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Ethical Considerations When Working with Those who Stutter

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- [Carolyn] At this time, it's my pleasure to introduce today's presenter. Dr. Lisa LaSalle is Professor and Chair in the Communication Sciences and Disorders Department at the University of Redlands. She is an ASHA-certified Speech Language Pathologist with specialty training in stuttering and fluency disorders. Dr. LaSalle has taught and supervised clinic and communication sciences and disorders programs for 25 years. She has published widely on many speech fluency related topics, including preschoolers who stutter, comorbid disorders associated with stuttering, cluttering, and use of medications with those who stutter. Dr. LaSalle, it's great having you on today and I'll turn the microphone over to you.

- [Lisa] Thank you so much, I'm really delighted to be with all of you in this virtual space today. I'm excited to discuss the part of my work that I'm really passionate about, which is working with individuals who stutter, and in particular today we're gonna focus, of course, on the ethics and ethical considerations. One disclosure, just to mention, is that I do have a financial relationship with speechpathology.com. There's no other disclosures but I should probably mention, before we get into our learning outcomes, that, of course, disclaimer always is important that I am not an attorney and we'll talk a little bit about how things will touch on school law, IDEA, as you know, Individuals with Disability Education Act, FAPE, Free Appropriate Public Education, and even ADA, Americans with Disabilities Act. So we'll touch on those, but of course, that's a disclaimer. Secondly, I'm separating out all of the research ethics as a separate topic, some of you have looked at that separately. Here are our learning outcomes and this is, first of all, describing the key components of ASHA's ethical standards, and particularly, we'll relate them to stuttering, discussing how stigma, advocacy, caseload management, and our competencies matter a lot in a variety of different settings, and we'll touch on those through some case studies at the end. Describing some ways to solve ethical dilemma cases involving people of various ages who stutter. This is our outline for the day, several sections with about 10 to 15 minutes each, and one really

important place to start is making sure we're all aware of and have read the ASHA Code of Ethics. ASHA has quite a few different documents out there for us to look at and be aware when they change, we'll even be touching on the Scope of Practice document as well today because you can't separate ethics from scope of practice in many cases, so just to be aware. Others who have presented on this topic, you know just, if in doubt, really go right back to that Code of Ethics and reread and sink yourself in it to understand better, so certainly you can link to that to look up parts. So I wanna begin with morals as one of our, like the differentiation between morals and ethics. Morals are really our self-guidance about what's right and wrong in life, right? And then ethics really are rules of an external source, so workplace ethics. Setting a simple example would be, what do we do when a client cancels several times in a row? What is our rule in this workplace and how might that affect preventing a concern called abandoned client, that is part of ethics?

So it's like the rules that we follow, and certainly, there are a number of different workplaces that we encounter as SLPs and audiologists. I've listed the main four here, the last one being that we even often will go into clients' homes, depending on different settings around the country, whether Birth to Three settings, et cetera, a variety of reasons, we might even be going outside of our workplace in thinking about how those workplaces change. This can impact ethics quite a bit. And because I put ethics are rules and not laws, again, I gave you a reminder about IDEA and FAPE, and then of course there are 13 disability categories under IDEA. Those are, everything from a specific learning disorder, other health impairments, including ADHD, autism spectrum disorder, emotional disturbance. The one that is near and dear to us is speech and language impairment, but you can also certainly have visual impairment, deaf, hard of hearing, deaf and blind, I'm trying to name off all the 13 here, cerebral palsy was an orthopedic impairment, intellectual disability, traumatic brain injury, and multiple disorders. Because we have 13 disability categories under IDEA, when we think about law, it is important to think about how our job as SLPs in the school, for example,

would be the school performance must be adversely affected by that disability. So one concern for me ethically occasionally is when someone says, "I can't qualify this "child who stutters for services with me," and I think, well, you documented that he stutters, that's a speech and language impairment, that's a disability category under IDEA. How is his school performance maybe adversely affected? Perhaps it's through social interactions. So thinking about laws as well is part, it always touches on ethics and thinking about IDEA is an important piece as well. So just kind of a fun thing is mottos. You know, if you think about mottos like, no worries, you know, hakuna matata, or mottos, we often worry a bit when we think about things that have to do with ethics and law, for good reason, right? But we also have some mottos that are important. I studied under Ed Conture and some lovely, my colleagues that studied under Ed Conture at Syracuse University for a PhD many years ago would like to quote some of the quotes he had from the '70s like, Marlo Thomas' quote, "Some kind of help "is the kind of help we can all do without."

You know, the idea of unsolicited advice might be an interesting motto we follow. That's just one example that relates to the concept of autonomy and stuttering. You know, sometimes people don't want to know what to do about their speech and language disorder, they haven't crossed your clinic doorstep for help. So a motto is really like a phrase that best represents our ideals, our beliefs, our vision and mission, our elevator pitch to someone about what we think we should do about a certain case. And morals, you know, should fit ethics somewhat, they may or may not. You might be at a workplace where you're struggling with some rules or ethics that are followed there, and we look to our profession for help. A quick reminder that the ASHA Board of Ethics is very accessible to us, we can call and talk through the problems, and so that's important as well. So why are we embarking on this topic today? Certainly ASHA has new requirements for CEUs into 2020, which is of course, just around the corner, and there is a requirement about ethics, looking to have us be professional and thinking through ethics in that way. And then also thinking when, where, how, why do

helping professionals treat stuttering. You know, which helping professionals are they? They're not just us, we're talking a lot now about interprofessional practice and it's not like a teacher of a student in the class who stutters would be treating the child stuttering, but they are going to be addressing the child, the student in the classroom in a certain a way, calling on him or her or not, and so we often need to take a step back and think what is the real help to the person who stutters? I will be using PWS as an abbreviation on these slides for a person who stutters. Most of you are familiar with that from the literature. And a caveat, like I said, not addressing research conduct, but we are gonna be touching on what's called The Belmont Report that informs both research and clinical practice. So suffice it to state, I wanted to just read this off to us for the ASHA Code of Ethics, this principle which is a new rule stated in a slightly different way. Individuals who engage in research shall comply with all institutional, state, and federal regulations that address any aspects of research, including those that of course involve human participants and animals.

So if you encounter an email for participating in a research with your students who stutter or patients who stutter, great. Go ahead and answer that email, but you always look for something about Institutional Review Board, has this been passed through, is it passed muster through institutional, state, federal, et cetera. So just kinda remembering about that as well. So here are our four principles of ethics from ASHA. The first is responsibility to persons served professionally and to the research participants. We do call people participating in research participants now. We kind of dropped that word, subjects, out of our vocabulary for the most part in research because they're not subjected to anything that they don't have in form consent for. Secondly, responsibility for one's professional competence, we're gonna be talking quite a bit about this one. Responsibility to the public, and there is one exception there that we don't have a responsibility for the public to legally protect people who stutter from discrimination. When it gets into legal categories, we will refer the person to look at, do you think there is a legal discrimination case here? Do you want to bring that up

in terms of American with Disabilities Act, but we are responsible to the public to get the public to better understand stuttering. We'll be talking about stigma, as I said today, and many people in the public, you could say well meaning, but they are pretty clueless about what is the correct helpful thing to do for someone who stutters in our society. So we're responsible to the public to educate and to advocate and to think about that aspect. And then certainly responsibility for our professional relationships, our colleagues who might be stepping into, stepping on thin ice, or stepping into an area where we see that and wouldn't we want someone else to gently say something, or very assertively say something.

