Chapter 10

Stine Brubak

Clinical Reflections on Group Treatment

Purpose of the article

Clinical practice and evidence-based research from multiple academic areas highlights how group treatment may bring new dimensions into traditional client-work. Participants often describe the group process as important in their stuttering treatment, because it provides a unique chance to share new experiences with people in a similar situation. This contributes positively to an increased effect of their stuttering treatment, with better generalization to real-life situations. Despite this clinical experience, group treatment does not seem to be equally integrated in clinical stuttering practise compared to individual treatment. According to Liddle, James, and Hardman (2011), one reason for this, in relation to school-age children, might be lack of consensus on what the main aims of group therapy should be. Further, they highlight that barriers to group-therapy provision can be a perceived lack of clients' interest in it, and insufficient numbers of clients able to travel to group venues.

With this article, the aim is to highlight positive aspects and effects of group treatment, as well as encourage and inspire clinicians to incorporate group treatment into their clinical practice. If relevant, practical examples from clinical practice will be used to show how most existing treatment programs can be used in group settings, and how this might enrich both treatment outcomes and participants' experience of their treatment process. As evidence-based documentation and research on stuttering treatment in groups is not yet easy to come by, most of the reflections in this article are based on clinical experience and practice. The article is thus neither a quantitative or qualitative research study, nor a case study, but is, rather, a clinical perspective on group treatment. Research from other academic areas will be incorporated within the discussion, given its relevance and purpose.

Preventive and diagnostic considerations

How should we define stuttering treatment in groups?

Group treatment within the framework of this article will be understood as being groups of different sizes organised and led by a professional speech therapist, with the purpose of forming either the main or a complementary component of the stuttering treatment given to an individual. It thus has a clear treatment purpose, in contrast to support groups where the main purpose is coming together for a shared sense of community with equals. According to Luterman (1991), one can define both counselling and therapy groups as treatment groups, as they are typically led by a professional who is responsible for choosing specific counselling and/or treatment methods. Therapy is thus understood as healthcare provided by a professional, using treatment methods that require education and/or clinical certification. Counselling is understood as educational help provided by a professional counsellor with the purpose of empowerment, defined as the process of enabling individuals to better help themselves. According to Luterman (1991), there is likely to be a gradual transition between therapy and counselling in a clinical treatment group.

Further, it needs to be pointed out that there are many definitions of a group as such. A critical trait that all such definitions seek to explain is 'group identity', understood as being how individuals come to see themselves as members of the group. Some definitions are grounded in the sense of emotional affiliation and equal dependence provided by the group. Such a definition tends to point out that a necessary trait of a group is social engagement by participants, who all define themselves as members of the group, sharing the same goals, and being engaged in a stable, structured, and equally dependent relationship with one another (Baron & Byrne 1987).

The framework into which such a definition belongs focuses on emotional aspects related to affiliation and community as the most central aspect of developing group identity. In contrast, other definitions highlight that such identity is a result of individuals defining themselves as members of a specific social category (Turner, 1987). In such definitions, emotional affiliation might be a consequence of group participation, but is not necessary for group identity to occur. Both frameworks add something to the understanding of group treatment in work with stuttering, and should be understood both individually and conjointly.

Often, stuttering treatment groups are initiated and organized on the basis of social categorisation. Because stuttering is a necessary criterion for being offered group treatment, all participants are necessarily being grouped into a social category

prior to meeting the other members of the group. For some, according to Turner's (1987) definition, this may create a sense of group identity. But what about those who are not comfortable with such categorization? Being offered treatment with equals may increase negative emotions towards a social category they find problematic, even though they somewhat accept the category when seeking help for their stuttering. Many of my clients have revealed that they were sceptical at the idea of group treatment to begin with, but changed their perception along the way. As therapists, we must keep in mind that this may well be due to negative experience of social categorization and further, that a later change in perception may be associated with a gradual growth of emotional affiliation leading to group identity. Participating and eventually identifying with a group, means acceptance of fitting in with certain characteristics applied to its participants (Jones & Corrigan, 2014). Yet, most clients reveal that they dislike being seen as a "stutterer". They distance themselves from this social category because they find it stigmatizing (Craig, Hancock, Train & Craig, 2003). Despite this, as mentioned above, many quickly settle down and come to see the group as a community which they can strongly identify with. If social categorization does not create such identity, what does?

In previous work with group treatment, participants have clearly pointed out that the group provides a safe setting, within which they find it easier to share their experiences. Essential to this sense of safety, is the feeling of belonging to a shared community. So, it may seem that the process of creating group identity is linked to affiliation as much as to social categorization. Even though people distance themselves from the social category of stuttering, they use the same category to explain how they came to experience the group as a safe community. The fact that other participants can relate to their problem on a personal level due to similar and shared experiences is due to the very category they are trying to escape from. In clinical practise, group identity thus seems to be the result of processes accounted for by both approaches. For some, the social category of stuttering may be one they originally identify with. For others, the social category is problematic, but is still a necessary part of experiencing the group as a safe community that creates affiliation. Within a clinical framework, I will therefore suggest the following definition of stuttering treatment groups:

> "...a composition of individuals belonging to a shared, yet not necessarily personally accepted, social category due to their fluency disorder that, either immediately or over time, creates unity, affiliation and a community where it is considered safe to share one's experiences, thoughts and feelings about stuttering with one another."

