Meet Them Where They're At: Maximizing Adolescents' Engagement in Stuttering Therapy

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ABSTRACT

Adolescents who stutter often pose a unique clinical challenge for clinicians. They are a population simultaneously striving for independence from adults and social connection with their peers at a time when social fears surge and lifelong habits take root. It is a time when they may seem "unmotivated" to learn and utilize new communication or coping skills related to stuttering. How can clinicians maximize adolescents' engagement in stuttering therapy to improve meaningful outcomes? The purpose of this article is to describe a transtheoretical approach to assessing adolescents' readiness to make positive changes to living with stuttering, and to provide motivational interviewing strategies that clinicians can employ to help propel adolescents toward personally significant change. These principles will be applied to the case study of a 14-year-old who stutters to demonstrate how clinicians can put this approach to work as they meet their adolescent clients "where they're at."

KEYWORDS: adolescent, stuttering therapy, stages of change, motivational interview

Learning Outcomes: As a result of this activity, the reader will be able to (1) describe the transtheoretical model and how it applies to stuttering; (2) explain the five stages of change; (3) summarize the tenets of motivational interviewing, including relevant discussion prompts that can be used to activate self-motivated change in adolescent stuttering therapy.

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CASE

Luca is a 14-year-old boy who was referred by his parents for a stuttering evaluation. Luca lives at home with his two mothers, older sister, and younger brother. His parents report that he has always been a "sensitive" child—that he is highly perceptive of others and his environment, prefers routines, has high standards for himself, and is easily upset when he thinks he has let himself or others down. His parents report that he began stuttering at around 6 years of age and has no concomitant issues or known family history of stuttering. He received school-based speech therapy for stuttering in first and second grades, and was then dismissed from services when he reached his IEP goals. During your parent interview, you learn that Luca's stuttering pattern was discrepant at school compared with at home; while his stuttering was imperceptible to the school clinician, Luca still stuttered noticeably at home. His parents explained that since his dismissal from school therapy, they never raised the topic with Luca because they did not want to draw his attention to the stuttering and "make it worse," although they have noticed that his stuttering "is really bad" at times. When asked how they respond to moments of Luca's stuttering, they reported that they are patient and try to give him plenty of time to say what he wants to say. As Luca starts high school, they hope that he can learn ways to "not stutter so much" because they are worried that stuttering will "get in the way" of his ability to do well in school and his social life.

During your initial evaluation, you collected an oral reading and conversational speech sample for the *Stuttering Severity Instrument – Fourth Edition* (SSI-4).[1] His total score of 20 suggested mild-moderate overt stuttering behaviors characterized mostly by silent blocks that lasted around 0.5 seconds. During moments of stuttering, he tended to close his eyes and purse his lips tightly. Luca completed the *Overall Assessment of the Speaker's Experience of Stuttering – Teens* (OASES-T)[2] on which he achieved an overall score of 3.03, suggesting a moderate-severe adverse impact of stuttering. The highest impact was in section II (speaker's reactions). When asked about his prior speech therapy, Luca reported that he used to practice talking slowly, but that he did not like using this strategy outside the therapy room because he "felt like a robot." When prompted to share whose idea it was for him to have an evaluation, Luca stated that his parents wanted him to come.

In your experience with adolescents, you understand how necessary it is to involve Luca in the therapy planning process. You dedicate your first few sessions with Luca to identifying what it is that *he* (not his parents) wants to change, how ready he is to make those changes, and the steps he can take to make the changes come to fruition.

INTRODUCTION

There is arguably no other time of development that elicits as much consternation from parents, educators, and clinicians like adolescence. The staunch independence, risk-taking, novelty-seeking, and crusade for peer approval are often difficult for adults to rationalize. Indeed, the transition from caregiver-dependent children to autonomous adults is a tumultuous one. In the context of stuttering, adolescents begin to realize that they can no longer rely on their parents to "fix" it. At the same time, they may feel uncomfortable talking about stuttering with their peers because doing so would highlight the very thing that makes them different. As a result, they often feel isolated not only in their experience of stuttering, but also in coping with it alone. It appears that for many adolescents, stuttering sabotages their fragile self-esteem and developing identities.

