

# Early Childhood Stuttering Therapy: A Practical Approach

(3-hour version)



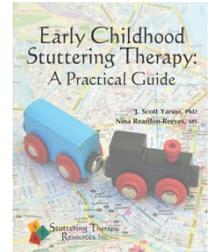
J. Scott Yaruss, PhD, CCC-SLP, BCS-F, F-ASHA

Professor, Communicative Sciences and Disorders, Michigan State University  
President, Stuttering Therapy Resources, Inc.

Email: [speech@yaruss.com](mailto:speech@yaruss.com) / Presentations and Publications: [www.Yaruss.com](http://www.Yaruss.com)

Books on Stuttering: [www.StutteringTherapyResources.com](http://www.StutteringTherapyResources.com)

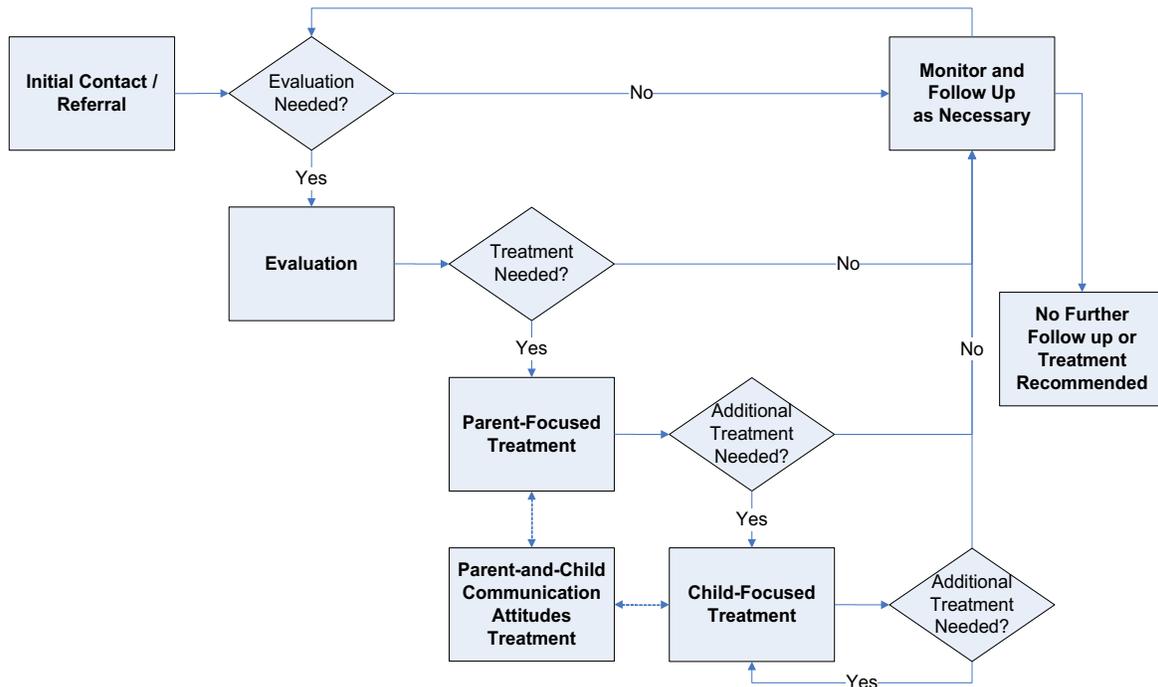
Financial Disclosures: Stuttering Therapy Resources (royalties/ownership),  
MedBridge Education (royalties), Northern Speech Services (Royalties)  
Non-financial Disclosures: National Stuttering Association (volunteer)



## Part I: Stuttering 101

(“Where do Preschool Children Who Stutter Come From?”)

### I. A Clinical Process Flowchart



### II. Where Do Preschool Children Who Stutter Come From?

#### A. All Clients Come From Somewhere

- I. Typically, we “inherit” our school-age clients from other clinicians...
  - a) We inherit their evaluation data.
  - b) We inherit their treatment goals.
  - c) We inherit their treatment activities (e.g., what the child is familiar with or comfortable doing).
  - d) We inherit the knowledge the child has about stuttering (or lack thereof).
  - e) We inherit their baggage, and this can affect their readiness to participate in treatment.