So we'll talk about that as well. I think the only thing to comment here too is that we have a responsibility when we think about, let me use my little pointer here, when we think about our responsibility for our professional competence is really about the literature as well, so really thinking about the literature and how we're handling that. Are we going to the literature? Are we going to CEU? So professional competence, as I said, is probably the biggest one that I encounter to highlight. It's hard, it's hard work to keep up with literature, I won't say that it is not. Even with stuttering being the most published area, there'll be times where I have, I have the luxury of teaching it in a graduate program where students will say, "You know, I found this article for my project," and I said, "Oh, that's golden, "that's a golden nugget, I'm gonna read that one "because I wasn't aware of it," right?

So to be frank with ourselves and others, that this is something that really applies right now. Okay, so specifics of these principles, if we think about some of the specifics. One of the biggest one is not to delegate tasks requiring unique skills. Do you have the credentials to treat? And I'm really talking about just having your C's, your certificate of clinical competence, whether you've gone on and gotten the board recognition, specialty for fluency disorders or any other area, great, that's icing on the cake, that's wonderful, but having our C's, we are obligated, really, to treat all of the big nine areas

and to really think about that. So if you don't have the skillset or expertise, we need to challenge ourself to learn it or to access a CEU opportunity. And referrals are really where I think the task delegation can be sort of a two-way street. So for example, if you are not expert enough in stuttering and you know someone who is more expertise in stuttering, as an SLP, and you are able to refer, great, you could do that. You think about the geographic concern for the client, but meanwhile, you are working hard, you know, you're like a duck, a little analogy that works for me is you're cool on the surface like a duck would be but underwater you're a little, you know, you're swimming, you're, what do you call this? Webbed feet for duck, right?

They're moving fast and you're trying to find out what CEU can I get right now? What journal articles can I go to that apply to my client who stutters, whose a little unique in certain ways? And I would say this pretty frankly, if you do not have the time or the CEU money for the learning, then this is really a different topic, this is about advocating at your workplace saying, "I need time off to go to the CEU, "this is important for me, my client," et cetera, and really advocating for yourself to be able to best serve your clients. So thinking about, are referrals appropriate? We'll talk a bit about counseling. If you discontinue services, you need to give fair amount of notice. This relates to abandoned clients, which is a big part of our ethical dilemmas of passing on. We certainly have more women in our field than men, and so there can be maternity leave, there can be all kinds of changes that happen and we owe it to our clients to give that continuity of services.

Of course, I don't spend a lot of time talking about this but maintaining and securing our records is a very important part as well. And a study by Kenny, Lincoln and Balandin looked at experienced SLPs in their study and they had a survey qualitative study where they looked at the responses to ethical dilemmas. And they found in the qualitative part of it five major themes that reflected our, I'll say, for those of you who consider yourself experienced SLPs, our approaches to ethical reasoning. We focus on

the well-being of the client, we have the passion for the field, that's why we're doing that. Secondly, fulfilling professional roles and responsibilities, making sure we refer and look at in our professional practice opportunities and seeing those as real opportunities for networking, for growth, for the betterment of the client, going back to number one. Attending to the professional relationships, keeping those going, managing resources, and integrating our personal with our professional values. Sometimes we do debate certain rules that are used in the workplace, especially when it comes to schools and case management.

I hear that a lot because I'm involved in, very involved in, even in the Board, for CSHA, California Speech Language Association, so that's an important part as well. And then I would say that one interesting from their studies is we are a range, we have a big range across all of us. Some of us wanna do narrative reasoning, we wanna talk it through. When we do that, we wanna make sure that we get the story straight. What are all the facts? What are the perspectives of each individual? We're gonna get now into a little bit of the nitty gritty about what happens. We're gonna talk about how one of the first things that we might wanna do is, in any complaint system, is if we're having a problem, we want to work with the individual that we're having the problem with, that's always the first step in almost every workplace setting, begin with the person who you have a concern with.

When that doesn't work, it is important to realize that any one of our helping professionals we might be working with has every right to file a complaint, sorry to scare any of us, but against any one of us. So the person filing the complaint, I put this in red, does not have to be an ASHA member. The Board, going back to the first bulleted point here, does have the jurisdiction to receive, deliberate, and act upon complaints filed against any of us, as ASHA members, who hold the CCC. So that could be audiologists or speech-language pathologists, and then the Board does not accept any anonymous complaints, if that helps to think about that. The respondent is

the person who you might have the complaint about, in a legal case, and we can have a, as I said, a complaint filed against us, if it gets to that level. The Board accepts complaints filed by mail only, so you can better believe, and that makes some sense, that someone's gonna take the time to, you would assume, carefully word a letter that is actually mailed to the Board of Ethics. Does anyone want to get to this step? Of course not, and so that's why I think a lot of us are interested in this topic now and ASHA's having us think about that. So the first step in almost any complaint process is addressing the complaint directly with the person with who you have the complaint, and I think of this, I didn't make a separate slide about this, but because this looks a little scary, this whole part here, I'll go to the next slide, we're about to start into stigma, but I just wanted to mention that, one thing that served me well in the '80s, and then maybe some of you remember school in the 1980s. I certainly think back fondly to those days, I'm sure there were problems then, too, but I took a course called Assertiveness Training 101, or something like that, and it was another great motto that helps me, and I even talked to my graduate students about this at orientation every year, and it goes like this.

You look the person in the eye, that you're having the problem with, and you start with an I statement, I feel, fill in the blank, we'll call that X, when you do, fill in the blank, we'll call that Y. Next time I'd really appreciate it, or it would be best for all of us to avoid further problems if you would do Z, right? So it's like fill in those three blanks, we might add rationale, you know, because this is unethical, perhaps bordering on illegal behavior. I am concerned, I feel uncomfortable, but we always start with that I statement, if we see a problem. Okay, so we're at 9:20, I wanna move us now into this stigma topic, because for stuttering, one of the things that we need to be thinking about is how stuttering is really quite a different problem in some ways from our other big nine. A stigma is a trait or an attribute, and so stuttering would count as a type of trait or attribute that is devalued or disapproved of by a particular social group. So those who do not stutter or, and let's face it, we're not all educated about everything,

we're not born knowing everything we need to know about stuttering, and I say we in society, as SLPs, we should've had a course in stuttering at one time. We have lots of resources at our fingertips and if you research stigma and stuttering, you come up with quite a bit. Michael Boyle is a person who stutters, who has come up with a scale for self-stigma, and I put that in your resources. I'm starting to use that in our clinical practice, a lot of new things are coming out about this topic. By we, I really want to, why do we fear the word stuttering? And by we, I really do mean us as SLPs. At one point in time, we had that course or half course, why are we fearing the word stuttering even still? I see reports many times that might have, you know, too much of the word fluency, fluency, fluency, and I'm reading the thing and I think does this kid stutter? Does he have a problem that we would call stuttering?

Certainly we don't wanna use the big heavy word stuttering with a cute little preschooler who barely has any awareness of what this getting stuck moment is, that's something that we still, I hold true to this day, but one of the reasons we might fear the word stuttering is because of the stigma of stuttering that we need to admit. And when we have that stigma, it prevents us from communicating directly when we would like to communicate directly, that's our job, right? We are all about clear communication as well as helping people with communication disorders. So when we write clinical reports, this is probably the most important part of this slide here, and we're writing about somebody who has developmental stuttering clearly. They began stuttering in childhood, maybe classic age of two to four, classic age of just before their third birthday, and then you're never using the word stutter or stuttering anywhere in a, even a brief report, then I believe we're really not communicating directly, and other experts in stuttering, if you wanna hear more about this, agree with this point and can also complain about it a bit. I would tell you about Stutter Talk, is a wonderful podcast, stuttertalk.org has Peter Reitzes, who's a person who stutters and has had almost 1,000 podcast episodes. So he and Craig Coleman talked about this one day and I see it a lot, too, and I was like, "Yes, this is true, we need to not do this." Because fluency

disorder is an umbrella term for different labels, for developmental stuttering is the most common of them, for cluttering, for psychogenic, late onset stuttering, and so certainly, if we have a child who began stuttering at age nine, that's quite unusual. Maybe it was due to a traumatic event sometimes and those are very rare cases in my experience, one out of even 100 kids who do stutter. So they are rare, so let's highlight that and then we can say it's a fluency disorder, we might wanna specify the word stuttering a bit more. Also, some individuals who stutter will identify themselves as a stutterer. They have every right to do that, that's something that they might say, "You know, I want to say, I wanna call myself a stutterer." It's rare but some different generations I find this might happen as well, and again, it's how the person wants to identify themselves. I've had a couple of clients over the years say, "Oh, this people who stuff, just say I am a stutterer, "and I'm proud of it, "and I go to self-help groups, et cetera." So to be, you know, kind of thinking about that word a bit.

