Helping The Clutterer: Therapy Considerations

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Overview

Cluttering is a disorder of speech and language processing resulting in rapid, dysrhythmic, sporadic, unorganized, and frequently unintelligible speech. Accelerated speech is not always present, but an impairment in formulating language almost always is. Landmark contributions describing individuals with such speech and language disturbances have been written by Arnold (1960), Luchsinger and Arnold (1965), and Weiss (1964). This disorder is distinct from stuttering per se although often the two disorders occur concomitantly (Daly 1986). This issue is treated in all of the chapters in this volume.

Three symptoms predominate the diagnosis of cluttering, according to Weiss (1964). They are excessive repetitions, exceedingly short attention span, and lack of complete awareness of any difficulty. Numerous associated, or facultative, symptoms, such as rapid rate, reading difficulty, jerky respiration, and motor discoordination are described in the cluttering literature reviewed by Weiss. Of all the associated symptoms identified in the literature, reading disability is the most prominent. Interestingly, Weiss even suggests that a reading disability may substitute for a decisive diagnostic sign when other conditions make a diagnosis uncertain.

Considered to be rare by many North American speech-language pathologists, cluttering has been identified more frequently over the last several years. This increased prevalence is related, we believe, to the large number of children and adolescents being identified as learning disabled (LD) or attention deficit disordered (ADD). Heredity plays a prominent role in most cases of cluttering (Luchsinger & Arnold 1965), just as it does in most LD and ADD youngsters (Lerner 1989). After working for many years with children and adults who demonstrate cluttering, LD, and/or ADD, it is my considered opinion that all three problems are related to congenital language disabilities.

I saw very few clutterers during my years as a school clinician and a medical center speech pathologist. However, for eight summers in the

1970's I directed the University of Michigan's Shady Trails residential summer speech camp designed primarily for stutterers. Clinicians from across the country would send their most difficult cases to our intensive six week program. Four therapy sessions a day were provided. Many of the youngsters we treated for stuttering problems also showed associated language, memory, motor, and articulation difficulties. Data we collected indicated that about 24% of the stuttering youngsters referred clearly were clutterers or clutterer-stutterers (Daly 1981). These cases resembled the Track II stutterers described by Van Riper (1971) in his longitudinal classification system.

Such cluttering youngsters do indeed exist, and I believe their number is increasing. For the last 12 years I have operated a private practice specializing in stuttering and cluttering disorders. Stutterers comprise the largest group we treat, clutterer-stutterers are the next largest group, and pure clutterers are the smallest group. Memory activities, language therapy, oral-motor coordination activities, and awareness training are necessary treatment components for the latter two groups of clients. These components are described in this chapter.

The primary intent of this chapter is to provide the reader with meaningful and practical therapy procedures found useful for cluttering clients. It is important to note that some cluttering clients do not recognize that a problem exists, while others are only partially aware. More than other clients we have worked with, cluttering individuals benefit from highly specific, short-term goals. The attention span impairments contribute in part to the challenge; however, clinical researchers have long commented on the negative attitudes and resistances of cluttering clients. A definite plan is recommended. Strong clinicians are needed to explain the plan of action to be followed. In addition, clinicians are urged to be prepared, positive, and persistent.

Diagnostic Suggestions

Noteworthy factors which set clutterers apart from stutterers are their apparent lack of frustration or nervousness about their speech, their time of dysrhythmic speech onset, and a consistently disfluent history (Daly 1986). Typically mothers of clutterers have told us that their child was never fluent. Unlike their stuttering counterparts, cluttering youngsters typically experience no sustained period of normal fluency. Speech and language

development are delayed and frequently disorganized. Repetitions (sound, syllable, word, and phrase) are exceedingly common, whereas sound prolongations and mouth fixations are rare.

Thus, clinicians must probe thoughtfully during the interviews with parents and teachers. How does the child react to his speech breakdowns? Does he get teased? And, is he upset easily by listeners who ask him to repeat? (Indications of frustration or avoidance may be of diagnostic significance as they reflect awareness or anxieties which are uncommon in clutterers.) Historical information from parents also is important. When exploring familial possibilities we ask, "Does your child's speech resemble anyone else's in the family?" because heredity has been reported to play a more prominent role in cluttering than it does in stuttering (Luchsinger & Arnold 1965). In addition, the interview should explore developmental milestones and note any delays in speech, language, reading, and motor abilities.