2. Preschoolers Are Different...WE are often the first SLPs to see them.
  - a) The initial contact comes from a parent or, occasionally, referral from another professional.
  - b) As a result, we sometimes think of preschool children as coming to us “fresh,” or without significant baggage.
  - c) Unfortunately, this is not entirely true.

#### B. Preschoolers Have Baggage, Too

### III. What Has the CHILD Experienced?

- A. We have traditionally assumed that preschool children are fairly oblivious to their stuttering. (Early researchers suggested that preschool children weren't even aware of stuttering.)



1. One theory warned of significant negative consequences if the child became aware of stuttering. (The “diagnosogenic” theory stated that the child’s awareness of stuttering was part of what turned normal disfluencies into true stuttering!)
2. Many clinicians have tried to prevent children from becoming aware by avoiding the word “stuttering” and using exclusively indirect treatment



- B. Recent research has shown that even young children are already aware of their stuttering... AND, there is very little evidence that purely indirect treatment works!

### IV. What has the PARENT Experienced?

- A. The most common advice that the parents receive is to **not draw attention to stuttering**

- B. What does this lead to? In a word? Fear!

1. Fear that she might have accidentally done something wrong that **caused** the stuttering.
2. Fear that she might make the problem worse by drawing attention to it or that she might make the wrong decision about the child’s treatment



- C. And That’s Not All...she has other fears too...

### V. What does that mean for us?

- A. Rather than postponing an evaluation, fearing that we might “create awareness,” **we can (and should) get involved** so we can be sure that the child gets the help he needs and so we can address the parents’ fears!

- B. Rather than using solely indirect approaches that have questionable validity, we can use more direct approaches that have proven efficacy!

- C. Recognizing the reality of the child’s awareness and the parents’ fears frees us to do our jobs!

## VI. Making the most of the initial contact

- A. Generally, our goal during an initial contact is to determine if a full evaluation is warranted
  - 1. Parents don't tend to contact us until the child has been stuttering for approximately 6 months!
  - 2. We are not consulted until after the parent has become very concerned about the child's speech
- B. Thus, the result of the initial contact will typically be a **recommendation for a full evaluation**
  - 1. Still, we have a decision to make about whether it is the right time to get involved...
- C. Definite evaluation triggers, I definitely recommend an evaluation if:
  - 1. ...the child is aware of stuttering
  - 2. ...the parent is concerned about stuttering
  - 3. ...the stuttering has continued for more than 2 or 3 months.
    - a) Although many of these children may still recover on their own, we can actually increase the rate of recovery through education and treatment
  - 4. ...there is a family history of stuttering.
    - a) If there is family history, then I don't really care how long the child has been stuttering!
- D. Questionable Evaluation Triggers...I might not recommend an evaluation yet if:
  - 1. ...the child has only been stuttering for a few days or weeks and there is no family history.
    - a) In such cases, the parent is probably very concerned or she wouldn't have called.
    - b) So, I might recommend the evaluation anyway so I can help set the parent's fears at ease.
  - 2. ...there is minimal concern on the part of the parents or the child.
    - a) This is rare – if the parent hadn't been concerned, she probably wouldn't have contacted us!
- E. Notice what's missing: Nowhere did I ask "how much" the child is stuttering...
  - 1. Surface behavior won't play much of a role in determining treatment recommendations either...
- F. The actual frequency of stuttering tells us little about whether the child needs treatment
  - 1. Of course, it affects the child's (and parents') experience of the disorder
  - 2. And, the surface behavior gives us insights into how the child is reacting...
  - 3. But, it does not tell us about the likelihood that the child will recover
- G. The ultimate value of the initial contact
  - 1. Regardless of whether I recommend a full evaluation, I still **provide the parents with information**
    - a) Depending upon your setting, you may do this during the initial contact or at the time of the evaluation itself.
- H. Either way, the parents have questions about stuttering and we have answers.
  - 1. The more the parent knows about stuttering, the better it is for the child.

## **Part II: Getting Ready for Treatment**

- I. **What is the purpose of the diagnostic evaluation?** To determine whether the child is at risk for continuing to stutter and, therefore, whether he needs treatment!
  