There are substantial brain-behavior changes rapidly unfolding at this time that help explain not only these challenging tendencies but also the remarkable learning that takes place during the adolescent years. In fact, the degree of brain plasticity that occurs during adolescence is second only to that which is seen in the first 3 years of life.[3] Lawrence Steinberg, a leading adolescent neuroscientist, explains, "The brain's malleability makes adolescence a period of tremendous opportunity—and great risk. If we expose our young people to positive, supportive environments, they will flourish. But if the environments are toxic, they will suffer in

powerful and enduring ways."[4] This has critical implications for our clinical work with adolescents who stutter. *How can we best support young people who stutter to ensure that they flourish during this challenging time of development?* A potentially powerful approach is to match our therapy to our clients' readiness to make personally meaningful changes. This article contains a description of how we can leverage the transtheoretical model, commonly known as the stages of change model, and motivational interviewing to assess and maximize adolescents' readiness to make positive changes to living with stuttering at a pivotal time in development.

Before we begin, we should establish common ground on the age range that is considered "adolescence." Experts have yet to reach consensus on the precise ages that bookend this period. Many say that adolescence begins in biology and ends in culture[5]—that it commences with the arrival of puberty and concludes when one assumes conventional roles of adulthood such as independent living, gainful employment, and marriage. From this perspective, we see that adolescence is longer today than it has ever been; puberty is arriving earlier and conventional adult roles are achieved later than in prior decades. Recent advances in neuroscience corroborate this extended period, where neural regions dedicated to self-regulation and learning are still developing well into one's 20s.[6,7] As such, it is not unreasonable to assume adolescence spans from 10 to 24 years of age,[8] which is the stance I take in this article.

TRANSTHEORETICAL MODEL

People set out to change all sorts of health behaviors over the course of their life: eating healthier, exercising more, managing stress, wearing sunscreen, and taking medication, to name a few. These changes can be achieved independently or with professional support. Either way, the change process is typically not a simple, linear journey. People tend to progress, then regress for a variety of internal and external reasons, then regain momentum, only to be setback again. This cyclical nature of change is an ordinary, albeit frustrating, part of the process—something we have likely all experienced. And it is our portal into empathizing with the difficult work that our adolescent clients who stutter face.

Since the 1980s, researchers in the fields of behavioral health and health psychology have studied *how* people intentionally change behaviors and establish new health habits. They have found that there are basic elements of intentional behavior change that cut across self-initiated and professionally assisted change, all of which are captured in the *transtheoretical model*.[9] The heart of the transtheoretical model is known as the *stages of change*, which situates a person's readiness to change on a dynamic five-stage continuum. What places a person at a particular stage of change, and what drives their movement through the stages? Research has shown that a person's current stage of change, and their progression and regression across stages, is predicted by how they think about the target behavior—specifically, how they weigh the pros and cons of changing (known as *decisional balance*),[10,11] along with how confident they are that they can maintain the new behavior in the face of challenge and setback (known as *situational self-efficacy*).[12] In the following section, the five stages of change are summarized, along with how decisional balance and situational self-efficacy typically operate in those stages.

Stages of Change

The five stages of change are Precontemplation, Contemplation, Preparation, Action, and Maintenance. As seen in Fig. 1, the earlier stages are characterized by the person's intent to change, and the later stages are characterized by overt actions that signal behavior change. In the following paragraphs, we will use Luca, our 14-year-old case study client, to demonstrate the defining features of each stage.

The first stage is *Precontemplation*. If Luca were in this stage, he would not be intending to change in the foreseeable future because he is unaware, under aware, or unaffected by the complexities of stuttering. Precontemplators tend to process less information about their issue, devote less time to introspection about it, and experience fewer emotional reactions to the