Here are some stigma-related studies. There are quite a few, I just wanted this one as an example because I thought it was pretty powerful when we go to teens. So Ingrid and Gordon Blood and the team of researchers here found that stigmatizing conditions for a majority of teens who stutter didn't even include stuttering. So, you know, think about how many things are stigmatizing to teens in some ways, they didn't even bring this up even though they all stuttered, I mean, as much as you would think, okay? But 60% of them admitted to us, I would say admitted here, rarely or never even discuss their own stuttering. Now this is 2003. I really hope in the last, you know, 15-20 years, we're gonna continue to change this one, that families are gonna feel comfortable talking about stuttering, going there, not being afraid of it. And this is what happens, is then younger teens who stutter perceive, you know, if it happens early on, where no one's talking about this thing that's happening in my mouth, or I'm getting stuck and nothing's coming out, then the young ones are perceiving stuttering even more negatively, in more stigmatizing ways, than older ones whose peers might be saying, "That's cool, man, I know what stuttering is, "I know somebody else who stutters." So

it's the younger ones who can't even express it, I still think this is an important study in our field when we think about our ethical obligation to use the word stuttering when we can. So unfortunately, stigma leads to self-stigma, and self-stigma, the problem is is that can be anger turned inward. Anger turned inward, many psychologists will tell us, can lead to depression, may not be as real clinical depression, but that's outside our scope of practice but we've certainly have heard things in the field recently even about another fearful word, which is suicide, or suicidal ideation. So being really thinking through what does this mean in our field about the stigma and trying to undo it. So our ethical obligation then is to decrease stigma and/or the impact of the stigma, and I have two slides about this 'cause it's quite important.

Advocacy, if we're gonna try to decrease the stigma in society, we better be doing some things like, I know May is a difficult time for us at our university clinic but we figured out ways around it, at CSHA, where sort of, like, every month is better speech and hearing month in different ways, and the second week in May is National Stuttering Awareness Week, and even more importantly for my teaching, love this time of the year, is International Stuttering Awareness Day, which is October 2nd. If you haven't participated in this, please, please do.

It's a great CEU opportunity and it's the International Stuttering Awareness Day, online conference all around the world, so almost all of the countries, there's so many countries now, I can't even name how many are involved, and so you get to see how culture and language impact stuttering as well, and while stuttering is a baby field for us, so to speak, we only started in the '30s and '40s, there are many countries around the world where it's really even more of an infant feel, they kind of need our networking as well, and sometimes we learn from them, of course. So another really important thing is in-services, and I love to bring back the idea of in-services. I think we've sort of forgotten about the opportunity for them, they were really kinda hot in the '90s, I feel like, and just doing a workshop, doing brown bag, grand rounds, if I can say that

phrase, in medical settings, really getting the word out there about that because that's really a big part of our obligation, because if you think about it, when someone says, "Oh I didn't know, "I didn't know about stuttering," we think, well gosh, stuttering is 1% of the population, kids can be falling through the cracks sometimes, in different kids and adults, and so if we were out there giving in-services and other advocacy strategies, we would get further, and that's another motto I have, is not letting people fall through the cracks. I mean, in this day and age, there's so many resources at our fingertips that people can benefit from and they can refer to us, right? Another thing that I do, and a lot of other people have started writing about how we do this, is requiring graduate students to go pseudo stutter, and sometimes they feel a little bit disingenuous about this so I help them work through this by talking about articles like Hughes and Hughes et al where they say, "Well, we may not just have pseudo stutter, "we have them also practice these crazy techniques "that we want our clients to use." So trying out what it feels like to do this, trying out some empathy. Inviting those who stutter to meet others who stutter is an important part of decreasing the impact of the stigma on them.

So here's the Stutter Talk, I believe is .com site. Group sessions led by SLPs are called support groups and group sessions not held by an SLP are our, what we might call self-help groups, okay, that's usually the term for them. So National Stuttering Association, almost in every larger city or town, has a chapter and go find it, invite yourself there, they certainly love to have normally fluent SLPs just quietly listening in, sending a client to them, et cetera, but you're not about leading it when it's something like this, it's about taking a step back and imagining what it would be like to look for others who also have the condition. I talked about this stuttering scale by Boyle, and this is just a few, there's so many out there that we could be using. Okay, we're ready to now turn to the topic of caseload management and our professional competencies in working with clients, and I'm gonna bring up , no matter what your political persuasion, a phrase that came, it's biblical, I believe it's Luke 12:48, but a former

president said this one and it was, "To whom much is given, much will be required," anyone remember that one? So we are the professionals here. So to whom much is given, much will be required. We have been blessed with the access to education, this almost chokes me up when you think about it, right? Knowledge of therapy, and therefore, we are required to access that information to help those who need it. This is powerful, right? We owe it to our clients and we owe it to ourselves, to challenge ourself and think about that.

So this is an important topic that I find with stuttering because unfortunately, yes, stuttering is the most well-researched and sometimes the least well understood, right? And we need to change that, I think we are changing that in many ways. So caseload management, this is also a scary word when I hear different cases out there. If you were to ask ASHA back a while back, they were like, "Oh, an ideal case size is 45," so I frankly get, my blood flow reverses when I hear someone say that they're in a school and the caseload might be something like double that, 90? No, that's not ethical, that's not okay. I don't know as much as some of you do about the challenges, of course, in making a caseload manageable. But the SLPs in the same study that looked at ethical decision-making, found two strategies, and I'm not here, I'm not gonna make a comment as to which one is better, but the first strategy is to distribute services equally across caseload.

So each client gets a predetermined number of sessions and then you have a waitlist. Waitlists are a bit of concern, I will say, when you think about the risk factors now for preschoolers who stutter. Some example risk factors are consistency, they're stuttering day in and day out and not getting any better, right? The time since onset has gone on past a year and here they are still on a waiting list, that's a bit of a concern for me, and it should be for you. They have high units of repetition. They're not just stuttering li-like this, they're stuttering li-li-li-li-li-like this and they're still on a waiting list and we know that that's a risk factor from the studies by Ehud Yairi and his colleagues at University

of Urbana-Champaign, the longitudinal work that's been done, I mean, some of these kids are still on a waitlist two years later. And now, let's add to the fact that they might have a genetic predisposition to stutter, their family history includes stuttering. So sometimes I have concerns about this, when other times, I'm like, "Oh, it's working for you, "you're not letting the kids who have high risk factors "sit there on the waitlist, fine." Another option is weighing treatment priorities based on who would benefit the most or who was at a higher risk if and when the services are withheld. So here's where we can be a little more, not super equal all across the board, we're gonna be a little more prioritizing. But just to remind you, if children whose stuttering doesn't resolve in about a year, they're still at that higher risk. Nina Reeves has given so much to our field in the schools and she has written an article I put in your resources and your reference list, and I just love this quote. You know, if someone who knows a lot about stuttering comes on board, it's not about this, you know? I mean, it sounds a little silly to say this, like, "Oh I'm so glad you are here as a stuttering expert, "will you be taking over all of our stuttering students, "so I can, you know pass the book and not do it myself?"