- II. **Where Do We Start?**
  - A. If the purpose of the evaluation is to see if the child needs treatment (based on his presumed risk for continuing to stutter), then we need to determine his risk for continuing to stutter!
  - B. Everything we do in the diagnostic evaluation is geared toward trying to determine whether or not the child is likely to continue stuttering.
    1. If he is at risk for continuing to stutter, then he is definitely in need of treatment.
    2. If he is not at risk, then perhaps treatment can wait.
  
- III. **Assessing Risk Factors**
  - A. Research over more than 20 years has sought to identify factors that make it more or less likely that a child will recover from stuttering.
  - B. Unfortunately, there is no single factor that necessarily differentiates children who will continue to stutter from those who will recover.
    1. This makes sense, given that stuttering is presumed to have multiple, interacting causes, but it makes our diagnostic task more difficult.
    2. What we can do is assess risk factors...
  - C. Some risk factors are related to the Causes of stuttering?
    1. Stuttering arises due to an interaction among several factors that are affected by both the child's genes and the child's environment
      - a) Language Skills for formulating messages
      - b) Motor Skills for producing rapid and precise speech
      - c) Temperament for reacting to/regulating disruptions
    2. An interaction among these factors contributes to the likelihood that the child will produce speech disfluencies and react to them
  - D. What are we looking for in the child?
    1. A mismatch between Language Skills and Motor Skills (any type of mismatch)
      - a) Advanced language skills & typical/lower motor skills
      - b) Advanced motor skills & typical/lower language skills
      - c) And...anything in between

**If you see a mismatch in the child's language and motor skills, this counts as a risk factor.**
    2. A sensitive or highly reactive Temperament.

**If the child is reactive or has difficulty regulating emotions, this counts as a risk factor.**

## IV. What about other risk factors?

### A. Stuttering Is Genetic

1. Stuttering runs in families – if you have one person in a family who stutters, chances are 60-70% that you will find another person in the family who also stutters.
  - a) If the child has a positive family history of stuttering, this counts as a risk factor!
2. Girls are more likely to recover than boys.
  - a) If the child is a boy, he is more likely to continue stuttering and this counts as a risk factor!

### B. The Environment Still Plays a Role.

1. The diagenosogenic theory suggested that parents caused stuttering, but we know today that this is not true. The child's environment does not count as a risk factor...
  - a) Still, the environment does play a role in the child's experience of stuttering!
  - b) We can still look toward the environment as contributing to a possible increase in stuttering.
2. What are we looking for in the environment? An advanced communication model.
  - a) This does not cause stuttering, but it can make it harder for the child to communicate successfully, so this counts as a risk factor.
  - b) Children are more likely to stutter on longer, more complicated utterances (adult language model)
  - c) Severity is related to dyadic speaking rate (the difference between the parent's and child's rate)
3. We are also looking for strong (fearful, anxious) reactions to stuttering by the parents or others
  - a) This does not cause stuttering, but it may convey that stuttering should be feared (Thus, it counts as a risk factor.)



### C. Most Children Recover...But Not All (Approximately 75% of children who stutter recover!)

1. Most do so within the first 6 to 12 months. After that, even though some can recover 2, 3, or even 4 years post-onset, the chances of recovery diminish.
2. The longer the child stutters (i.e., the greater the time since the onset of stuttering), the less likely his is to completely recover.
3. Longer time since onset counts as a risk factor. (Longer than what? The field does not agree.)

## V. Summary of Risk Factors

- A. Positive family history of stuttering
- B. Time since onset > X months (Exactly how long is still under debate – I use 6 months)
- C. Child has language / motor mismatch.
- D. Child has concomitant speech/language disorders (Indicates a fragile language or motor systems.)
- E. Child is highly reactive to mistakes or disfluencies (Esp. if the child is concerned about stuttering)
- F. Parental reactions are negative or fearful
- G. Again, notice what's missing...
  1. I did not mention the frequency of speech disfluencies exhibited by the child.
  2. In fact, the frequency of disfluencies tell us relatively little about whether the child is likely to recover from stuttering



- a) Some children who stutter severely can still make a complete recovery, while others who stutter mildly may still be at risk for chronic stuttering!
- b) “Initial severity does not predict chronicity.”

