides an overview of the treatment program. The baseline sessions dealt with client and clinician perceptions and assessment. The intensive treatment sessions dealt with speaking behavior and motor changes. The extended treatment sessions dealt with feelings and attitudes toward stuttering and relapse management. The follow-up sessions took place at 6 and 12 month intervals after the termination of the extended treatment sessions.

Baseline Sessions

After the client and clinician agreed upon the diagnosis of a stuttering problem, the overall treatment plan was outlined and discussed. The baseline sessions consisted of 10 to 15 minute videotaped conversations with the author. The baseline sessions were used to determine if the stuttering behavior was changing, increasing or decreasing before the initiation of treatment. Subject 1 (S1) had 5 baseline sessions, subject 2 (S2) had 10 baseline sessions, subject 3 (S3) had 12 sessions, and subject 4 (S4) had 15 baseline sessions.

Intensive Treatment Sessions

This phase of the treatment consisted of an intensive treatment in changing the speech motor behavior on CAFET. Clients were requested to find a 42-60 hour block of time that could be concentrated over a maximum
of three weeks (13–20 hours a week divided over 3 or 4 sessions per week). Treatment time ranged from 46–55 hours using the computer-assisted biofeedback program.

**Extended Treatment Sessions**

During this part of the treatment program, the extended treatment sessions, fifty minute sessions were held three times a week for approximately for 6–8 months. The POWER² Program was introduced. These treatment sessions were divided into approximately 15 minutes of carryover and transfer activities as recommended in the concluding steps of the CAFET program. The remaining 35 minutes were dedicated to attitude change, problem solving, relapse management, self-esteem, self-responsibility, and coping skills training through the POWER² program. The extended treatment focused on the feeling/thinking phases of the program. These phases were introduced after the client had stabilized the fluent speech behavior in the clinic setting.

**Follow-up Sessions**

Clients were encouraged to maintain contact during the next year. They were asked to return at 6 and 12 months intervals after the termination of the extended treatment sessions to complete all the assessment measures.

**RESULTS**

Inspection of Figures 1–4 showed decreases in percentage of stuttered syllables (%SS) per minute during each of the phases of treatment. At the end of the CAFET training, all subjects had reduced their percentage of stuttered syllables to the criterion level of less than 3% SS. Similar to an earlier study, two of the four subjects increased their percentage of stuttered syllables to above 3% level during the extended treatment phase of the program. However, these levels never approached pre-treatment levels. During the extended treatment sessions S3 had a mean of 5% during sessions 27–31. S4 also showed increases in his %SS to 6% at sessions 10 through 12. Both of these clients reported greater amounts of outside stress during this time. In addition, both clients were able to implement many of the procedures taught in the treatment sessions and reduce their %SS to below criterion level in subsequent sessions. It is interesting to speculate that the relapse management and extended treatment sessions were probably most beneficial to these clients because they were able to implement the strategies during a period of relapse. Table 3 provides a summary of
Figure 1. Percentages of stuttered syllables produced by Subject 1 during baseline, intensive treatment, extended treatment and follow-up sessions.

Figure 2. Percentages of stuttered syllables produced by Subject 2 during baseline, intensive treatment, extended treatment and follow-up sessions.
Figure 3. Percentages of stuttered syllables produced by Subject 3 during baseline, intensive treatment, extended treatment and follow-up sessions.

Figure 4. Percentages of stuttered syllables produced by Subject 4 during baseline, intensive treatment, extended treatment and follow-up sessions.
Table 3. Changes in Speaking, Feeling, and Thinking Measures in 4 Adults Who Stutter For Baseline (B), Post-Intensive Treatment Phase (PIT), Post-Extended Treatment Phase (PET), 6 month and 12 month Follow-up Sessions.

<table>
<thead>
<tr>
<th>Dependent Measures</th>
<th>Subject 1</th>
<th>Subject 2</th>
<th>Subject 3</th>
<th>Subject 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>PIT</td>
<td>PET</td>
<td>6mo</td>
</tr>
<tr>
<td>1. % SS</td>
<td>21</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Syllables Per Minute</td>
<td>168</td>
<td>200</td>
<td>204</td>
<td>218</td>
</tr>
<tr>
<td>3. SSI score</td>
<td>20</td>
<td>7</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Feelings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) PRCA Scale</td>
<td>108</td>
<td>99</td>
<td>61</td>
<td>68</td>
</tr>
<tr>
<td>2) Assertiveness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scale</td>
<td>-14</td>
<td>+2</td>
<td>+21</td>
<td>+33</td>
</tr>
<tr>
<td>Thinking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) SESAS—Overall Score</td>
<td>46%</td>
<td>66%</td>
<td>73%</td>
<td>83%</td>
</tr>
<tr>
<td>2) Erickson S</td>
<td>24</td>
<td>20</td>
<td>19</td>
<td>9</td>
</tr>
</tbody>
</table>

* 100% SS = percentage of stuttered syllables; SSI = Stuttering Severity Instrument; PRCA = Personal Report of Communication Apprehension; SESAS = Self-Efficacy Scale for Adult Stutterers.
attitudinal measures employed in this study. All measures showed positive changes with the introduction of the extended treatment program. These changes were maintained at both the 6 and 12 month follow-up sessions.