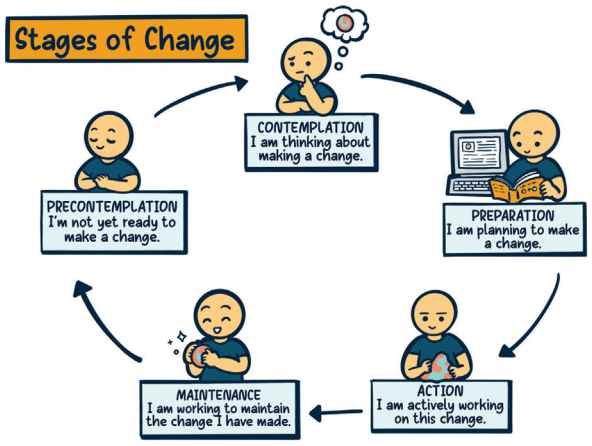

Figure 1 The five stages of change in the transtheoretical model with cognitive precursors to active change occurring in earlier stages and overt behavior change occurring in later stages (Reprinted with permission; adapted from Yoshimura, J. Stages of Change [Infographic]. Published in McClary-Jimenez, C. Y'all ready for this? The Informed SLP[36]).

negative aspects of the problem.[13] indeed, adolescents who stutter and are in Precontemplation tend to have lower OASES scores (i.e., less impact of stuttering on their lives) than those in the next few stages.[14] In this stage, a clinician may feel frustrated when working with Luca because he seems "unmotivated" to be in therapy; he is not demonstrating any desire to change how he communicates or copes with stuttering, and he may even deny that stuttering is an issue in his life. *A typical feature of precontemplators is that the cons of making a change far outweigh the pros; that is, there are many reasons why Luca does not want to change and those reasons are more important to him than the minimal benefits he expects to receive.* It is possible that he truly does not believe that stuttering is interfering in his life in any way. It has not held him back and he has not experienced societal consequences for stuttering. Another possibility, and an unfortunately common one, is that Luca may have received ineffective speech therapy in the past and is thus feeling hopeless that anyone or anything can help. Either way, Luca is probably attending therapy because his parents and/or teacher(s) are urging him to be there. He will likely resist talking about stuttering or doing anything about it. Worse yet, he may feel coerced into changing because of external pressure to do so, and thus the changes that occur are to appease others (e.g., parents, teachers, clinicians) rather than coming from a place of self-motivated, personal desire to change.

The next stage is *Contemplation*. If Luca were in this stage, he would begin to acknowledge that stuttering is an issue in his life and would be seriously thinking about making some sort of change without yet committing to taking action. He may remain "stuck" in Contemplation for long periods—even years—because of his ambivalence toward the situation. Ambivalence is a cognitive state in which the importance of the pros and cons of changing weigh equally. Luca may have important reasons why he wants to make positive changes to stuttering, but he has equally important reasons why he does *not* want to. For example, perhaps he has noticed that other people who stutter (e.g., George Springer, baseball player from the Houston Astros) have made positive changes in living with stuttering, but he is afraid of failing if he tries doing it himself. In this stage, Luca's clinician can help him resolve his ambivalence by increasing the importance of the pros and decreasing the importance of the cons. This would assist him in moving toward the next stage.

Preparation comes next, in which behavior intention and overt behavior change overlap. In this stage, Luca would be on the brink of taking action in the immediate future (within the next month), and he may have even taken some small

steps in the desired direction. Perhaps he has browsed the internet and social media to gather information about stuttering and things that can help. Maybe he has tried some things out on his own, or told his parents that he wants to start working with a speech therapist. He likely perceives the pros of changing as outweighing the cons. He thinks the benefits of making positive changes to stuttering are more important than the costs, and this constructive perspective propels him toward action. However, he is likely feeling unsure of his abilities to make these changes. Luca's clinician can help bolster his self-efficacy in this stage by focusing his attention on other times that he has successfully changed and on other skills he has developed that people would say he is good at.

The next stage is *Action*, which is where clinicians typically assume clients are when they first attend speech therapy. In this stage, Luca would be intentionally modifying his behaviors, experiences, and/or environment. This stage involves the most overt behavior changes and requires considerable time and mental effort. Luca is likely participating in regular speech therapy sessions and/or support groups, as well as engaging in new communication and coping behaviors outside the therapy setting. Perhaps he is making phone calls, pseudo-stuttering, maintaining eye contact during moments of stuttering, and/or disclosing his stuttering. The most important element here is his persistent and steady effort to act, not necessarily the outcome of his actions. His clinician should praise those efforts, regardless of their magnitude or outcome, to help Luca recognize and believe that he is capable of change. This would serve to increase his sense of self-efficacy[15]—that he is not at the mercy of his stuttering, but rather that he has the ability to make choices about, and changes to, how he experiences it. His increasing sense of self-efficacy is higher in the Action stage than it was in previous stages; it is a critical source of hope for him and will help protect him from regressing back to old tendencies that may not serve him well.