3. Still, everybody will ask you how much the child stutters...

- a) So, you still need to make accurate and reliable counts of stuttering frequency and severity.
- b) I have a CE course on measurement online at [www.MedBridgeEducation.com/scott-yaruss](http://www.MedBridgeEducation.com/scott-yaruss)



## VI. A Final Word on Risk Factors

- A. Remember that these risk factors are not definite determiners of who will continue to stutter (or who will need treatment) they are simply predictions based on presumed likelihood.
  - I. Even children with family history can recover!
- B. Still, by considering these factors in our diagnostic evaluation, we can make a reasonable prediction about whether the child is likely to recover on his own – and if he is not, we can feel more confident recommending treatment.



## VII. Summary of the Diagnostic Evaluation

- A. The purpose of the evaluation is to determine whether the child needs treatment, based on his presumed risk for continuing to stutter.
- B. The more at risk the child is, the more likely he is to need treatment!
- C. This does not mean that everybody receives the same treatment – we can scale our treatment based on the perceived level of risk!

## *Part III: A Family-Focused Treatment Approach for Preschool Children Who Stutter*

### I. What’s the Primary GOAL of Treatment for Preschool Children?

- A. To Help Them Speak More Fluently! (i.e., to eliminate the stuttering)
- B. How Do We Do That? “There’s more than one way... ..to skin a cat”



### II. Treating Preschool Children Who Stutter – the OLD Way

- A. Historically, treatment for preschool children who stutter has been indirect, based on the (incorrect) diagenosogenic theory
- B. No specific instructions were provided to the child about how to modify his speech or improve his speech fluency
- C. In fact, no mention of speech was made at all, for fear that the child would “get worse” or “become aware of his stuttering”
- D. This is old news! Times have changed!

### III. Treating Preschool Children Who Stutter – Some NEW Ways

- A. Over the past 15 to 20 years, researchers and clinicians have moved toward providing direct treatment for preschool stuttering

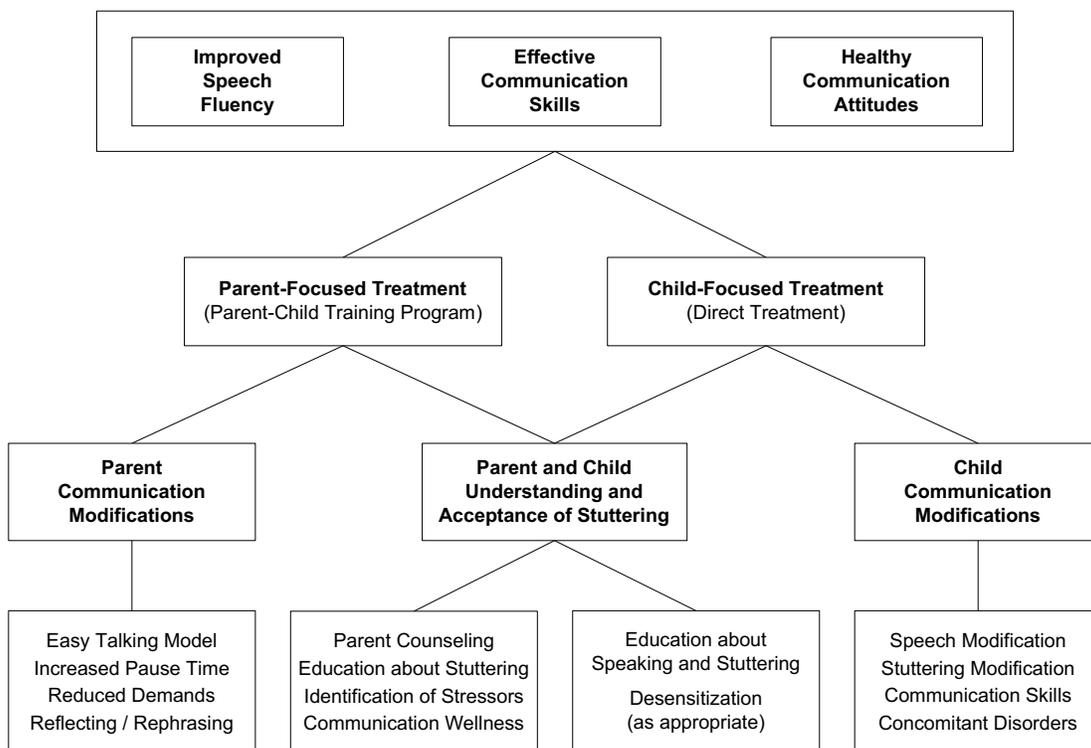
1. Direct treatment of speech fluency through:
  - a) Establishment of fluency-facilitating environment
  - b) Direct discussion of stuttering to ensure development of healthy, appropriate communication attitudes
  - c) Modification to the child's speech to enhance fluency
2. Operant correction of stuttered speech and praise for fluent speech (e.g., Lidcombe program)