You know, again, this is a, please, this is not the right attitude, the attitude is, "Can I learn from you? "Will you be doing a workshop? "Can I read some of the materials you have out there?" Because stuttering kids are the best to work with, I just started clinic yesterday here at University of Redlands, after a sabbatical, and brand new clients and i just went home, just happy about the challenges, for sure, but just enjoying the process. Once you know an area in any of the big nine, we certainly should be having fun with the learning process and the passion should come back for us, so. Our potential professional competencies in truly helping people who stutter depends on our ethics and our scope of practice and it also informs our ethics and our scope of practice. So this is a complicated statement but I hope you follow along here that we are really thinking about the aspects of, you know, what are we able to do, we have all of big nine, we're challenged by that, but it is in our scope of practice, even counseling,

we'll talk about, is in our scope of practice. If it has to do with a disorder, that's our. If the negative feelings are about stuttering, that's our scope of practice right there, and so we're informing, we're kinda going back and forth with that. So complicated statement here but I hope that this kinda sums up this part of it. So counseling is huge, that's on the next slide. This is a bit of a busy slide for you but let me just say, first of all, in 2016, they did, they, the committee that wrote the scope of practice for 2016, came out, interestingly, the same year that our ethics document came out. So the advances of happening collaboration, a lot of you would agree that collaboration is a huge part, it always has been but now we're focused on calling it, we're calling it interprofessional practice, we're actually acting differently in some ways as well, like looking at new ways of teaming up, and I look forward to ASHA Convention this year 'cause I try to keep up in the IPP area. Just being in a university clinic, we don't have the same opportunities that some of you do to have as much.

We try for some but I think you guys even have more, if you think about different settings. Counseling. Look at this long list here of counseling, I'm not gonna read them all off for you, in the interest of time, but empowering the individual to make informed decisions. How do they make informed decisions? They tell us, "I have no clue, "I know what I'm doing is the wrong thing," they feel terrible about that. Some parents are saying, I heard a mom say last night, "I've been catering to my daughter "and now I realize that's a mistake perse." She was doing a little talking for her daughter with down syndrome, who stutters severely. She's not the first mom I've heard that for, right? From. So that's a tough one, we don't rescue them from feeling like, I'm ready to make a change, and even if there's guilt there, we can't rescue them from that, but they're here now, they're ready to think about what can I do differently? How can I help her to talk more? All of that is important part of what we do. Educating, providing support, and helping them to be self-advocates, so all of that is important. Discussing, evaluating, and addressing negative emotions, as long as those have to do with the communication. A person who stutters says, "I'm holding back, "I'm really not talking."

School-aged kids, "I don't wanna raise my hand right now "'cause there's this other kid "who says something teasing, bullying, all of that." That's heavy but that's our job, that's part of what we do and there's a lot of resources out there for that. So I'm looking at the time, we're right on time now for assessing stuttering. If some of you are thinking of questions along the way, I'm really hoping those will come out through the cases at the end.

So I'm excited to hear what you're thinking about with some of these. But I'd like to go ahead and begin talking about a couple things related to assessing. And I wanted to start out by saying, you know, it is still amazing to me when I still encounter professionals at various stages of their SLP career, who think that we should refer this person with negative, uncomfortable emotions to someone else when they really do have to admit they are part and parcel of the stuttering. So even though I'm leaving the topic of counseling behind and starting into assessment, if you think about assessment, one of the first things that happens is, like, triage, right? It's sort of the idea of I got an email, I got a phone call from someone who reached me.

Often I'm reached at a university clinic by Stuttering Foundation of America, hopefully you guys all know about that, amazing source, as is the National Stuttering Association, they're both amazing sources, but for Stuttering Foundation of America, stutterhelp.org. You guys should all have that in your Favorites bar somewhere, and that's in your references. stutterhelp.org has a referral site across the nation, so you can look up anyone who says, "I'm a relative expert in stuttering," and refer. And so, triage starts there with assessment, and this person is saying that it's a real problem for them, that's why they're calling me right now. Sometimes the first contact can be they're devastated about the problem, so being sensitive to that is important. It happens to me that the highest negative emotion is my first contact, is my early contact with people who stutter. Sometimes it's along the way, of course, but it can sometimes be often in that first contact. So one of the challenges with varied group of

you who as learners in this webinar are in varied settings, that you find yourself in, please think of stuttering and fluency as a screening tool. So if some of you are, like, "Oh, I don't really work with people who stutter very often but I am interested in today's webinar because I do encounter them sometimes," we all know how to screen, basically, I think for stuttering. Screening is an important idea, I don't know how to do a full audiological evaluation, I'm not a certified audiologist, but I know how to screen hearing. And the reverse can be said. Some of you will not ever really work with preschoolers, but then you're in a setting where you're hearing a preschooler repeat three or more times per hundred words, you just hear it and you can see the struggle, physical struggle, refer, that's a screening right there. You saw it, you heard it, that's called stuttering, refer, that's a quick kind of screening. Now obviously we could be wrong, we might be just getting excited about one stuttered event and it was only two utterances, we have to be careful about that, but it's better, I think, to err in that direction, right, than to err in the direction of, "Oh yeah, I've been hearing that kid stutter on the playground for weeks now.

"I didn't know there was an SLP I can refer him to, oh, that's great," and so if that goes on for over a year, that can be a problem. And I'm seeing a question pop up, which is great, the big nine is the way ASHA defines all of the areas in. So the lingo now is big nine, so that means stuttering and fluency, articulation, phonology, speech sound disorders, hearing impairment, social communication, including autism, TVI, et cetera, all those kind of, so it goes on to a list of nine, so you can check out ASHA.org to see the nine. I guess we talk a lot about the big nine because we have a university clinic, of course, and so our graduates, you know, we pride ourselves on do our graduate students, or master's students graduating from a program, have experiences much as possible in the big nine? Even though the only need, only, right, 400 clinical clock hours in children, adult, of vowel treatments, but we still wanna hold true to the idea that they have had some experience with stuttering, they've had some experience in aphasia, et cetera. Hope that helps. So then related to stuttering, our ASHA scope of practice

reflects advances in prevention and wellness. Probably don't have to underscore prevention too much when you think about the risk factors for preschoolers, and then I just mentioned here the data for screening. If you can, just listen to a child, most of us can figure out when about 100 words is going by and oh wow, I heard three or more of those little repetitions or prolongations. That's enough to screen, and even if you don't hear that, you don't have the time to count how many words, if you see visible and you hear audible physical tension and you know the child cannot get through the word, because of stuttering, that's probably stuttering. If the parent's telling you at home he can't get a word out, that's a good indication that you wanna listen a little bit, you hear it too, fine, refer, or take them on your own caseload, of course. So then related to stuttering assessment and treatment, in terms of assessment, we know some of our very important scope of practice guidelines, when you think about we shouldn't be using, and this is almost, this gets into even legality. If you look at a standardized test, that isn't normed on people with down syndrome, for example.

We can't use a standardized test and make a big deal of those norms when they were normed on neurotypical children or adults, we can't use those norms when we talk about, they're all English speakers and we're dealing with someone who's bilingual or even multilingual. So we know some of those kind of practices and that's a scope of practice issue where we realize that maybe we are gonna be working with, for down syndrome, for example, a special education teacher who has another way of getting kind of an interview with this young lady who has down syndrome and stutters, for example. You know, maybe we wanna work with ELL teachers, we certainly wanna work with interpreters, translators, whenever necessary. That's the law, you know, that's more legal things. And then for treatment, we wanna think about, obviously, is there an evidence-based to what we're doing? So you might remember from evidence-base information, you probably learned recently that the largest part of the evidence base is the literature, that's the heaviest cog, the biggest cog in the wheel, and the other two cogs in the wheel, of course, are our own clinical experience of I

know this works, I've seen it work. Great, hopefully literature says so, too, usually that's the case, and then also, what are the clients informed wishes? What do they want and are they informed about what the options are. So we're looking at modalities, technology, instrumentation, population, but we're also, if you think about it, we're looking at this advocacy, so again, the art of planning in-services. This is a really important one, I'm gonna let the cursor just sit on this one about stuttering incidence and prevalence. Think about your setting, and many of you can just jot down right now what is the population of your school? If you look at the population of your school, the math is pretty simple. You should have, out of your school, one out of every 100 children should be stuttering.