Maintenance marks the final point in the change continuum, although it is not guaranteed that once Luca reaches Maintenance he will stay there indefinitely. In this stage, he is focused on consolidating the gains he achieved during Action and preventing regression to earlier stages. His clinician may notice that he is approaching communicative situations that he knows are challenging. Perhaps he "moves on" after difficult moments of stuttering or negative listener reactions rather than ruminating on them. Ideally, he is independently problem-solving how to cope adaptively with difficult situations, possibly by advocating for his needs or educating others. We can expect Luca's pros of changing to be surging over the cons, and his self-efficacy to maintain these new behaviors to be at its highest. He may be in Maintenance for several months but then regress to an earlier stage, or he may experience a lifetime of sustained change. In our prior work, adolescents who stutter and are in Maintenance tend to have lower OASES scores (i.e., less impact of stuttering on their lives) than adolescents in prior stages.[14] As such, this would be a natural time for Luca's clinician to consider gradually reducing the frequency of his therapy sessions. In this process, the clinician should counsel not just Luca, but his parents as well, about the inherent variability of the stuttering experience (behaviors, thoughts, feelings, environments). This will help prepare the family for the inevitable ebbs and flows of Luca's progress, and to know that the clinician's door is always open should they need support if regression occurs.

Cyclical Nature of Change

As with attempts to modify other target behaviors, such as weight loss or exercise, most people do not successfully maintain gains on their first attempt. A variety of internal and external factors often impact progress, from mental fatigue and busy schedules to more difficult circumstances. From a transtheoretical perspective, when this happens, the person typically regresses from Action or Maintenance to an earlier stage. This regression, or return to previous behaviors after a period of improvement, is par for the course; it is the rule rather than the exception. However, many clients are likely not aware of how normal regression really is and they may feel like failures—embarrassed, guilty, hopeless. Some of these clients may fall back to Precontemplation and stay there for some time. Others may not feel as defeated and may slip back to

Contemplation or Preparation and make their way through the stages again rather quickly. Research on stage movement in other populations has revealed that people who have regressed typically move through the stages quicker the second and subsequent times through, and the change that results tends to be increasingly more durable. They have learned from the situation and can try something different the next time around.[16] In transtheoretical parlance, this process of going through multiple cycles of change is known as "recycling."[13]

Summary of Research Findings Related to Stuttering

In recent work that I have conducted with health psychologists and fellow stuttering specialists, we have found that the transtheoretical model applies to the change process for adolescents and adults who stutter. That is, people who stutter categorize themselves as being in one of the five stages of change, and the cognitive predictors of their stage placement mirror those of other populations.[14] The first step of this work was to define what "change" means for people who stutter. This was a challenging pursuit, as "change" for people who stutter is multidimensional and highly personal. Through thematic analysis of interviews with dozens of adolescents who stutter and speech therapists who specialize in stuttering therapy, we developed a three-part definition of what it means for adolescents who stutter to manage how they live with stuttering (listed in no order of importance)[17]:

1. Learn and use strategies for speaking more fluently and/or stuttering with less tension and struggle.
2. Changing negative thoughts and feelings about stuttering.
3. Saying what they want to say without avoiding sounds, words, or situations.

Once presented with the definition, we asked adolescents who stutter to "stage" themselves by indicating how ready they are to manage stuttering globally, and then how ready they are to address each of the three domains of change. The options were:

A. I am *not* thinking about doing this in the next 6 months (aligns with *Precontemplation*).
B. I am thinking about doing this in the next 6 months (*Contemplation*).
C. I am planning on doing this in the next month (*Preparation*).
D. I have been doing this for *less* than 6 months (*Action*)
E. I have been doing this for *more* than 6 months (*Maintenance*).