**B. This workshop presents the Family-Focused Treatment approach**

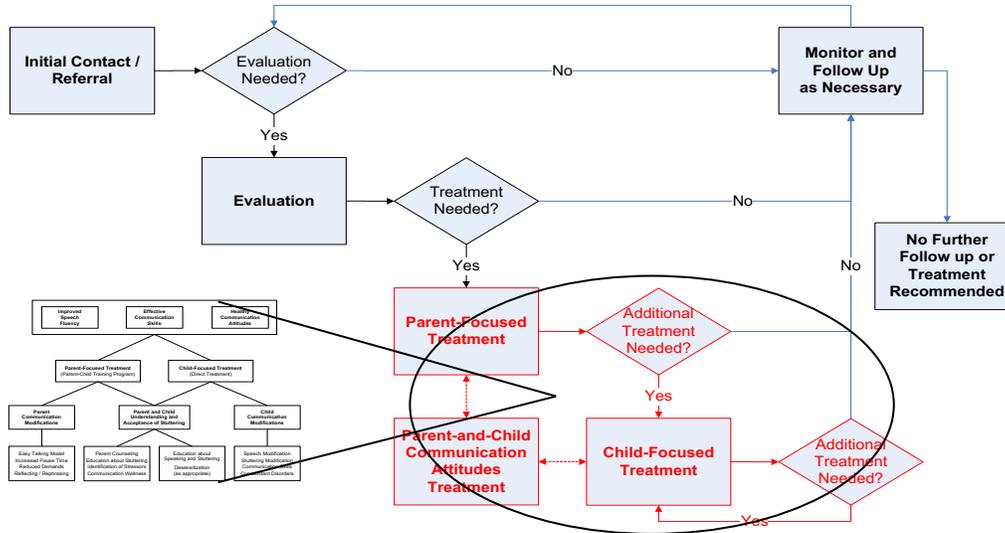


1. For young children who stutter, the first goal of therapy is to improve their fluency
2. Still, our therapy is not focused entirely or exclusively on fluency
  - a) We also work to ensure that children develop effective communication skills
  - b) And, all along the way, we want to ensure that children develop appropriate attitudes toward their speaking and stuttering
3. Fortunately, we have several effective tools to help us accomplish these broad goals!

**IV. A Family-Focused Treatment Approach for Preschool Children Who Stutter (from Yaruss, Coleman, & Hammer, 2006)**



## V. Family-Focused Treatment in the Context of our Flow Diagram



### Part IIIa: Parent-Focused Treatment

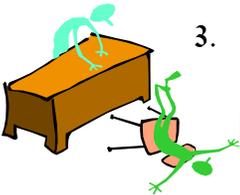
#### I. Treatment Goal #1: Educate the Parents



A. Goal: Parents will (continue to) receive provide information and support as they learn about stuttering and how they can help their child.

B. Procedure: The parents and clinician will...

1. continue discussions started at the initial contact or diagnostic evaluation so the parents will have a greater understanding of stuttering.
2. discuss information as needed so the parents are ready to assume the role of “home clinician.”
3. Answer their questions but don’t overwhelm them—too much information at once can be confusing.
  - a) Remember that counseling ≠ informing, so watch out for too much informing
  - b) We do need to provide information, but don’t bowl them over with too many facts and try not to be too directive in treatment
4. I have a series of courses on counseling for SLPs at [www.MedBridgeEducation.com/scott-yaruss](http://www.MedBridgeEducation.com/scott-yaruss)



#### II. Treatment Goal #2: Identify Fluency Stressors

A. Goal: The parents will identify factors (fluency stressors) that make it more difficult for their child to maintain fluency.