Therapeutic considerations: Probable benefits of group treatment

There is a strong evidence base for individual treatment approaches being effective in working with stuttering (Herder, Howard, Nye & Vanryckeghem, 2006). The focus of such treatments varies, on a continuum between fluency-shaping and stuttering modification. The former focuses on taking control over stuttering by using certain techniques which involve some form of modified speech, whereas the latter focuses on accepting stuttering. This description of stuttering modification as an *approach* should not be confused with the *model* of stuttering modification by Van Riper (1973), in which one of its steps includes a clear element of speech alteration (the use of techniques to control stuttering), and thus places itself more towards the centre of the continuum. Admittedly, one could say that cancellations as suggested in Van Riper's (1973) model requires voluntary stuttering (easy repetitions following the cancellations), which is normally considered to promote desensitization, but the element of working with speech alteration cannot be overlooked as a fluency-shaping technique. Pull-outs, and reparatory set techniques (in terms of staying in the stutter, or slowly and calmly working through every sound of the word) also require a great deal of exposure, while fluency-shaping approaches focus on using a technique in order to keep stuttering away (the exposure-element here is having to use more technique than one is comfortable with, but no stuttering nor voluntary stuttering).

In a clinical context, most approaches that are used in the individual treatment of stuttering can also be used in group treatment. In fact, receiving the same treatment in a group, may provide several benefits that can be grouped into the following categories:

1. Experiencing affiliation to a community.
2. Reduced anxiety and increased acceptance.
3. Better generalization of treatment outcomes.
4. Socio-economical value.

Experiencing affiliation to a community

A common clinical challenge when treating stuttering is the client's feeling of being alone with their disorder. Many admit that they have never or hardly spoken to anyone about their stuttering, and have never met anyone else who has the same challenge. Thus, they totally lack any sense of affiliation to, and companionship with, equals (Raerdon & Reeves, 2002). According to Luterman (1991), group treatment provides a unique opportunity to engage with people in the same sit-

uation as themselves, and creates a context for understanding that they are not alone. In the safe setting of the group, they can open up about emotional, practical or social problems, or simply share general experiences about stuttering with someone who has the same reference frame as themselves. This is of great importance, as stuttering can still be misunderstood by the population in general. As an example, Everard (2007) points out how the complexity and significant impact of stuttering on an individual is highly underestimated. Further, people fail to recognize the influence that such a disorder can come to have on everyday life, for planning ahead and making use of opportunities. Stuttering has the power to undermine a person's self-confidence, even self-esteem, and in turn influence both personal relationships and their participation in social, academic and professional settings (Everard, 2007).

The context of a treatment group gives participants an opportunity to build self-confidence and get new perspectives that might challenge generalized truths. (Reardon & Reeves 2002). One might have to reconsider such fixed truths when meeting others who, despite sharing a similar reference frame, think differently. Further, the community in a group may reinforce individual treatment processes and generate motivation to continue the initiated work on one's own (Luterman, 1991). Individual treatment does not seem to create an equal motivation. On this note, one might claim that group treatment should constitute a natural and even necessary part of a stuttering treatment process. It can inspire increased individual effort and contribute to a positive treatment outcome (Egan, 2007; Manning, 2001). This might include a reduction in %SS, as well as changes in individual negative emotions and reactions to stuttering. In my experience, the affiliation to the community of a group which is experienced will most likely create a more positive identity and attitude towards stuttering. The social category of stuttering might change from something one views as stigmatizing and which one does not want to be associated with, to a community one does wish to identify with. This is in large part supported by a comparative study, where Boyle (2013) found that adults who stutter who have experience of support groups have lower internalized stigma, better self-esteem, and less focus on fluent speech compared to those without such experience. However, it is not quite certain whether the lower internalized stigma is due to group participation, or is the reason for participating in a group in the first place.

Reduced anxiety and increased acceptance

Both clinical experience and research (Egan, 2007) show that people who stutter often have a strongly prejudiced opinion of how other people judge them. They attrib-

ute negative attitudes to others about stutterers being stupid, deviated, retarded etc. When confronted, such opinions are often justified by explaining that people react negatively when they stutter. They experience people smiling, laughing, or looking away, as well as becoming too helpful, too nice, or too neutral, etc. Of course, in some instances such reactions might have a negative character, but a smile from the clerk at the local shop might also be just that – a friendly smile which one would give to all customers. Even the most natural facial expressions, and behaviour that has nothing to do with stuttering, can sometimes be interpreted as reactions that 'prove' how other people judge and disvalue them. Most however, are resistant to the idea of such misinterpretations on their part. Their opinions are fixed, and often lead them to start avoiding situations where they need to talk (Shapiro, 2011). Such avoidance may come to compromise large parts of a person's life, and lead to limitations in their quality of life. Recent research has revealed that up to 60% of those who seek help for their stuttering have such a high fear of talking in public, that it can be characterized as social anxiety (Menzies, 2008).

In a treatment group with equals, one might experience getting approval for anxiety related to public speaking. Participants might have similar experiences of situations where they have felt disvalued by others, which they can start discussing with one another. Without confrontation, this might lead to strong validation of already fixed attitudes, and it is necessary to make them reflect on their experiences in a different way. Providing new perspectives in such discussions is thus an important part of the therapy process, and may be done through different activities. One can challenge participants to observe one another in dialogue. Which facial expressions are used within the group? What do they mean? Raising one's eyebrows, for example, is something we do all the time, when confirming something non-verbally. It might also follow the pause we take before answering something. Further, wrinkling one's eyebrows does not necessarily mean something negative. It is often seen in concentrated conversation, or when we disagree with something.