These are the kids that are falling through the cracks. So if you have a long history of no kids who stutter on your caseload, then we are missing the opportunity for this one, to plan in-services, let our teachers know what stuttering is so that they can refer kids who are stuttering in their classroom to you. Regardless of the size of your caseload, because that's a separate issue of caseload management and there's a lot material on that as well. Another concern is that, but this one is a concern, right? So if you think about it, our obligation is to go ahead and, it's an ethical dilemma, I believe, if an SLP says, "I've never had a child who stutters on my caseload," and they come to my workshop and I say, "Well, you're at a large public elementary school, "so what's the problem there?"

Because if it's 1% and it's even 5% of kids who are going through a phase of stuttering, these kids are very rewarding kids to work with. If they have high risk factors, you work with them for a year or so, if they have low risk factors, you get to work with the parents and monitor and maybe they outgrow it, but you still need to be working with them, right? So don't let 'em fall through the cracks, you should also be doing in-services, hopefully that's clear. This is the controversial area recently about stuttering being invisible, silent or covert, certainly passing as a fluent person.

Constantino and others have written about that in 2017, but I have found, in my own practice that there have been some case where the client was told that the stuttering is all in her head in one case, the stuttering is in your head, because they listen for maybe 300 words, didn't hear the stuttering and said, "I'm not hearing the surface level," and that's a concern, right? So if you have a kid who's contributing recently but then he stopped, he's not raising his hand in class anymore, maybe he's being bullied, maybe he's letting the stuttering go underground, that's part of our obligation, to figure that out. So I hope I've made the point about not letting kids fall through the cracks be pretty clear on this slide. Okay, so scope of practice, I'm gonna take a moment to let you take a look at the supervision, education, research, administration/leadership areas. In my field, I am doing this a lot, I'm doing the supervision, but I should also be in some of these other areas as well.

So this one probably is just more of an appreciation slide for you to realize, in terms of education, I believe in our area of California. Now this might not be true for you all, in where you are across the country, but in California, we have an embarrassment of riches of stuttering CEU events. We have Camp SAY, which is amazing, look that up, Camp S-A-Y, we have Friends Who Stutter, and sometimes people say, "Well you do a workshop on stuttering," and I get to say, "No," , I say, "Look, look at what's going on "this month and next month. "Maybe next year, maybe when there's a little bit."

So there's a lot out there, of course you're on a webinar, et cetera, so there's a lot of education and that's part of our scope of practice as well. Another interesting thing is will you be using, some of you are familiar with these terms, Lidcombe approach, will you be using that by the book, so to speak? Are you gonna go to the manual, download it, and use it exactly as it is researched? Well, I believe we can be eclectic as clinicians, and I believe that we can take response-contingent stimulation and many other authors are saying this now in the literature, I'm not alone, and we can borrow from response-contingent stimulation, which basically means child stutters and after

they understand the difference between smooth and bumpy, five times more often you're saying, "I like how you said that so smoothly, cool idea, "smooth talking, way to go," you say that five times, then you have a license to say, "Oh, that was a bit bumpy, "let's say it again, how should we do that?" Or, "Do you know if that was smooth or bumpy? "Cool, you knew that was bumpy." So we're being very positive and neutral at the best and positive at the best and neutral at the baseline, and that's really response contingent stimulation. Parent implementation might work in your setting and it might not. So thinking about that, our setting is different than maybe your settings. I supervise, maybe you don't. Looking at a couple of questions, one is good resources for parents who know very little about stuttering. I love Stuttering Foundation of America for that because they have streaming video. So you go to stutterhelp.org, great. And then, what's the information to refer a client?

The same thing, Stuttering Foundation of America, stutterhelp.org, and then click on Referrals, it'll say Referrals and it brings up the whole country and for any state, you can find people who tend to, they're either Board recognize fluency specialists, and they might have that after their name, the extra alphabet soup, so to speak, which is great, or they might just, like myself, I have my name out there and then I say, "Just so you know, I supervise graduate students, "that's the type of program I have." Okay. Diagnosogenic Theory.

This is a problem , I mean, you guys maybe went to school, some of you might've gone to school a long time ago, I wanted to bring it up as a new topic because, I'll be brief on this, I assume this history is a review for many of you. The Diagnosogenic Theory said that the origin, the genesis, of the stuttering was the diagnosis of normally fluent speech as stuttering. And of course, it often involved moms being type A, you know, being too highly anxious or perfectionistic about their child's normally fluent speech. We've come to know, since 1959, that this is just not the case, that it makes more sense to us that a parent might be a little freaked out, so to speak, highly anxious

about their child starting to stutter, but that is an effect, not a cause of the stuttering. So I like to tell parents many times in my practice, "You did not cause your child to stutter," and that's helping in a counseling way. We have no evidence, there have been a lot of theories that came after this, it spawned some other good theories, I'll list out a lot of other. It spawned the Anticipatory Struggle Hypothesis, which can be helpful and you guys can go get more CEUs on some of this in another format. We also have a lot of other, I just listed a bunch of theories that are out there for us but this was one of the first, and unfortunately, it has really affected a lot of areas. So for example, I get referrals sometimes, from SLPs, even to this day, and an SLP might say, in different ways, "The mom of this child is a real, you know? "No wonder her kid stutters, she's a real piece of work," or something, and I'm like, "Oh my goodness." Let's be careful how we talk about parents, right? Let's think about what that parent might be going through, you never know, so again, we have to really, I think, think about nonjudgmental, go back to Ken Moses and really think that some of that is coming from a theory that has gone by the wayside and we really don't have any, have never had any evidence, no evidence to support this theory, I should say.

So think about how do each of these theories that you're aware of and form the way we screen or assess a person, no one theory is the best, but you should be keeping up with the theories in the field of stuttering. And right now, if someone asks me what causes stuttering, it's not still correct to say, "We have no idea," we don't get to say that anymore. I often sum it up with there's a heavy genetic component to stuttering, as is true in your family, so we really don't know all the other, if we're talking to a family, we might keep it really simple, but certainly, a lot of the newer theories incorporate genetics in that. Here's ethics according to Fletcher and other authors I put in your references. Benef, yes, let me see if I could get my syllables stressed right, beneficence, yes, beneficence is doing good for others, basically, that's the first one here. Non-maleficence, avoiding doing bad for others. Respect for patient autonomy, and an important one that we'll be talking about with one of our cases is justice.

Justice can be socioeconomic justice, you know, researching people in poverty who don't really have, and back in the old days when there wasn't good IRB and they didn't even know that they were being studied, that isn't done anymore hopefully, I will say that in a positive manner. So for justice also power relationships comes into play here. So all of these are important when we think about our cases. What about patient privacy or confidentiality, this is an important piece as well. When we think about, even people who stutter, who talk to my class. I have the lovely opportunity to have college students who stutter, I had one who wanted to get into one of the UC universities, the University of California, which are notoriously hard to get into, a real bright young man in high school, and I'm very careful about inviting him to talk to my class and seeing it as a two-way street. What benefit might he get out of talking about his stuttering to my class? Should it be my entire class of 30 students or should it be my staffing of 10 graduate clinicians? Guess which one he chose?