Several notable findings have emerged from this work. First, it adds to the mounting evidence that making positive changes to living with stuttering requires a multidimensional approach that spans affective, behavioral, and cognitive domains.[18,19] As such, clinicians are encouraged to measure progress across those three domains rather than simply focusing on changes to overt speech behaviors, likely through the use of self-report measures and clinical discussions. Second, people who stutter can be at different stages of readiness to address different aspects of their stuttering experience. This suggests that clinicians should help clients express what they want to change about their communication or coping, along with helping them express how ready they are to address each of those things. For instance, Luca may suggest that he is in Preparation for changing something about his speech and changing how he thinks and feels about stuttering, but in Precontemplation for saying what he wants to say without avoidance. If this were the case, the clinician would be wise to help Luca explore the value of doing those things and then plan action-oriented therapy activities associated with the related domains. Increasing his participation through nonavoidance may come later in the therapy process when he has made other changes and is perhaps more ready to work on it then. A third finding of importance from this work is that the pros of changing are the most meaningful predictors of readiness to change for adolescents who stutter. Thus, clinicians are encouraged to help their clients unpack "the good" and "not so good" things about making changes to how they live with stuttering, with a focus on increasing the client's valuation of the pros. Motivational

interviewing provides a useful roadmap for facilitating these types of discussions, which is discussed in the following section.

MOTIVATIONAL INTERVIEWING

One lesson we can learn from the transtheoretical model is that adolescent clients' motivation to engage in the therapeutic process and make positive changes to how they live with stuttering reflects their *readiness* to do so. As discussed, readiness to change is a dynamic cognitive state that fluctuates over time due to a variety of factors that are both unique to and common across clients. A common factor that is vital to promoting effective action is the clinician's interpersonal approach. One such approach that is well-documented and empirically supported is called *motivational interviewing*.

Motivational interviewing is a counseling style—a clinical "way of being"—that helps clients explore and resolve their ambivalence about behavior change. The guiding philosophy of motivational interviewing is that all people have the potential to change. Thus, the clinician's role is to support clients in becoming more aware of the implications of change and/or not changing through a nonjudgmental discussion in which clients do most of the talking. While originally designed for adult substance users in the 1980s, motivational interviewing has since expanded to a range of health-related behaviors across ages including diet, exercise, and management of chronic pain and various psychopathologies. Meta-analytic reviews have documented that motivational interviewing outperforms traditional advice giving across treatment studies of adults[20–22] and adolescents.[23–25] In the field of speech-language pathology, motivational interviewing has been applied to voice therapy,[26,27] hearing aid use,[28] and cognitive rehabilitation.[29–32]

The spirit of motivational interviewing is threefold.[33] First, it values *collaboration* over confrontation. For example, in relation to Luca, the clinician would facilitate a collaborative partnership with him in which they are truly working together to figure out solutions to the issues that are relevant to him. Second, motivational interviewing prioritizes *evocation* (i.e., drawing out the client's perspective) over education. Indeed, "people are more likely to be persuaded by what they hear themselves say."[33] In relation to Luca's case, it is not the clinician's role to educate or convince him of what to do or why he should do it. In fact, if the clinician pushes an agenda too hard, Luca is likely to respond with even greater resistance.[34] Rather, the clinician should connect behavior changes to the things Luca cares about to activate his own motivation and reasons for change. Focusing on his strengths—those that he identifies within himself and that other important people in his life notice about him—and what's *right* with him, rather than focusing on the problem, can stimulate his internal resources for achieving personal goals.[35] Third, motivational interviewing focuses on the client's *autonomy* over the clinician's authority. The clinician would respect that it is Luca's responsibility to make choices about how he lives with stuttering and would honor the choices that he makes. This often requires the clinician to detach themselves from the outcome by recognizing that people make choices about their own lives. This three-pronged ethos of motivational interviewing is especially important in our work with adolescents who stutter because it supports their growing desire for independence. It is our "in" to connecting with adolescents and maximizing their engagement in the process.