B. Procedure: The parents will

1. Learn about the “bucket analogy” so they can understand the role of stressors.
2. Complete the “stressor inventories” so they will see what “adds water to the bucket”

C. Treatment Activity #2a: The Bucket Analogy (see back of handout)

D. Treatment Activity #2b: The Stressor Inventories

### III. Treatment Goal #3: Introduce the Concept of a “Fluency-Facilitating Environment”

- A. Goal: Parents will understand the value of making changes in their own communication style (a “fluency-facilitating environment”) to help their child speak more fluently.
- B. Procedure: Parents and clinicians will...
  - 1. Review “stressor inventories” and bucket analogy to see what stressors can be diminished.
  - 2. Consider changes to the parents’ communication style that may enhance the child’s fluency.
- C. Examples of a fluency-facilitating environment
  - 1. Slower speaking rate (n o t t o o s l o w!)
  - 2. Easier interaction style
    - a) Increased pausing both within and between utterances
  - 3. Less hurried daily pace / lifestyle (?)
    - a) Less hectic scheduling of daily life activities; one-on-one time with the child

### IV. Treatment Goal #4: Teach the Parents to Provide a “Fluency-Facilitating Environment”

- A. Goal: Parents will learn how to provide a fluency-facilitating environment for their child.
- B. Procedure: The clinician will...
  - 1. Model communication changes for the parents
  - 2. Give parents the opportunity to practice, both in the therapy room and outside the therapy room (at home and in other settings).
- C. Examples of communication modifications
  - 1. Reducing parents’ speaking rates slightly
  - 2. (i.e., using an “Easy Talking” model)
  - 3. Reducing time pressures (also called “delaying response” or, simply, “pausing”)
  - 4. Reducing demand for talking (if demand is high)
  - 5. Modifying questioning (if and only if necessary)
  - 6. Providing a *supportive environment* for both fluent and stuttered communication

### V. How Can We Help Parents Do All These Things?? (and do them consistently)

- A. “Parent-Child Training Program” -- A 6-to-8 session treatment program in which we address the 4 key goals presented thus far.
  - 1. **2 to 4 parent-only sessions** for counseling and education (expanding upon the process started at the initial contact and covering Goals 1 and 2).
  - 2. **3 parent-child sessions** when parents learn and practice fluency-facilitating communication modifications (covering Goals 3 and 4).
  - 3. **1 to 2 review and problem-solving sessions** where the need for further treatment is assessed.

## Part IIIb: Focusing on Parent and Child Acceptance

### I. Is It REALLY Okay To Talk About Stuttering ?!?

A. YES! Talking about stuttering (in a supportive way) will not make stuttering worse.

One treatment approach (the Lidcombe Programme) even teaches parents to point out disfluencies in a child's speech and ask them to say the words again smoothly, without "bumps."

B. It's even okay to say the "S" word: "Always use the proper name for things. Fear of a name increases fear of the thing itself."

### II. Treatment Goal #5: Talk to the Child about Talking



A. Goal: Parents will create an environment where stuttering is viewed in a straight-forward, matter-of-fact manner, so it is nothing to fear.

B. Procedure: The clinician help parents learn to...

1. Model appropriate attitudes toward the child's speaking abilities and stuttering behaviors

2. Respond to stuttering in a supportive manner

3. Talk directly to children about stuttering

C. Example: Help parents learn to respond to stuttering the same way then do when the child, e.g., colors outside the lines

a) They acknowledge the problem: "Yes, I see you colored outside the lines a little."

b) They let the child know he is okay. "That's okay. Coloring outside the lines is part of learning."

c) They refocus his attention on the task at hand: "I really like the picture you drew..."

### III. Treatment Goal #6: Addressing More "Big Fears"



A. Goal: Parents will develop the tools they need to help their children overcome their own fears and concerns about stuttering.

B. Procedure: The clinician will...

1. Listen to the parents' concerns about how they should respond to their children's fears.

2. Give parents concrete suggestions about what they can say when their children express their fears.

### IV. What's next? Treating the child directly (if needed)

## Part IIIc: Child-Focused Treatment

### I. First, Decide If It's Necessary

- A. For many children, this is all you need to do.
  - 1. 67% of the children in the Yaruss et al. (2006) study recovered completely following just the 6- to 8-session parent-child training program.
    - a) This included the parent-focused treatment AND the attitudinal work described thus far.
  - 2. The remaining 33% needed additional treatment. (Some just a few sessions; some more.)
- B. So, the next step is to determine whether additional treatment is needed.
- C. The Key Decision...How long should I try this before “giving up” and trying something else?
  - 1. I rarely stay only with parent-focused aspects of treatment for more than **3 months** (6 sessions, every other week).
  - 2. If the child isn't better by then, move on!