The staffing of the 10 graduate clinicians. It's autonomy, he's choosing how much he wants to come out as a person who stutters to a entire class, right? So we don't require, we invite and we think about what they might want. That doesn't always just relate to confidentiality, but it could, like, if they're undergraduates versus graduates, you know, I mean all our undergraduates sign confidentiality agreements when they meet real people who have real problems, real communication disorders, we make sure they sign a confidentiality statement, but again, the person doing the talking about their disorder should have a lot of the choice. Just because we wanna fill our class period with that, just 'cause I want it doesn't mean it's the right thing. Of course, we don't wanna put power relationship pressure on individuals. Honest communication about the assessment and treatment and prognosis. So this would be wrong, to say the stuttering is all in your head when you haven't really elicited maybe enough of a sample, there's a reason it might be more covert, et cetera. Determining who makes what decisions is important to think about as well. And then, of course, conducting an ethically valid process of informed consent, which goes right back up to this case of

informed consent. I understand what this class is gonna be like, that I might talk to, or if you had somebody come in your in-service, that'd be great, a patient whose made great gains with you in the area of stuttering and they wanna talk about what worked for them, that's a lovely opportunity but make sure it's done with them understanding how this might happen and let them have a choice in how it goes. So we're about to move into treatment and I am focusing a bit more in school, so I certainly wanna make sure we allow time for questions about medical.

So now, in terms of treatment, we're gonna start into a little bit. Now there's IEPs for public schools, and then some of you might find yourself sometimes working in private. I know some of you are itinerant SLPs in schools, for example, and LEA means that you would have a service plan. So these vary a bit in terms of what you might find. In my experience, of course, I'm dealing with supervising, and some of you in this webinar might also be, hopefully you are supervising. I think ASHA has now said, after nine months of full-time experience treating, you know, and after 2020, and you're moving into supervision, and hopefully you've looked at all of these documents that ASHA has. There's a good document from 2010, right here, on Supervision of Student Clinicians in various settings. So we'll be talking about a case that relates to supervision.

There's a power relationship, of course, with supervision, where the graduate student, for example, wants to do the best work but they also are learning from the supervisor and sometimes, let's be real here, the graduate student might have information to share with the supervisor, and so, that comfort is part of the area as well. So we are talking now about many times as supervisors, we're busy guiding the pre-SLPs to explain why, not just how they are doing what they are doing. Please always talk, even to your clients who are able to understand that about why we are doing this task. Some of our tasks we can't explain why before because it will ruin, I can't think of a better word right now, the results of that particular, for a standardized, we can't always

say everything about the rationale before we get to standardized assessment, but when we can, give rationale because, especially with stuttering, stuttering is variable, stuttering is complex, stuttering varies across the ages, it varies across individuals, it varies across the day, it varies across the hour you're working, with the half hour you're working with the client. So certainly, the rationale is important, and I gave a little hierarchy, if you will, for our supervisors. First, you know, the rationale. Then the rationale based on the evidence that is part of the therapy. Then the rationale and where the EBP literature is, where's the literature of the evidence-based practice of why we do this? I just sent something to my students yesterday on down syndrome, a really wonderful, it was a case study but who cares? It was a great case study about down syndrome and severe stuttering and that's exactly what we saw yesterday, so you send that to them.

And then, you deliver that rationale fairly empathetically when it comes to people who stutter because we can only imagine, as an individual who happens to be an SLP, and we got into this field, I got into this field because my father stuttered, and I was fascinated by why stuttering therapy wasn't working back in the '70s. So I can only imagine, too, I'm a normally fluent person. 25 years of experience doesn't mean I can imagine exactly what the person who stutters is going through when we're asking him to just do this test, "I gave you the rationale, "here's what we want you to do, "we want you to get on the phone, "we want you to call this individual," "and here's why.

"It helps many individuals like yourself, "we know it's got good results to make these phone calls," and they're like, "I can't today, I can't do it." Now it's time for counseling, now it's time to listen why and not, you know, rush through a plan and I think all of you know that, but that's part of ethics as well, autonomy, thinking about that. So in other words, when we are looking at our treatment, we wanna think about what is the good evidence-based rationale for the therapy that the person who stutters is currently receiving? We should easily be able to explain that to the parents, spouses sometimes,

of adults who stutter. You occasionally involved a significant other that the adult wants in the room or wants to be part of, and the client themselves, absolutely, the client themselves. For example, let's take a case of, just a quick example, Kevin. Kevin wants to no longer stutter. Let's see, he's a 12-year-old, I've encountered this before, just wishes the stuttering would go away first time we start working with him. But stuttering-modification approach is gonna show him that some pseudo stuttering is gonna help him decrease that stigma. He wants to just erase stuttering, we can't do that for him, so we're gonna gently start to introduce a new approach to him, like he wants to maybe get fluent by reading and generalizing the reading, that's a possible thing, we could certainly work on fluency shaping. But we also owe it to him to introduce some stuttering modification. Increase his overall communication, self-efficacy, if you will. And then later, we can target stuttering modification on four out of five stutters, so we explain that to him, we give him that rationale. Another example might be Amy, she's stuttering on 25% of words with physical tension, we wanna try to find, that's a lot, right?

She needs some fluency shaping, for sure. We wanna find a sort of island of fluency that we can build, that she can grow from, and so we're gonna help her ease out of stuttered words, we're going to help her build a little island. We might use delayed auditory feedback for a bit of time. We're not gonna use that all the time, we're gonna explain why, why are we putting this crazy device in the headphones and delaying, giving your voice back at an echo? We want you to try to talk like this for a bit. Not that we want her to talk like that all the time, but we're explaining, "This is just a way for you to feel "a time where we don't hear any stutters, "how does that feel, what do you think?" So we're giving options, we're explaining why we're doing what we're doing. Some clients, we would truly scare away if we just put the headphones on and start trying things, and I know this goes without saying but a lot of times we move into a new task and we don't explain, especially, let's be frank, when we're in a hurry, and I think some of you don't have the number of minutes. Our dosage, as it's been called in

the field of literature, treatment is dosage involves how many minutes do we work with a client how many times a week? And so at our university clinic, we have the luxury of 50-minute sessions twice a week if we want and we can see really good gains in one semester. Many of my commuting clients are much longer. This is one I put in red because I've encountered it before, so. I think fact is stranger than fiction but please do not ever defend your IEP goals for a child whose stutters because you didn't write them, they were handed down to you by the last SLP because this is lack of good evidence-based rationale, clinical rationale, so I said, "Okay fine, "they're handed down for you, that's not correct, "but they're handed down to you," but why are you working on three goals about breathing, for example, which we're about to get into, why would you have, those are the only goals for your client who stutters?

Could you explain, and then sometimes, I don't take people the task, and like many others, Lisa Howard De-fure has a great talk on ethics that has to do with feeding and swallowing in the schools, on speechpathology.com, and she makes a nice point, we're not out to get someone else, that's not the point of ethics, we're not trying to get someone in trouble, or take them down or anything like that, but you know, you have to be able to defend your IEP goals and I've been on the phone with clinicians, I mean, thankfully not that often but when this happens, it's like wait a minute, wait a minute.