After the exercise of observing and interpreting facial expressions within the group, it is useful to then do the same in real social situations. How does the clerk in a local shop use facial expressions when talking to customers in general? Does anything change if the SLT stutters voluntarily? It might be easier to interpret reactions as being neutral when the stuttering is done by someone else, and group participants often start to discuss reactions in a different and more reflective way. They also become more aware of the absence of expected reactions, especially when the stuttering model uses more severe stuttering. As Manning (2003, p. 433) highlights: "There is probably nothing as effective as a good support group for increasing a person's social involvement".

Through discussions that neutralize presumptions about how people who stutter are judged and perceived, it is easier for group participants to start facing fearful situations. They become more aware of the biased interpretation process that occurs when talking to others, as well as how one will naturally look for evidence to confirm fixed presumptions. With the support of other group participants, the confrontation of avoidance is easier, and when facing situations which one previously avoided, one often discovers that the fear of the expected reactions is a bigger problem than the reactions themselves. Also, it becomes clear that the chance of getting a feared reaction isn´t worth the amount of energy used to worry about such situations.

In short, the problem of avoidance is that one never gets the opportunity to disprove one's own presumptions and fixed attitudes. Safety within a group might lower the threshold for confronting the comfort-zone related to speaking, and such confrontation can lead to discovering new perspectives on received reactions (Menzies, 2008). In turn, this more neutral mind-set might create increased acceptance for stuttering. In my clinical experience, this process takes time, and demands many positive experiences to rule out previous assumptions. With acceptance and support from equals in a group however, it is easier to take the necessary steps. The goal is not to move from negative thoughts about stuttering to positive ones, but to become oriented towards, and start believing in, more neutral thoughts about how stuttering is perceived and viewed in everyday life (Menzies, 2008).

Better generalization of treatment outcomes

A well-known challenge in a clinical context is the generalization or transfer of treatment outcomes to real-life situations. Managing one´s stuttering through techniques and/or acceptance outside the treatment room is a challenging goal to achieve, not least because many clients have an idea of getting rid of their stuttering, so as to no longer be judged as being different. Their first reaction to techniques might often be that this is just another way of talking strangely, which triggers the same experience of being different from others. Such a mind-set can be difficult for an SLT to challenge. One must get past a person's fixed and stereotyped idea about stuttering, as well as how this makes other people judge them (Egan, 2007). Group treatment provides a unique opportunity to challenge and get challenged by equals, help each other to refine techniques, and push one another outside established comfort zones.

For techniques to be useful to an individual, they need to feel manageable end effective in every-day situations (Guitar, 2014). In a treatment group, it is possible to practise techniques within an extended social setting that contributes to erasing

the difference between a treatment room and real-life context (Gregory, Capbell, Gregory & Hill, 2003). According to Williams (2006), teenagers – who are especially preoccupied by the approval of peers – can more easily transfer to real life what they learn in therapy when they feel comfortable within a group of equals. Although this phase of the treatment process is very important, many SLTs find it challenging to help clients take small steps towards the real world. Group activities are a very good alternative, because one can train in a small, safe social setting, get feedback from people one trusts, and be supported to move closer to actual social contexts. If needed, the group can be extended, thus providing a larger social setting for training.

Socio-economical value

Finally, it should be mentioned that stuttering treatment in groups can be said to have a socio-economical value related to benefits from treatment effectiveness. Group therapy can ease the workload of SLTs, which will in turn lead to increased capacity and shorter waiting lists. Clients may also be less dependent on repetitive or persistent treatment, because a treatment group can continue as a support group that generates empowerment and a stable maintenance of the treatment effect achieved. Reducing the risk of stuttering relapse is thus a good investment from a socio-economical perspective. Added to the fact that clients report good treatment outcomes of group treatment, it seems advisable to highlight this therapy form.

However, the advantages mentioned above should not be used as an argument against individual treatment. An SLT should always consider what will provide the best treatment effect for each client, independent of treatment effectiveness and socio-economic value. For some, a treatment group can be a supplement to, or an extension of, individual treatment. For others, it can be a primary treatment form.

Effect of stuttering treatment in groups

The measured effect of group treatment for speech problems in general, and fluency problems in particular, is not well documented. Perhaps this is due to the fact that it is hard to document a direct effect of measures implemented, and even harder to document the repercussions of such processes. One needs to ask what should be measured – and how – to get a precise picture of a person's treatment effect. Measuring instruments such as standardized tests may fall short in such documentation, because the effect of treatment is not solely related to quantitative features like %SS. It is equally important to get qualitative information about changes in emo-

tional and/or social functioning and quality of life through personal conversations. Which treatment effect to focus on is dependent on the treatment goals chosen in collaboration with each client.

In recent years, Elman (2007) has contributed relevant research on the effect of speech treatment in groups. His research is based on neurogenic communication problems, and documents that group therapy for aphasia clients results in better generalization to everyday life than individual treatment sessions. Even though his research is based on a different client group than stuttering, and results cannot be generalized outright from the former to the latter, it highlights a positive effect of group treatment in the context of everyday life. This should be an important effect measure because, at the end of the day, clients need to benefit from treatment in real-life situations.

