

Treatment research on children & adolescents:

Lidcombe Program: “a direct treatment for stuttering in preschool children. Treatment is focused on children’s speech and not on family relationships, parenting styles, or children’s temperaments” (Harrison, Onslow, & Rousseau, 2007, p. 56). Operant conditioning program.

- Parental verbal contingencies during everyday conversations: following stutter-free speech, parents may acknowledge it (neutrally & briefly), praise it, or ask child to self-evaluate his speech. Following unambiguous stuttering, parents may acknowledge it (neutrally & briefly) or ask child to self-correct the stuttered word. Child self-evaluation of stutter-free speech and self-correction of stuttering are non-essential treatment components that parents are only encouraged to incorporate (Harrison, Onslow, & Rousseau, 2007).
- Stage 1 involves eliminating child’s stuttering or reducing it to a very low level; Stage 2 involves maintaining that reduction for a long time (Harrison, Onslow, & Rousseau, 2007).
- Parents collect 2 speech measures: perceptual scaling of the severity of child’s stuttering (10-point scale severity rating; SR), and a stutter-count measure (stutters per minute of speaking time; SMST). SMST is an optional measure intended to supplement parental SRs.
- Evidence base: Phase I and Phase II clinical have been completed for this treatment, indicating that it is safe and effective (Onslow, Andrews, & Lincoln, 1994; Onslow, Costa, & Rue, 1990; Rousseau, Packman, & Onslow, 2005). A Phase III RCT has been published by Jones et al. (2005), concluding that “the reduction in stuttering in the Lidcombe program group was significantly and clinically greater than natural recovery” (p. 3).

Family-Centered, Indirect Treatment Approach for Preschool-Age Children:

“Involves making changes to a child’s environment through parent training and clinician modeling without directly or overtly identifying stuttering to the child and/or overtly attempting to change the child’s speech-language production” (Richels & Conture, 2007, p. 77).

- Therapeutic regimen involves simultaneous parent-treatment groups and child-treatment groups in different rooms, divided into 3 phases: (1) initial; (2) transfer; and (3) maintenance. Initial = 50-min therapy sessions once a week; transfer = moves from bi-weekly schedule, to once every 3 weeks, to once every 4 weeks; maintenance = session once every 8 weeks or longer (Richels & Conture, 2007).
- Evidence base: With a sample of 32 children, Richels & Conture (2007) reported an average decrease in stutter-like disfluencies (SLD) of 31% and an increase in non-SLDs of 10%. They viewed the slight increase in non-SLDs as reflecting a more normal speech pattern because some SLDs were replaced with more normal types of disfluencies.

Fluency Rules Program: Operant conditioning treatment approach designed for preschool and early grade school children who stutter. Utilizes response-contingent hand gestures when stuttering occurs (Runyan & Runyan, 1993, 1999).

- Regimen is divided into 3 sections: universal rules (Speak Slowly, Say a Word Only Once) used with all clients; primary rules (Use Speech Breathing, Start Mr. Voice Box Running Smoothly) used when airflow and laryngeal difficulties are present; and secondary rules used when concomitant behaviors are present.
- Evidence base: Reporting on a sample of 9 children (av. age 5:5 pre-treatment) treated in a public school setting 2-3 times a week for 30-40 minutes, they report that “all of the children evidenced a significant improvement in fluency while maintaining a normal speaking rate and eliminating all secondary behaviors” (Runyan & Runyan, 2007, p. 112). Reporting on a sample of 17 children (av. age 6:10 pre-treatment) treated for an average of 9 months in a private practice setting, they report all of the children were judged to have speech within the acceptable range on the naturalness scale at their release from therapy (Runyan & Runyan, 1999).

Comprehensive Stuttering Program for School-Age Children (CSP-SC): Designed for kids aged 7-12 years, integrated program that addresses both overt and attitudinal-emotional consequences of stuttering, delivered in a 4-week intensive format but can also be delivered in the clinic or via telehealth (Kully & Boberg, 1991; Langevin, Kully, & Ross-Harold, 2007).

- Evidence base: Kully and Boberg (1991) report that, for 9 out of 10 children at 8-18 months follow-up, stuttering reductions ranged from 79% to 98%. In covert samples obtained for 6 of those 9 improved children, stuttering reductions ranged from 65% to 100%. In another report, stuttering reductions for 3 out of 4 children (av. age 8:8) ranged from 52% to 75% at 6-19 months follow-up (Langevin, Kully, & Ross-Harold, 2007)

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