DISCUSSION
The purpose of this paper was to provide speech language pathologists with an effective treatment protocol for treating adults who stutter. The CAFET combined with the POWER²: Dealing with Stuttering approach appeared to be an effective technique for reduction of stuttering behavior and augmenting positive changes in attitudes and feelings. It was also important to note that these changes were maintained over a 12 month period. The CAFET appeared to be an effective way to introduce changes in speech behavior for these four clients. The changes in feelings as measured by the assertiveness and communication apprehension scales, as well as changes in self-efficacy and communication attitudes suggested that the treatment was effective in altering how clients perceive themselves and their stuttering. If stuttering is “a disruption of speech experienced by the speaker as loss of control”, then a treatment program that reduces the disruption and establishes a sense of empowerment should be used.

APPENDIX: COMMON COUNSELING TECHNIQUES FOR FLUENCY CLIENTS
Clients interactions with other clients or the clinician should center on examining problems (including stuttering) and discovering ways to deal with them. One of the goals of these discussions should be to help clients “reframe” their thinking about stuttering. They can also “reframe” their use of global descriptions of their attitudes and feelings about stuttering and other events in their lives. A goal for the clinician is to reinforce the idea that feelings and attitudes should describe specific moments, not global events. For example, the client might say “I always stutter worse when people laugh at me”, “I could never ask anyone at a dance to dance with me”, or “Everybody hates me in the junior high because of my stuttering.” This is a great time for the clinician to reinforce the idea that global feelings and attitudes (use of the words like ALWAYS, NEVER, SHOULD HAVE, EVERYONE) may not be realistically describing the events. Reframe those events with specifics. These statements also allow the clinician the opportunity to discuss other solutions to these perceived problems. What would happen if you asked someone to dance, what could you do if they say no, how would you feel? Is it only because of your stuttering? A summary of different types of counseling techniques you might use during the interactions is included.
Direct and Nondirect Counseling Skills

Directive counseling requires the clinician to control and direct the therapy sessions. There are times when clients are in “choice overload” or “ignorant” of the right information. They may need the therapist to tell them exactly what to do, and for how long. This type of direction usually occurs during the first phases of therapy. The clinician acts as an instructor, not a coach, cheerleader, or mentor. The directive approach provides the client with accurate facts and reassurance. It is an easy method of counseling. The clinician clearly directs the therapy. Clinicians label their opinions and provide direct answers to questions asked. Statements like these would be representative: 1) That’s not quite what you wanted to do. Slow it down and get an easy onset; 2) Good, that was much better; 3) So you felt that people were making fun of you; 4) Did you get up and explain to the person what you wanted? 5) It sounds like you should have been more assertive, doesn’t it?

Nondirective counseling deals with stimulating growth and letting clients “discover” the answers to their questions. It assumes that change can occur with introspection, examination, and discussion. This nondirective approach leads to increased self-responsibility. Clinicians try not to interrupt the client, often “repeat or rephrase” what has been said, and do not provide advice about what to do. This technique is also called “mirroring”. Comments like these would be representative: 1) Would you like to talk some more about that? 2) That sounds interesting to you. 3) So you’re saying that people who do not stutter are less personable.

A Few Examples of Helping Skills

Confrontation as a Helping Skill. Confrontation counseling is similar to directive counseling and is used by Van Riper during identification and desensitization to the stuttering problem. Sheehan (1975) was also a strong advocate of this type of counseling. Again, confrontation counseling can be very systematic in nature. Remarks are made such as: 1) What did you just do there? 2) Are you aware of those disfluencies? 3) Were you avoiding that? 4) What were you trying to say? 5) You are stuttering. 6) Raise your hand, or I’ll raise mine every time you stutter.

Information Helping Skills. Informational counseling helps clients to understand the disorder and through understanding start to “own” their problem. This type of counseling provides new knowledge about stuttering or validates some of the client’s thoughts about the disorder. This is also a form of directive counseling. Comments like these would be representative: 1) Did you know that there are over 3 million persons who stutter in the United States? 2) One definition of stuttering is . . . 3) Many successful and famous people stuttered including . . . 4) More males than females stutter.
Encouragement as a Helping Skill. This technique helps clients expand on what they have already stated. Statements like: and then what happened, and tell me more about that, will encourage clients to continue discussing and exploring their stuttering. This type of counseling helps clients to talk more freely and identify the treatment sessions as “safe places” to talk about stuttering.

Clarification Skills. Clinicians do not want clients to misunderstand the information or assignments. The use of clarification during counseling sessions attempts to eliminate any misinterpretations or misconceptions that clients have developed about their stuttering. Statements like: “I’m not sure I understand, did you mean . . .?” or “I just want to make sure I have this right” help to clarify the treatment.

Empathetic Listening Skills. Empathetic counseling requires active listening and clarification of what the client has stated. This type of listening is very similar to nondirective counseling. It reinforces the idea that the clinician understands what the client is saying to them. You are trying to be sensitive to the client’s needs and emotions. Comments like these would be representative: 1) Oh, I see; 2) Uh huh, mmm, yes; 3) Giving a label to their feelings with a comment like “That sounds frustrating.”

REFERENCES