### II. Child-Focused Treatment: Improving Fluency Directly

- A. If the child continues to stutter following the use of the parent-focused treatment (and attitudinal work), then it is time to begin direct child-focused treatment.
- B. At this point, the goal of treatment is actually the same as it is for older children who stutter
  - 1. To improve the child's fluency through direct modification of the child's communication skills
  - 2. To ensure that the child develops and maintains healthy, appropriate communication attitudes

### III. Treatment Goal #7: Prepare the Foundation

- A. Goal: The child will learn about speaking and stuttering so he will be prepared to make changes in his speech.
- B. Procedure: The child will learn more about...
  - 1. How people talk (in general).
  - 2. What stuttering is and what happens when people stutter.
  - 3. Differences in speech production.



### IV. Getting Ready to Use Techniques

- A. Now that we've laid the foundation, we're ready to introduce techniques for enhancing fluency.
- B. The problem is... the child is still very young!
  - 1. There are a lot of different techniques and we don't want to confuse him with too much to do.
  - 2. So, we need to think carefully about which techniques we'll use, why we'll use them, and how much we'll expect the child to do.
- C. Fortunately, most (all?) of the techniques for enhancing fluency involve changes to just two parameters: **timing and tension**.



## V. Treatment Goal #8: Making Changes to Speech Timing

- A. Goal: The child will demonstrate the ability to reduce his speaking rate to enhance his fluency.
- B. Procedure: The child will:
  - 1. Learn the difference between “too fast,” “too slow,” and “just right” speaking rate.
  - 2. Practice using a speaking rate that is “just right” (i.e., slightly slower than his habitual rate).

## VI. Treatment Goal #9: Making Changes to Speech Tension

- A. Goal: The child will demonstrate the ability to reduce physical tension in his speech mechanism in order to enhance his fluency.
- B. Procedure: The child will:
  - 1. Learn the difference between “too tense,” “too loose,” and “just right.”
  - 2. Practice using physical tension that is “just right” (i.e., slightly less tense than normal).



## VII. Treatment Goal #10: Ensuring Healthy Attitudes



- A. Goal: The child will (continue to) discuss stuttering in an open, matter-of-fact manner that reflects acceptance rather than fear.
- B. Procedure: Even while talking about ways to enhance the child’s fluency, the clinician will keep the child’s and parent’s focus on successful communication as the primary outcome of therapy.
- C. Treatment Activity #10: Remember the Goal
  - 1. When a child opens his mouth to talk, his goal is to communicate a message, not to be fluent. (The time may come when he starts to be more concerned about being fluent, but for now, we want to keep the child’s focus on communication for as long as possible.
  - 2. Help the parents create an environment in which the child is praised for his communication success (not just his fluency): ***What the child has to say is valuable and worthy – even if it sometimes comes out bumpy.***
- D. Continue Monitoring and Follow Up as Necessary

## VIII. Summary of Family-Focused Treatment

- A. **The Family-Focused Treatment Approach** help preschool children achieve and maintain normal speech fluency. Treatment involves parent-focused and child-focused that are designed to:
  - 1. Help parents make communication modifications to indirectly facilitate children’s fluent speech
  - 2. Help parents and children develop and maintain healthy, appropriate communication attitudes
  - 3. Help children make communication modifications to directly improve their speech fluency

## IX. Summary

- A. The primary goal is to help preschool children eliminate their stuttering.
  - 1. Although more needs to be done, there is at least preliminary evidence that this approach is effective
- B. *In addition to addressing fluency, treatment should ensure that the child develops appropriate communication attitudes so he does not struggle with his speech (and, in case he does continue stuttering and needs more advanced treatment)*



## Key Stuttering Organizations and Resources

- I. Stuttering Foundation of America (SFA) - [www.stutteringhelp.org](http://www.stutteringhelp.org) -- (800) 992-9392
- II. National Stuttering Association (NSA) - [www.WeStutter.org](http://www.WeStutter.org) -- (800) We Stutter (937 8888)
- III. Friends: Association for Young People Who Stutter - [www.friendswhostutter.org](http://www.friendswhostutter.org)
- IV. SAY: The Stuttering Association for the Young – [www.say.org](http://www.say.org)
- V. American Board on Fluency and Fluency Disorders - [www.StutteringSpecialists.org](http://www.StutteringSpecialists.org)
- VI. The Stuttering Home Page (<http://www.stutteringhomepage.com>)