Research conducted by Hearne, Packman, Onslow and Quine (2008) supports Elman's findings. Participants in their study had years of experience with severe stuttering, and had not sought treatment until they felt compelled to do so because of specific circumstances. The study revealed that all group participants were satisfied with the group as a primary treatment alternative, and with the treatment effect achieved. From Norway, a relatively new qualitative Master of Science thesis (Lien & Trønsdal, 2009) shows that group treatment is well received by clients, and that they report a satisfactory treatment outcome. The experience of a positive community was highlighted as decisive for thinking about stuttering in a more positive way, both generally and personally.

The role of an SLT in group therapy

The functioning and positive effect of a group is not a matter of course. It depends on good planning and targeted implementation. As early as 1987, Cole highlights that the SLT plays an important role in this process and needs to be well prepared for the role of group leader. Without good leadership, the effect of group treatment can be of a negative kind, and thus an SLT must be aware of how one can influence the therapy process and treatment outcome.

Planning and implementation of group therapy

As pointed out, an SLT has to spend time on planning a group for stuttering treatment. How big should the group be? Which clients should be invited? How will a participant contribute to the group dynamic? Should participants be at the same

stage in the treatment process? As the purpose of a group may vary, it can be relevant to mix participants with complementary treatment experience. If the goal is to implement a treatment program from beginning to end, it might be advantageous if all the participants start from scratch. Still, having someone with knowledge of the program to take the role of mentor, can enrich the group. If the goal is to challenge avoidance, my experience indicates that mixing experienced and fresh clients in a group can be positive. The more experienced clients can share their experiences, and encourage other participants to "hang in there", thus contributing to progression in the program.

In general, I would say that SLTs are too often worried about clients being different when planning group therapy. In most cases, a pitfall when planning treatment groups is to think that participants need to be as similar as possible. Clinical experience indicates that a group dynamic can be balanced and positive even if participants vary in age, personality, gender, %SS, or former experience with stuttering treatment etc. A mix of different ages can lead to fruitful and potentially desensitizing deliberations about stuttering in different phases of life. Different types of stuttering can highlight variations within the disorder, and provide different perspectives on the strategies used to handle or avoid it in everyday life. Different emotional reactions can bring forth a shared understanding that stuttering is not perceived in the same way by all those who stutter. And different personality types can coexist, with the help of an SLT who is aware of the process of making shy and introverted clients step forward, and extrovert client take up a bit less space (Manning, 2001). In general, this leads to the conclusion that SLTs should be more open to the possibilities of different group compositions. With good leadership, one can create the best prerequisites possible for good social interaction, balanced group dynamic and positive treatment outcome.

The SLTs role as a steady and evident leader

To achieve a positive treatment outcome in group therapy, the SLT must create confidence in the treatment process. In turn, this can create the necessary motivation in participants to start or continue an ongoing treatment process, and face the challenges of their fluency problems. How can the SLT create such confidence in the treatment process?

Clinical practise suggests that it is crucial to give participants a clear understanding of all the activities they are expected to do in therapy, especially if the activities in question challenge individual comfort zones related to exposure. The SLT needs to explain the purpose of each activity in a way that makes it clear to each

participant that the techniques leant will never gain utility if they are not brought out of the comfort zone of the group and the treatment office. Obviously, the SLT him/herself must have faith in the treatment method (program) for clients to have the same faith. Thus, the SLT needs to appear confident and sure of the content of the methods chosen. Of course, there must be room for adjustments along the way, and the SLT should be honest about the fact that there is seldom a one-off answer to complex treatment options, but one should be in control and appear calm, steady, evident and responsible (Cole, 1998). Without such a leader, the group dynamic can get out of hand, and damage the treatment outcome, no matter the size or composition of the group.

The dynamic of a treatment group will be constantly changing, seeing as different people are in mutual interaction with one another. The SLT needs to monitor this dynamic interaction in a present but not overpowering way. One must see each client's treatment process in a social context, and make use of the possibilities that lie in the intricate group interaction (Conture, 1990). The potential of this interaction is to increase the transfer value of competence, but it can also lead to a negative treatment effect for participants who do not feel cohesion within the group. However, being aware of the client – therapist interaction is equally important in individual treatment.

Case-descriptions

It is not possible to provide a specific recipe for organizing and implementing group therapy. In clinical practice, virtually all individual treatment methods can be used in a group context.

Thus, what characterizes group treatment is not the specific method chosen, but rather the way dynamic interaction adds possibilities to the treatment process that each participant goes through. It can ultimately flip the treatment outcome in a positive direction. How the particular benefits of group treatment may come to light will be highlighted in case studies below. Hopefully, it will serve as inspiration to SLTs who wish to include groups in their therapy options. It should be emphasized that several treatment methods or programs could have been used in all groups, but the purpose here is not to account for or justify any of these in particular. Rather, the goal is to show how the context of the group contributes to reenforce the treatment process.

Case-description 1: Kindergarten group

Participants: 6 children between 4.3 and 5.8 years old.
Gender: 4 boys (4.3, 4.9, 5.4, 5.5) and 2 girls (4.7, 5.8).
Goal: working with desensitizing through playful activities.
Therapy choice: MiniKIDS (a program for pre-school children).