In view of clutterers' tendency to speak rapidly, a careful analysis of disfluencies is necessary. Some clinicians (e.g., Sheperd 1960) suggest an exact written transcription of the clutterer's utterances. Detailed transcriptions allow the clinician to unravel exactly what clients are doing. Because accelerations, repetitions, substitutions, distortions, and deletions of sounds and syllables in the client's speech, detailed audio-analysis is a worthwhile procedure. This time-consuming task may be especially true for some of the more unintelligible clients.

We are reminded that Weiss (1964, p. 1) regarded cluttering as the "verbal manifestation of a Central Language Imbalance." He maintained that all channels of communication (e.g., reading, writing, rhythm, and musicality) may be involved. The only way we know to determine if language is involved is to formally test the various language abilities. If weaknesses or deficiencies are found, then language therapy should be planned as an integral part of the overall treatment plan. Story telling activities and sequencing activities may be necessary.

Over the years we have noted an interesting phenomenon. As our clutterers become more articulate and fluent in therapy, there is a tendency for more word-finding problems to emerge. We are currently collecting data to test our hypothesis and invite other clinical researchers to join us in this area of inquiry. Word-finding difficulties are also discussed in Chapter 6 by Myers and Bradley.

Another dimension of cluttering which must be assessed is attention span.

Weiss (1964) listed concentration and attention span as one of his three obligatory symptoms. Memory deficits are considered by numerous researchers (e.g., Riley & Riley 1980; Daly 1981; Tiger et al 1981) to be quite common in stutterers. We take the position that attention and memory abilities also must be explored and evaluated with cluttering clients. Many memory test batteries are commercially available. We have collected data on immediate auditory memory abilities using a sentence test developed by Ostreicher (1973) while at the University of Michigan. An experimental version of the sentence imitation test and our findings (Daly et al 1981) on normal children ages four through 18 years may be found in the Appendix to this chapter. While Ostreicher originally constructed the sentences for use with elementary school-age children, we have found this sentence imitation task appropriate with adolescents and young adults. Although the language and linguistic complexity of the sentences may be limited, we have never had any high school- or college age- students question our sincerity when trying to determine their strength and weaknesses with this test. Clinical experience over the past ten years suggests that when youngsters are two or more years behind their peers on this sentence imitation memory task, specific activities to teach memory strategies are warranted. Whatever diagnostic measure clinicians decide to employ, the clutterer's memory abilities and attention span should be evaluated.

Disorganized breathing patterns are common and should be analyzed. Luchsinger and Arnold (1965) point out that all observers have stressed the clutterer's dysrhythmic speaking and reading patterns. We suggest that clients read aloud standard paragraphs and timed monologues so that comparisons with fluent speakers can be made. We concur with Froeschels' (1946) observation that clutterers' dysrhythmic respiration accounts in part for their jerky and explosive speech patterns. Analysis of timed vowel productions also afford an examination of respiratory control. We use Wilson's (1979) guidelines of 20 seconds for adults and 10+ seconds for children's sustained vowel productions as a gauge of adequacy. Breathstream management procedures may be utilized if warranted.

Concomitant articulation disorders are prevalent in cluttering. Detailed testing is recommended. Common error patterns include the telescoping of consonant combinations into single productions (Sheperd 1960) or the addition of filler syllables (Weiss 1964). Testing to ascertain whether the clutterer is apraxic (Seeman 1966) or shows motor dis-coordination (de

Hirsch 1961) is recommended. Use of video-tape analysis to increase client awareness of correct and incorrect productions has proven helpful (Daly 1987).

Treatment Suggestions

Speech Rate Modification

Many clutterers speak too fast. We have found the delayed auditory feedback (DAF) device most helpful in reducing their rate. As with their stuttering counterparts, the DAF assists clutterers in coordinating the respiratory, phonatory, and articulatory aspects of speech (Perkins 1973; Perkins et al 1974). As will be noted in the next section we also use the DAF device to heighten the client's awareness of his rate. Some cluttering clients do not like wearing the headphones and listening to their artificially slowed rate. Some will present innovative excuses for taking the headset off and try to avoid use of the DAF. While we appreciate their creativity, we "stick to our clinical guns" and insist that clients put the headset on and continue with the treatment plan. Because it is possible to "beat" the DAF even when hearing it, we strongly urge the client to cooperate and let the device help them adjust their rate of speech. We recommend wearing the DAF for four or five sessions. This allows the client to experience slower speech rates at each of five delay settings: 250 msec., 200 msec., 150 msec., 100 msec., and finally 50 msec.