And this borders, if you think about the Rehabilitation Act, Section 405, this borders on IDEA and FAPE infringement, again, not being a lawyer, because this IEP is individualized to a specific child, it meets a child's unique needs. It provides access to the general curriculum, you know, meeting the grade-level standards established by the state from which the child receives educational benefit. The IEP, quote, must be reasonably calculated to enable the child to receive educational benefits. So if you're using goals, and let's say these three breathing goals, I mean, I'll just be, just put it out there, let's say that the SLP can show me baseline pre and post-evidence that this is a particular kinda client where these three breathing goals are working, fantastic, but I

probably wouldn't be on the phone with the SLP talking about, gosh, we're using these goals with the child in our university clinic, what are you using, you know, if it wasn't a problem, lack of progress, or problem, right? So, I mean, it's a progress, it's their progress, then you can defend your IEP goals right there, I can show progress, but don't just say, "Oh, I don't know, they were handed down," okay, that's not something that we should be doing as professionals. Client abandonment is the next one. So this is the professional who, it sounds pretty dramatic, but it's the term used in ethics, abandons their client without making effective efforts to provide for their continuing care and that violates Principle I of the Code. You need, I think this goes without saying, give sufficient notice, protect records, and then, and that's just not monitor competencies of the new clinician but I would say be a guide on the side to that new clinician. You don't have to be, this is another motto, be a guide on the side, not a sage on the stage, that's another lovely Conturism, I've always loved Conture motto.

I don't know where he got it from, some of these are anonymous to me, but be a guide on the side, help that new clinician, say, "Hey, watch me for a moment or two," or, "Here's some notes to help." Otherwise, we're doing a disservice about continuity. When progress plateaus or stuttering severity worsens, we have an obligation, we gotta check what's going on, why am I not having progress for the last three weeks? You know that might be too long even, but why is he getting worse? One client who got worse with us, I still remember the little guy, Javier. Javier started getting worse, and you know what we did is we followed, we, the clinicians and I, I got to work with the mom, I had that luxury, too. I knew a lot of the literature, like we were using a good approach with him, I knew that things had been progressing before the relapse, if you will. I sent my students some of that same literature, gave them some learning opportunities, and I knew that the mom was concerned about this stuttering across the board. She was concerned, she knew that she wished for better for him and wasn't sure why it was worsening. Guess what was going on? He was being tested with what's called DIBELS dynamic. Some of you have heard of DIBELS before, so it's the

dynamic indicator, oh, ah, spell out that acronym. Sorry, I'll have to look it up, but it is a reading test that in the manual it says, if the person stutters, do not use this test with a person who stutters. It says clearly in the manual, others in the field have, Lisa Scott and others in the field, in the profession have talked about DIBELS as a no-no for people who stutter. So cool, mom was a teacher, she was able to go to the other teacher, and you know, again, dealt with it assertively. There was no drama or fight, she just said, "You know, Javier shouldn't be put through this, "let's not finish it out," and then the stuttering got better and he's back on track. So we gotta look into, it's like little mystery cases sometimes, we gotta found out, that's our obligation. The evidence-based of stuttering therapy, I would say, I'm gonna hit the breathing pretty hard on this one because I see a lot of that in my area for whatever reason.

Yes, there can be breathing goals in an entire approach, there can be a technique where you might work on belly breathing. Kristen Chmela has a wonderful fluency kit published by Super Duper, there are many others, I'm not trying to promote that one. Kristen Chmella is a person who stutters, she gets it, but belly breathing is one of 20 different techniques in that, I think I could count, okay? So the concern is we don't have an evidence-based of stuttering therapy when there are only goals about breathing.

Disordered breathing does not cause stuttering, and that's it. All ages of onset, we have no evidence, I can show you some of the evidence that long volume is both larger and smaller in individuals who stutter. There's a lot of different things out there. Yes, stuttering perturbs breathing. By stuttering, if you sit there and have a feigned or a fake block and you go, "Oh, oh," like that, you are adducting the vocal folds, you are cutting off the breathing but that is because you are feigning or faking pseudo stuttering, it's not because the other way around. Yes, I mean, I'll let you read this on your own, I hope that that is a point that you can change in, you know, and I don't know what areas of the country. Sometimes it's like someone just borrows from someone else and

that's not okay either, we need to go to the literature. Well good, we are ready for our cases, and this is the time I wanted to start our cases. Our cases now, first of all, I'm just gonna read the case and this is where I get the interaction from you. I'm gonna take a quick look at my questions before we do this and I see that, to add to the referral list, this is a great one, I'm really glad that Chamonix brought this up. Stutteringspecialists.org lists all of the Board-certified specialists in fluency. Frankly, I've phased in and out of that, I was on the inaugural Board of that, and because my university clinic, if I had a private practice clinic, I probably would go for that one as well, I may get back into it, but for yourself, either you wanna go for it yourself and do that or you wanna refer and look that as an alternative. She says that she mentions this because she, herself is Board-certified and not on the Stuttering Foundation list. So some people choose to be on one or the other and that's very important.

It's wonderful, I think it's a great thing to do, the Board-certified specialists, thank you, Chamonix and thanks for putting that out, okay. So now the cases involving children who stutter, I will be, first of all, telling you that, you know, these are fact/fiction blends, as are the best cases. I'm not, certainly changed a bit of these, and there are many areas of gray, so I'm looking for your answers and your thoughts in these. I will just read the case, you can do the mental image of it, and then you'll have a chance, with each case, to ask one of three different types of questions. Those questions will be what else do you wanna know about the case? What are the ethics involved or the ethical dilemmas or ethical issues? And then what would you do about the case, what to do? So here's the first one, it's a case of a fluency group. There are three fourth graders who stutter. They're grouped for a 20-minute session twice a week in your school, that little short time. You're the SLP I and you and SLP II divide up your caseload. And then SLP II tells you, you know, she's delighted that she's been able to group these three students together, that's been good case management for her, she's learned from her graduate training years ago that the whole idea of you're not alone is a good philosophy for rating stutter, but other than that, she kind of admits, she does

admit to you it's all she really knows or recalls about stuttering treatment. She's just like glad to get the kids together. And then she gets contacted by a local university, students, they all have a project for their stuttering class and based on being in an undergraduate fluency class, they wanna observe the capital fluency group for their class assignment. And let's just imagine, this probably isn't too hard for some of you, that you've both been swamped with a high caseload and a lot of paperwork, and one day you observe her telling one of the undergraduate students, who was observing, for this particular assignment, "Hey, I need to work on some paperwork, "you know, you'll be great at this group. "You're seeing how I'm leading the kids, et cetera, "so take over from here. "Please come back next week with a detailed lesson plan "and I'll be down the hall, if you need me." So hopefully your blood flow's reversing a little bit on that one.

The question on this one that I'd like to start right now is to go ahead with, I'm gonna tell you you shouldn't really need to know too much else about this case, I made it kinda detailed, so I'm just gonna go with what that case is. You might be thinking that you do wanna know a couple, you could pop that up, but the survey time is I wanna know what are the ethical considerations? What are you seeing here? What's the wording that we wanna put? The ethical considerations and/or the dilemma here. So we'll start the survey and see what your answers are. I wanna make sure, so I'm seeing, you know, leaving an undergrad unattended during therapy, absolutely. Student doesn't have the credentials, absolutely, and it could be misrepresented credentials if the little kids went home in the afternoon and said, "We didn't have Ms. Amy, we had a new speech teacher, "Ms. Kristen." Wait a minute, Ms. Kristen isn't your, right? So we have that problem, but the biggest one I just saw pop up is this SLP is delegating tasks that require unique skills. She needs to do her work, she's delegating to a complete non-expert and she needs to be expert enough, let's just say, at this moment in time. She might need to do a lot of work across a week or two to really get some good plans going for this fluency group. You guys are right on it, I would say the best, simple

answer there is delegating tasks that require unique skills. So what did I do in this case, this actually happened. I called the SLP, I got the phone number, I mean, I wasn't the SLP so we got a little fiction going on here but I called the person who did this and I did my X-Y-Z assertiveness formula. I said, "I'm really uncomfortable "because I understand you did, right, this "and I hope you understand that this is "against our code of ethics to do this," and so, you guys get the picture on this one very good. Some of you are saying someone's not properly trained and that's the part of the credential.