Mini-KIDS was chosen as a therapy program for this group, because it was considered to be suitable to both the treatment goal and age range of the participants. The program proclaims that "children are allowed to stutter", and highlights that soft and easy stuttering (repetitions) should be accepted and even encouraged through playful voluntary stuttering. The goal of the program is to make children meet their stuttering with acceptance and tolerance, and thus prevent the development of severe (blocked) stuttering moments, struggling strategies and a negative attitude or emotions towards stuttering (see other chapters for further descriptions).

In Mini-KIDS, one uses concrete objects to identify and talk about stuttering. It is important to create a harmless and neutral language that the child can relate to, and use to describe what he or she experiences when stuttering appears. Which objects to use as identification figures is optional, but they should be representative of the different types of stuttering that exist. In this case, Winnie the Pooh is used when blocking, Tigger for repetitions and Piglet for prolongations.

During the first group session the children got to know each other. Initial identification and desensitization was conducted by the SLT doing pseudo-stuttering in natural conversation. The language chosen was neutral. All children showed a recognition of stuttering moments, by looking up from their activity the moment such imitated fluency problems occurred. The conversation below clearly identifies the naturalness of the communication:

Girl to SLT: Did you get stuck on the word?
SLT: Yes, did you all hear it?
Children: Yes (some nodding)
Girl: …just like mine sometimes
Children: Mine too … mine as well
SLT: Perhaps all of you get stuck on words sometimes?
Children look at one another and nod…
Child: Then we're kind of alike…
SLT: Yeah… can words do something besides getting stuck?
Child: Mine is kind of jumping sometimes
SLT: They do? Li li like this?

Child: Yes…
Other children: Mine as well…
SLT: So sometimes they get stuck and sometimes they jump…
Children: Mhmm… Yeah (some nodding)
SLT: Perhaps we can give such words a name. Have you heard of Winnie the Pooh?
Child: Yeah, he likes honey
SLT: Yes, and when he eats too much of it, he gets stuck in the jar
Child: Because his stomach gets so big
SLT: Perhaps we can call words that get stuck 'Pooh-words'?
Children (exited): Yeah
Child: What about jumpy words?
SLT: Should they get a name to?
Children: Yes
SLT: Have you heard about Tigger in Winnie the Pooh?
Children talk excitedly about Tigger
SLT: Tigger tends not to walk on his legs… can anyone remember what he does instead?
Children: He jumps… on his tail … all the time
SLT: Yeah, he jumps… Just like words can do sometimes…
Child: It's 'Tigger-words'
SLT: Should we call them Tigger-words? What do you think?
Child: Yeah, when a word Tigger-jumps
Child: Like this (illustrates with a Tigger-doll) – ju ju jump
Child: Can I try – juuu juuu jump
All Children try to jump like Tigger on a word
SLT: Now, everyone has tried to Tigger-jump
Child: Yeah, but like pretending
SLT: Well, doesn't it sound quite similar when a word ju ju jmps for real?
Child: Yeah, like yours did now…
SLT: It did…? Does it matter?
Children: No … Not at all … That's OK
SLT: Perhaps we should just let them jump a bit…
Child: we can jump on purpose
SLT: Course you can. Like we did before.
Child: That was fun
SLT: Shall I tell you a secret?
Children (exited): YEAH … tell us (some nodding)
SLT: If a word gets stuck you can jump on it instead

Child: On Pooh-words?
SLT: That right. If you get a Pooh-word you can jump on it
Child: Will it stop being stuck then?
SLT: Yes, like when Winnie's stomach shrinks and he gets free
Children: I'll try that… me too… and I
SLT: We can call it a Tigger-trick.
Child: I like magic tricks
Child: Me too

In the example above, the SLT makes use of some words that the children themselves introduce, and creates a language that makes it possible to describe and talk about stuttering on their terms. It creates a safe space with group cohesion, where stuttering is not only tolerated and accepted, but encouraged in the form of easy voluntary repetitions. Children are allowed to feel part a community, instead of isolated (Reardon & Reeves, 2002). They hear other children stutter, and get comfortable with admitting their own stuttering. They identify different types of stuttering together, and confirm to one another that stuttering is not such a big deal. According to Everard (2007), self-esteem and self-confidence is strengthened through this process, and a positive attitude towards stuttering may develop. In such circumstances, the development of fear or shame of stuttering, and the emergence of avoidance and reinforcement of secondary behaviour are both less likely.

A similar approach can certainly be used in individual treatment, but the group creates a companionship that reinforces the process of neutralizing stuttering. Agreeing with peers that stuttering is OK can be many times more effective than hearing it from the SLT. This indicates that one should never underestimate the importance of talking about stuttering to children in a natural and neutral way. A customized language on children's own terms will enable them to express their thoughts, feelings and experiences with others. Participation in a group seems to reinforce the positive process that this initiates, not least because participants sharing the same references can identify with the chosen language. There is yet no evidence to suggest that one should be afraid of making children aware of their stuttering, and that this in turn might worsen the disorder. On the contrary, children appear to react positively when presented with words about stuttering that they can relate to, and according to parents, often show clear signs of relief.