The core skills of motivational interviewing are rooted in the clinician's ability to strategically elicit, listen for, and respond to certain forms of change talk. The clinician does this by posing *open-ended questions*, making *affirming statements* about positive things noticed about the client, *reflecting understanding* of what the client is thinking and feeling by saying it back to them, and offering *summaries* of what the client has shared.[33] The catchy acronym DARN-CT frames the types of change talk and sustain talk that clinicians can elicit. By asking strategic questions (examples provided in Table 1), the clinician listens for change talk that signals the client's intent to change (*d*esire, *a*bility, *r*eason, and *n*eed) in the earlier stages of change, as well as the client's mobilization in the later stages of change, also known as sustain talk (*c*ommitment, *a*ctivation, *t*aking steps).

A useful way of summarizing a client's responses during the motivational interview and strengthening commitment to change is to co-create a workable change plan. To do so,

Table 1 Motivational Interviewing Prompts that Elicit Change and Sustain Talk Across the DARN-CAT Categories

Type of sustain talk	Listening for change talk that signals	Example prompts
Desire	I want to change	- What would you like to see different about stuttering or how you live with it? I'm interested in what you want to be different, not what you think your parents might want for you. - What excites you about the possibility of making those positive changes? - What ideas do you have about what needs to happen? - Often people have a hunch about what is causing a problem, and also how they can resolve it. Do you have a theory of how change is going to happen here? - In what ways do you see me and this process helpful in attaining your goals?
Ability	I can change	- On a scale of 0–10, how confident are you that you will be able to make positive changes in the next month? - What would it take to move from a [rating] to a [higher number]? How would your life be different at [higher number]? - What are you good at? What do your friends and family say you're good at? - Think of another time in your life when you wanted to learn something, or change something. What did you do? What happened? - Who are the people you do, or could, turn to for help or understanding? How do each of these people help and support you?
Reason	It's important to change	- What are your top three reasons for making a positive change to your stuttering experience? - What makes you think this might be a good time to make this change? - What would be the not-so-good things about changing? - What will your life be like 3 years from now if you changed what you're doing about stuttering? - If you don't get a handle on the issue, how do you imagine things playing out?
Need	I should change	- On a scale of 0–10, how important is it for you to make these changes? - Why are you at a [rating] and not at a 0? - What might happen that could move you from a [rating] to a [higher number]? - On a scale of 0–10, how important are each of the pros of changing? - On a scale of 0–10, how important are each of the cons of changing?

Table 1 (*Continued*)

Type of sustain talk	Listening for change talk that signals	Example prompts
Commitment	I am going to change	- What do you think you'll do? - How are you planning to get in regular, daily practice? - Given everything else that's going on, what do you feel is realistic for you to accomplish with your stuttering experience during the next month?
Activation	I am ready to change	- What are you willing or ready to do now? - What is one step you can take right now to make a positive change to how you live with stuttering?
Taking steps	I am taking specific actions to change	- Tell me about the steps you've already taken to make some positive changes to your stuttering or how you live with it? - What are some things you did last week that allowed you to make positive change so consistently?

the clinician and client work together to document the plan using prompts such as the following[26]:

- The changes I want to make are:
- The most important reasons why I want to make these changes are:
- The steps I plan to take in changing are:
- The ways other people can help me are:
- I will know that my plan is working if:
- Some things that could interfere with my plan are:
- What I will do if the plan isn't working:

This change plan is similar to, but not synonymous with, a treatment plan. While treatment plans are necessary for professional service provision, change plans help the client verbally express what it is they want to change and how they are going to go about integrating those changes into their life. It helps the clinician focus on what is most important to the client so that the treatment plan can be well-matched to the client's values and preferences. Short- and long-term goals specific to the client's expressed goals for therapy may be developed based on the change plan.

CONCLUSION

In this article, a client-centered approach to planning therapy *with* an adolescent client who stutters is summarized. This approach leverages theoretical and empirical evidence about how people change behaviors and frames a client's readiness to change as an integral factor in their outcomes. Clinicians are encouraged to identify what their adolescent clients want to change about their stuttering experience (understanding that this may be at odds with what their parents want for them), why the client wants to make those changes, and how ready they are to do so. Readiness to change falls along a five-stage continuum that clients can cycle through several times before sustaining new communication and coping behaviors in the long-term. Motivational interviewing prompts that elicit change talk and sustain talk can guide these collaborative discussions at the outset of therapy and over the course of the therapeutic journey with young people who stutter. This unified approach offers clinicians a foundation for "meeting them where they're at."

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