## Some Helpful Resources and References

- (This is just a selection. There are many resources available to help clinicians improve their confidence in helping people who stutter)
- Bloodstein, O., & Bernstein Ratner, N. (2008). *A Handbook for Stuttering* (6<sup>th</sup> ed.) New York: Thompson-Delmar Publishing.
- Conture, E.G. (2001). *Stuttering: Its nature, assessment and treatment*. Needham Heights, MA: Allyn & Bacon.
- Conture, E.G., & Curlee, R.F. (Ed.) (2007). *Stuttering and related disorders of fluency* (3<sup>rd</sup> ed.). NY: Thieme Medical Pubs.
- Franken, M.C.J., Kielstra-Van der Schalk, C.J., Boelens, H. (2005). Experimental treatment of early stuttering: a preliminary study. *Journal of Fluency Disorders* 30 (2005) 189–199.
- Gregory, H.H. (2003). *Stuttering therapy: Rationale and procedures*. Boston, MA: Allyn & Bacon.
- Guitar, B. (2006). *Stuttering: An integrated approach to its nature and treatment* (3<sup>rd</sup> ed.) Baltimore: Williams & Wilkins.
- Guitar, B., & McCauley, R. (2011). *Treatment of stuttering: Conventional and controversial interventions*. Baltimore, MD: Lippincott Williams & Wilkins.
- Manning, W.H. (2017). *Clinical decision making in fluency disorders*. (4<sup>th</sup> ed.). San Diego, CA: Plural Publishing.
- Millard, S.K., Nicholas, A., & Cook, F.M. (2008). Is parent–child interaction therapy effective in reducing stuttering? *Journal of Speech-Language-Hearing Research*, 51, 636-650.
- Shapiro, D.A. (2011). *Stuttering Intervention: A collaborative journey to fluency freedom*. (2<sup>nd</sup> ed.) Austin, TX: Pro-Ed.
- de Sonnevile-Koedoot, C., Stolk, E., Rietveld, T., & Franken, M-C. Direct versus Indirect Treatment for Preschool Children who Stutter: The RESTART Randomized Trial. *PLoS ONE* 10(7): e0133758. doi:10.1371/journal.pone.0133758

## Selected Author References on Childhood Stuttering

- Logan, K.J., & Yaruss, J.S. (1999). Helping parents address attitudinal and emotional factors with young children who stutter. *Contemporary Issues in Communication Science and Disorders*, 26, 69-81.
- Reardon-Reeves, N., & Yaruss, J.S. (2013). *School-age stuttering therapy: A practical guide*. McKinney, TX: Stuttering Therapy Resources, Inc.
- Onslow, M., & Yaruss, J.S. (2007). What to do with a stuttering preschooler and why: Differing perspectives. *American Journal of Speech-Language Pathology*, 16, 65-68.
- Yaruss, J.S., Quesal, R.W., & Reeves, P.L. (2007). Self-Help and Mutual Aid Groups as an Adjunct to Stuttering Therapy. In E.G. Conture & R.F. Curlee (Eds.). *Stuttering and related disorders of fluency* (3<sup>rd</sup> ed.). New York: Thieme Medical Pubs.
- Yaruss, J.S., & Quesal, R.W. (2008). *Overall Assessment of the Speaker's Experience of Stuttering (OASES)*. Bloomington, MN: Pearson Assessments.
- Yaruss, J.S., & Reardon-Reeves, N. (2006). *Young children who stutter (ages 2-6): Information and support for parents* (4<sup>th</sup> Ed.). New York: National Stuttering Association.
- Yaruss, J.S., & Reeves, N., & Yaruss, J.S. (2017). *Early childhood stuttering therapy: A practical guide*. McKinney, TX: Stuttering Therapy Resources, Inc.
- Yaruss, J.S., Coleman, C., & Hammer, D. (2006). Treating Preschool Children Who Stutter: Description and Preliminary Evaluation of a Family-Focused Treatment Approach. *Language, Speech, and Hearing Services in Schools*, 37, 118-136.