One of the children from the group mentioned above said excitedly to her mother after the first session: "Mum, if my words get stuck at home, I'm going to Tigger-jump right out of them". The mother answered: "What a great idea, and you can explain everything to dad". The child responded: "Yeh, I'm gonna tell him about Winnie… and Tigger… and jump on some of my words, and… can I tell him to jump

on a word too?" The mother answered: "Of course you can. You can teach him. How do you think he will feel?" After thinking about it for a few seconds the child answered: "I'm gonna tell him it's ok". For the first time, even though the child had been stuttering for a while, the two of them had a conversation about it with mutual understanding, using a shared language. This was significant, as the child had never before wanted to talk about her stuttering even though she had been showing clear negative signs of awareness.

Several of the parents reported that their children had used Tigger-jumping at home after the first session. All of them reported that the stuttering had become easier during the last week, and that the children seemed more unaffected by it than before. This indicates that the process of transferring was already initiated, and continuing group sessions built on this further. Soft and easy stuttering was encouraged, and volunteer stuttering was used in playful activities. Using Tigger-jumping as a trick to handle Winnie-words was continued whenever more severe stuttering occurred, but all in all it was emphasized that stuttering is allowed. The main goal throughout the group sessions was to strengthen the children's self-esteem and self-confidence related to stuttering. The children developed a strong group-identity that included stuttering as a naturally present feature shared between them.

Case-description 2: Middle school children

Participants: 5 children between 11.2 and 12.7 years old.
Gender: 3 boys (11.2, 12.3, 12.7) and 2 girls (11.7, 12,6).
Goal: Working with fluency techniques through graded activities.
Therapy choice: *Camperdown* (a program for older children and adults).

For this group, the *Camperdown Program* was chosen as for treatment, but it should be emphasized that other fluency shaping approaches could have been chosen as well. The aim of using this example is to show how the context of the group helps to reinforce the treatment process, rather than highlighting a specific treatment method.

In the *Camperdown Program*, the first step of the treatment process is to learn a specific way of speaking by reading a text recorded by a speech model – first along with the model, then alone using similar speech. The speech of the model is characterized by a very low speech-rate, phrasing, soft onsets, slow breathing, prolonged vowels etc. Clients usually find it incomprehensible to begin with, and it is therefore important to explain the purpose of breaking the speech down to such a degree. In my clinical experience, it is not hard to persuade them to try, when they come to

understand that this is not the way they are expected to talk after having learned the technique, but is a way of teaching the voice a totally new way of speaking.

An element of competition can be added when working with children, in order to make them forget the awkwardness of the speech in the beginning. Who is able to sound most like the model? Between each exercise, they explain to each other what they did, and give each other advice. The conversations that arise during this process illustrate how the community of the group brings a new dimension to fluency-shaping treatment therapy.

Example 1:

Boy: "I don't stutter when I imitate the speech model."
Girl: "Me neither."
Boy: "I wonder why…"
Girl: "Because the speech is so slow."
Boy: "But I don't stutter when I forget and speak faster either…"
Girl: "Weeel… I wonder how fast one can speak before stuttering again."
Boy: "Yea, 'cause I don't want to talk like the speech model at school."
Girl: "No, that would be weird."
Boy: "Mmmm, but the SLT said it was only when learning it."
Girl: "Yea, perhaps one can talk a bit slower…"
Boy: "…or only occasionally."

This conversation illustrates that the children are aware that "model-speech" provides them with control over their stuttering, and they are reflecting on why. Despite this, they are clear about not wanting to talk as exaggeratedly as the model. The group provides a context in which the children can present such concerns to one another and receive recognition. At the same time, they are being challenged to be patient and see where the training will take them next.

The next step after learning the model-speech, is to explore how little the speech needs to be exaggerated in order to provide control of stuttering. Slowly the children try to move down a scale from 10 to 0, where 10 is the model-speech and 0 is the use of no technique at all (which is not really a goal, as one, two or three on the scale represent the limits of normal speech rate). Rather, the goal is no stuttering, and if the children still achieve this at a speech rate of, for example, 6 on the scale, they can choose to stay at that rate. If they later end up at a rate of 3 on the scale with no stuttering, they can stay at that rate, etc.

All children in the group came close to a speech that sounded natural (no stuttering present), but found it hard to believe themselves. When doing something with

one's own speech, it is natural to believe that others will notice, and it is difficult to perceive one's speech as normal. Speech recordings might illustrate the speech's naturalness, and feedback from equals can also enforce a positive perception. Combined, they might cause a shift from being sceptical of the technique, to putting faith in it. The next example illustrates this.

Example 2:

Girl 1: "I find it awkward to talk like this…"
Girl 2: "Me too."
Girl 1: "…but you don't sound awkward to me."
Girl 2: "Neither do you."
Girl 1: "Are you saying that to be nice?"
Girl 2: "No."
Girl 1: "But I sound totally different than usual…"
Girl 2: "Not really, listen to the tape."
The girls listen to the recorded conversation using the technique
Girl 1: "I can hardly hear anything different…"
Girl 2: "That's what I told you."
Girl 1: "It sounds so awkward in my head."
Girl 2: "Yeah, I feel the same way, but on the tape it sounds quite normal."
Girl 1: "Perhaps I will try it at school."
Girl 2: "Me too … maybe…"
Girl 1: "I worry that I won't succeed… and stutter, right?"
Girl 2: "If it fails, you can do what you usually do…"
Girl 1: "Mmmm…"

In this conversation, the two girls have clearly developed an initial trust in the technique. They are slowly grasping that an altered speech pattern (talking with the technique) will always feel more exaggerated than it actually sounds to others. They are equally anxious about trying it out in every-day life, but challenge this fear in the conversation. With the useful support of one another, they question the perception that it will sound awkward to speak differently. The two of them play with the idea of using the technique in a real context, but are nervous that this might fail – or that they will make a fool of themselves.