But remember, the credentials have not yet been misrepresented, they're not misrepresented until, and it can easily happen, the three kids go home and say, "We got a new speech teacher," and the parent calls up, "What, who's the new speech teacher?" And it can't be a student, now we've got another problem on top of the original one, but the original problem is we shall not delegate to persons without credentials, we shall not delegate unique tasks. So you get the idea. Great, you guys are doing very well with that and a lot of great answers here. Now we're gonna go to one that is a little bit more of two cases combined, and this gets, we can talk about what kind of ethical obligation for this one, but this one where we have Katelyn and Carter, and they both really need, let's assume for this case, that they're both quite, they have high risk factors and they really need our services, they're not the type of kids who are gonna outgrow the problem without our help.

One referral comes from a graduate student clinician, a family member, which is fine, we love those, I mean, that's great, and then another referral comes from both the mom, who stutters, and a dad who stutters. So we see there that we have the heavy genetic predisposition, that's Carter. We start to realize that Katelyn's family's got a long commute and they're just not showing up very often, the family's just not making it to the clinic. And then with Carter, the parents work a considerable amount, they have a considerable commute as well, they're starting to cancel more. We look at our

services, we realize our services look pretty good, and here is where this is real dilemma for me, 'cause I wanna reach these kids, I don't wanna, you know, have professional burnout by trying to rescue everyone but I wanna reach these kids, I want them to have access. We don't have telepractice yet established. Some of you might be thinking that's something to do. So my question, the survey on this one, would be what else do you wanna know about cases like this? Do you encounter? So this a little more open-ended because it's not maybe a serious of a type of thing. Some of you might be thinking on what you might do, right? But I wanna know kinda what else do you wanna know about these cases, they're pretty real cases for me. Progress and treatment, great. So that's an important one, looking at have they made enough progress before the cancellations start to happen where we can monitor, you know, is the stuttering worsening? Is the child continuing to get better? Calling the parents, yes, I've tried that one.

Not getting called back again, and again, I don't take it personally but these are important. Are they receiving services in school? This is a big one, thank you, whoever brought up the one. This is my problem, right? So well, we don't really think the SLP is working. Well, the SLP should be working with these kids in school from a university clinic perspective. You know, maybe I should be getting on the phone with those SLPs, we're trying to reach them and see, you know, you got this one and we worked with them for a while but they can't commute, it's not their fault, you know? They're trying their best, et cetera. Wanna know some other risk factors, good, other resources they might have. Child-parent wishes for treatment in light of complicating factors, that's a good one as well. Bu the biggest one, any services closer to home, like the child's school? Both of these kids are not home schooled, they're both, right? So looking into that. Thank you, very good. The ethical dilemmas here is I would say some of justice, some of access. They get the obligation to try to treat their problems with access, I think we can think of that more in the justice realm. And then I think I wanna beginning to develop telepractice. You know, my nephew, ready in time, but looking at that as a

possibility, and then definitely looking at the schools and telling the parents, "Let's go back to the schools." Here's what I've done in the past, let's have an SLP come see what we were doing, if that's possible. Let's get together, let's see what we're up to, give her some information. I've certainly done that as well, cool. All right. Teens and adults. I think what I'm gonna do, in the interest of time, we're just about to the point where I wanna ask some questions, so I'll tell you about Ellen briefly. Ellen, here's a little bit of information, the point is she stutters severely. A teacher pulls you aside and says, "I think she'd benefit from using a Proloquo2Go," so sort of something to talk for her, like that other student.

This was a bit of a concern because, obviously, there's a lot the teacher needs to know in a case like this. We wanna think about, first of all, when someone talks about an AAC device, that's used for nonverbal, Ellen is not nonverbal. The teacher maybe hasn't been educated adequately about the stuttering. Time, time is the major accommodation for kids in the schools, reasonable accommodation, wait her out, that type of thing. But there's other options here, too, to look at, going back and that's a dilemma of looking at accommodations, which is really even part of law in some cases too. Waiting her out. I wanted to end with Miguel. Okay, Miguel's an adult who stutters, Spanish-English bilingual speaker, master's program. You're one of two supervisors, your colleague, Mary's the other.

Miguel asks to meet with you. He tells you, "Hey, I stutter, "you're gonna hear me stutter from time to time. "My stuttering's one reason "I wanna be part of this profession. "You know, I don't let my stuttering hold me back. "You can ask me any questions." I got the opportunity here, Nina G., who's a comedian who stutter, but let's say Miguel says, "You know, hey, I really like this lady, "She kind of fits my philosophy "of what's it's like to stutter. "Hand do her book or an article about her work," and I gave you that citation. And then Mary says, "Okay, well thank you, Miguel, "but you know, you need to seek out "speech-language pathology services for your stuttering,

"and then if you could just show us some proof "that you've done that, that would be great." And hopefully your blood flow is reversing on that one too because that's a big problem. So I wanted to ask you, last survey, let's do this one. What would you do? So the survey is what are you gonna do? While the answers are popping up, I'm reading about a student, from Julian, just reading that one here for a question. Shy. Okay good, so some of these are respect autonomy. There's a justice, I think respect autonomy is a big ethical issue but justice is a big issue here because we have a power relationship, right? So it's like we're taking someone who we should've respected. If this was ADA and it was an employer, if this was an employer saying this to an employee, we would be in more of a legal situation. But because this is a supervisor and a graduate student and they think, "Oh you got all this opportunity "to go get your own therapy," yes, it's autonomy, but on top of that, I think it's really justice. So some of you are saying you would educate the person about the respect for patient autonomy, inappropriate for the supervisor to demand he get treatment, absolutely.

Good answers, be encouraging to him about, I would even say, learn from what he's doing, take a step back, Mary, and he's got this about his stuttering, he's okay with it. You know, he's ready for the patients in the, let's say it's a medical setting, he's just learning to work with people in medical setting. If they have questions about his stuttering, they can ask, right? The stuttering's not getting in the way of his ability to communicate, he's cool with it, so to speak. But if this was an employer saying this to an employee, it would be ADA kinda time, whether they blow the whistle on them or not. I'm reading a, because there's barely time for questions, last couple of minutes, but Julian has a question about a referral, where no stuttering was observed in the screening, but the student insists that she is stuttering and needs help talking. And that can happen, I wonder, Julian, if that client might be covert in nature, like showing some stuttering only in certain situations, but she's only heard about the difficulty from her family. So it's a good question about, and this is a student at a young age, preschool, kindergarten. So I wanted to just end with any other questions, I know we are wrapping

up for time. I hope that you've learned a little bit more. Sorry, the main ethical dilemma in that last case would be justice because of the power relationship, I wanted to be clear on that. Yes, respect for autonomy does come into play on that one, but remember, the autonomy would be taking care of, if he was an employee. And again, I'm not a lawyer, some of you might email me later and debate it a little bit, there's many areas of gray in ethical dilemmas and I think here that it's the fact that it's a power relationship, he feels, is he gonna be able to advocate for himself to a supervisor? Likely, he's gonna return to the university clinic and ask one of us what to do, and that happened in this case, so. Other questions? I see that we've had some great comments from the participants, for sure today, really good information from all of you, and we learn from each other, right? That's what's wonderful about this field. Okay so I am looking at the time and get it wrapped up a little bit to go, thank you so much.

- [Carolyn] Thank you so much. Dr. LaSalle, we're getting so many comments in the Q and A saying thank you, thank you, great course, great information, and for all of our participants, thank you for participating in those questions that Dr. LaSalle put up. I just think it's great to hear from all of you as well. Dr. LaSalle, we very much appreciate your time and expertise and hope to have you on speechpathology.com again soon, and for everyone today that's earning CEUs, just a reminder to take your CEU exam before it expires and your pending courses on speechpathology.com, and we hope to have you in another webinar again soon as well. Have a great day, everybody.

- [Lisa] Great, thank you so much, Carolyn, really appreciate it, and thank you to all the participants, thanks.