Treatment issues like the ones above are quite common in therapy, and difficult to challenge. In the group however, the girls simultaneously acknowledged and challenged their own fears. As one of them said: "If it (talking with the technique) fails, you can do what you usually do". She's aiming at replacing words, which is a strategy

frequently used by the other girl to avoid stuttering. By saying this, she manages to reduce her fear of plunging into real-life situations. She also encourages her partner to give the technique a chance, by adopting the attitude "What do you have to lose?" and "What is the worst that can happen?". The SLT can certainly encourage the same thing in individual treatment, but in the community of the group it develops a dimension which is hard to imitate. The cohesion of the participants due to their shared background makes them able to support each other in a fundamentally different way than the SLT could manage in a treatment relationship.

A cohesion like the one which develops in a group builds self-esteem and self-confidence (Everard, 2007); (Hearne et. al., 2008). The mutual support within it contributes to increase the chance of participants being able to confront their fear and plunge into real-life situations that they have previously avoided. But first, they have to confront the perception of how others will look at them when using a fluency-shaping technique. A common impression was to be perceived as awkward, strange, or weird etc. To challenge this, the group went outside, where the SLT spoke using the technique in different contexts, allowing the group participants to observe reactions from others. They all agreed that the SLT used the same amount of technique (if not more) that they themselves were required to use in order to control their stuttering. Back at the office they discussed different aspects of the exercise.

Boy: "I clearly heard you talking slower."
Girl: "Yeah, she spoke slower that we do when practicing."
SLT: "Did we get any reactions?"
Boy: "No, no one looked awkwardly at you."
Girl: "I thought someone would."
SLT: " …and I spoke more exaggeratedly than you normally need to do?"
Boy: "Yeah, your speech was really slow that one time…"
SLT: "What might that teach us?"
Girl: "That we can actually speak really slow without anyone caring."
Boy: "But we don't need to…"
Girl: "Well, we might … if we suddenly stutter anyway."
All children are looking at the SLT with anticipation…
SLT: Yeah, you might need to exaggerate a bit more sometimes, if you want control."
Boy: "It's so cool though … that we can be in control."
Boy: Yeah, that cool."
Girl: "I'm gonna try it at school tomorrow…"
SLT: "Why don't you all try it out before we meet the next time…"
All the children answer positively and encourage each other…

All the children in the group agree to give the technique a chance before the next session. The conversation reveals that they have become positive about the new way of speaking. They have been presented with evidence that the technique can be used in real life without the risk that others will react to the way they speak. Conversations with group participants have given them new perspectives on fixed perceptions. They have been able to practice the technique in a safe context, in a way that eliminates the gap between the treatment environment and real-life.

Many speech and language therapists admit that they find this process difficult, and it turns out that group treatment can be of great help. In this case, the group was first used to learn and practise a new technique in a small social context that felt safe, and provided feedback from equals. Then, the group entered an arena where they could confront fear and avoidance of stuttering, and adjust their perceptions about how others may react to the technique. Finally, the group also worked as a support to take the plunge into real-life situations.

Conclusion and implications

The aim of this article has been to present clinical examples of how group treatment has the potential to reinforce the effect of stuttering therapy. Consequently, it is neither a quantitative nor qualitative research study, nor a case study. Hopefully, it is still valuable within a context that aims to give a broad picture of stuttering and stuttering treatment. Both clinical practice and evidence-based theory from related disciplines highlight that treatment in a group can add a positive dimension to stuttering therapy – either as a primary / sole treatment option, or as a supplement to individual treatment.

The benefit of a group is, first and foremost, related to the experience of belonging to a safe community with peers, which contributes to an increase in positive self-esteem. Further, it seems evident that the group creates a safe context for confronting anxiety, fear, and avoidance of stuttering. Finally, it can contribute to reducing the gap between the treatment room and a real-life context, and ensure better stabilization and long-term treatment effect – not least in terms of quality of life, which has received increasing attention in recent years. It is by no means a replacement for individual therapy, but should receive the same careful clinical consideration. Sometimes it can be a fully-fledged treatment alternative; at other times a good supplement to, or a continuation of, individual treatment. One cannot rule out that it might be unsuitable in some specific cases, but in my experience, the majority of clients adjust to, benefit from, and thrive in group therapy.

Throughout this article I have tried to share my clinical experience, and show that stuttering treatment in groups does not necessarily require a singular competence. All approaches which are used individually can be transferred to a group treatment. There is no reason why treatment groups should continue to be underused by SLTs – especially when most existing evidence points towards the effectiveness of group therapy. More research is obviously needed for the effect of stuttering treatment in groups to become evidence-based, but feedback from a significant number of clients with experience of group treatment suggests that group treatment should not be overlooked.

Multiple choice questions

1. What kind of competence does stuttering therapy in groups require?
   a) Certified competence in treatment approaches designed for groups
   b) Minimum competence in treatment approaches designed for groups
   c) Required competence in treatment programs adapted to the group sessions
   d) No specific competence whatsoever
2. Which treatment approaches are suitable for stuttering group therapy?
   a) Approaches specifically designed for group therapy
   b) All approaches used in individual treatment
   c) Approaches that focus on fluency shaping
   d) Approaches that focus on stuttering modification
3. For which clients can stuttering therapy in groups be suitable?
   a) For those who benefit from it as a primary treatment option
   b) For those for whom individual therapy fails
   c) For all clients seeking stuttering treatment
   d) For those to whom it is only a supplement to individual therapy
4. What benefits may come out of stuttering treatment in groups?
   a) An experience of affiliation to a community
   b) Reduced anxiety and increased acceptance
   c) Better generalization of treatment outcomes
   d) Socio-economical value
   e) All of the above

Suggested reading

Boyle, M.P. (2013). Psychological characteristics and perceptions of stuttering of adults who stutter with and without support group experience. *Journal of fluency disorders*, *38*(4), 368–381

Williams, D.F. (2006). *Stuttering Recovery: Personal and Empirical Perspectives*. Lawrence Erlbaum Associates.

Hearne, A., Packman, A., Onslow, M., & Quine, S. (2008). Stuttering and its treatment in adolescence: The perceptions of people who stutter. *Journal of fluency disorders*, 33(2), 81–98.

References

Boyle, M.P. (2013). Psychological characteristics and perceptions of stuttering of adults who stutter with and without support group experience. *Journal of fluency disorders*, *38*(4), 368–381

Cole, M.B. (1998). *Group Dynamics in Occupational Therapy: the theoretical basis and practice application of group treatment*. SLACK Incorporated.

Conture, E.G. (1990) *Stuttering*. Prentice Halls.

Craig, A., Hancock, K., Tran, Y., & Craig, M. (2003). Anxiety levels in people who stutter: a randomized population study. *Journal of Speech Language & Hearing Research*, *46*(5), 1197–1206.

Egan, G. (2007). *The skilled helper: a problem management and opportunity- development approach to helping*. USA: Thompson Brooks/Cole Publishing. Elman, R.J. (2007). Group treatment of neurogenic communication disorders: the expert clinician's approach. Plural Publishing Inc.

Everard, R. (2007). «My Stammer Doesn't Have to Define Me». *Adults Learning*, *19*(4), 20–22.

Gregory, H.H., Campbell, J.H., Gregory, C.B., & Hill, D.G. (2003). *Stuttering therapy: Rationale and procedures*. Allyn & Bacon.

Hearne, A., Packman, A., Onslow, M., & Quine, S. (2008). Stuttering and its treatment in adolescence: The perceptions of people who stutter. *Journal of fluency disorders*, 33(2), 81–98.

Herder, C., Howard, C., Nye, C., & Vanryckeghem, M. (2006). Effectiveness of behavioral stuttering treatment: A systematic review and meta-analysis. *Contemporary Issues in Communication Science and Disorders*, *33*, 61–73.

Ingebrigtsen, A., Olsen, T., Melle, A.H. & Hoff (2019). Flytskapende og stammemodifiserende tilnærminger. *Stamming i praksisrettet perspektiv*. Artikkelsamling. Statpeds læringsressurser. NorMedia AS

Jones, N., & Corrigan, P.W. (2014). Understanding stigma. In: P.W. Corrigan (Ed.), *The stigma of disease and disability: Understanding causes and overcoming injustices* (pp. 9–34). American Psychological Association.

Liddle, H., James, S. & Hardman, M. (2011). Group therapy for school-aged children who stutter: A survey of current practices. *Journal of Fluancy Disorders*, 36, (4), 274–279.

Lien, S.E. & Trønsdal, I. (2009). *I samme båt. En kvalitativ intervjuundersøkelse om hvordan voksne stammere opplever logopedisk behandling i gruppe*. Masteroppgave ved Institutt for Spesialpedagogikk, Universitetet i Oslo

Luterman, D.M. (1991). *Counselling the communicatively disordered and their families.* Pro-Ed.

Manning, W.H. (2001). Clinical decision making in fluency disorders. Singular Thomson Learning.

Melle, A.H., Guttormsen, L.S., Brubak, S. & Ingebrigtsen, A. (2019). Oppfølging av stamming i barnehagealder og tidlig skolealder. *Stamming i praksisrettet perspektiv*. Artikkelsamling. Statpeds læringsressurser. NorMedia AS

Menzies, R.G., O'Brian, S., Onslow, M., Packman, A., St Clare, T., & Block, S. (2008). An experimental clinical trial of a cognitive behavior therapy package for chronic stuttering. *Journal of Speech, Language, and Hearing Research. 51*(6), 1451–1464.

Reardon, N.A., & Reeves, L. (2002). Stuttering therapy in partnership with support groups: The best of both worlds. In *Seminars in speech and language*, Volume 23, No. 03, pp. 213–218).

Shapiro, D.A. (2011). Stuttering Intervention: A Collaborative Journey to Fluency Freedom. PRO-ED.

Stensaasen, S., & Sletta, O. (1995). *Gruppeprosesser: læring og samarbeid i grupper*. Universitetsforlaget.

Turner, J.C. (1987). Rediscovering the social group. Basil Blakwell.

Van Riper, C. (1973). *The treatment of stuttering*. Englewood Cliffs, N.J: Prentice-Hall.

Williams, D.F. (2006). *Stuttering Recovery: Personal and Empirical Perspectives.* Lawrence Erlbaum Associates.