Self-monitoring variations in rate without the DAF is a critical next step in fluency training for cluttering clients and has proven to be highly valuable. Clients are directed to self-monitor their rate by using pluses and minuses on evaluation sheets which then can be utilized to facilitate the transfer of monitoring skills outside of therapy (See Daly 1988). Burk (1986) suggested the use of an audio tape illustrating different rates to help clutterers distinguish various rates of speech. After the DAF training, we make each client a rate tape too. Our clients report that listening to themselves speak and read at various rates helps them identify when they are speaking "off-target."

Structured therapy materials help to keep the client at the target rate during the early phase of treatment. We utilize Froeschels (1946) technique called "window reading" in which he had clutterers read words aloud one word at a time. The clutterer places a paper with a hole in it over reading

material and reads only the word visible through the hole. We typically start this phase of treatment by requiring our clients to read word-pairs, that is, two-word combinations arranged for number of syllables per word. Specifically, the first list of word-combinations would consist of one syllable words, the next list would consist of two-syllable words, and so on. Length of utterance is controlled and increased only after a success rate of 90% accuracy is achieved. (See Daly 1988 for structured therapy materials and evaluation forms).

Because many clutterers speed ahead at commas and periods when reading aloud, rather than use the punctuation marks to pause and take a breath, we have found that punctuation marks are convenient indicators for helping clutterers modify their aberrant breathing habits.

Use of specifically designed phrases and sentences help clients control their length of utterance and breath support. Structured therapy materials are utilized prior to introducing conversational speech or monologue. Clinical experience suggests that use of structured oral reading exercises facilitates faster progress on spontaneous speech, positively effects the client's intelligibility, and allows the clinician to maintain control over the therapy process and over verbose and reluctant cluttering clients. An additional benefit of employing sentences of specific length is that this strategy helps control for an optional feature of cluttering which Wohl (1970) described as "festinating," i.e., speech that becomes faster and faster as it proceeds. Luchsinger (1963) reported that clutterer's tendency to accelerate the rate is proportional to the number of syllables uttered. As the client practices material of controlled length, he produces clearer, more fluent speech. The improvement should be recorded and pointed out to the clutterer who may be unaware of any difference. Small changes as well as large changes in performance must be highlighted for each client. The importance of increasing client awareness is discussed in the next section.

Increase Client Awareness

In his excellent chapter dealing with disfluent mentally retarded clients, Cooper (1986) asserts that every attempts should be taken to teach clients the "language of fluency." He contends that meaningful progress in therapy is unrealistic until the client establishes basic language which allows a discussion of fluent versus disfluent speech. Specifically, Cooper wrote, "conditioning procedures eliciting fluent speech appear to have little lasting

effect unless clients are capable of verbalizing the goal of the procedure and their desire to achieve that goal" (1986, p. 146). We believe clinicians should tell cluttering clients what they are doing and why. Client awareness of the goals and purposes of treatment may be heightened in a variety of ways.

Video-tape Playback

The old saying "One picture is worth a thousand words" is frequently true for cluttering clients. We have found that showing them a video-tape of their disfluent, jumbled speech often helps them immediately see their disfluencies as others see them. This is not true for everyone; some clients ignore the showing of themselves on video-tape. For these individuals, we suggest repeated viewings, pointing out specific unintelligible utterances or repetitions.

We have also found that comparing segments of disfluent versus fluent, clear speech is a very powerful technique. Following several viewings and discussions in therapy we suggest that the client take the video-tape home for periodic viewing there. This procedure is described more fully elsewhere (Daly 1987).

Clutterers need more than verbal encouragement and reinforcement. Neurolinguistic researchers (e.g., Bandler 1985; Robbins 1986) maintain that only seven percent of a person's communication is transmitted through words. Their research suggests that 38% of a person's communication is transmitted through vocal intonation patterns. Clinicians should be most interested in their finding that 55% of our communication is transmitted via our physiology, that is, such behaviors as head nods, eye contact, smiles, frowns, body position, and breathing. The physiological components or "body language" feedback the client views via video-tape may be exceedingly important. Clinicians are encouraged to repeat viewings five or six times.

Audio-Tape Analysis

Contrasting segments of speech just recorded in therapy with a client's anchor (rate controlled) tape (discussed earlier) is often beneficial. This comparison technique may be most useful after the client shows increased awareness as therapy progresses. Again, just because initial efforts do not seem to achieve the desired results, the procedure should not be abandoned. The clinician should not hesitate to repeat the comparisons illustrating improvement five or six times as repetition is necessary with

clutterers.

Delayed Auditory Feedback

As described earlier, we are in favor of using the delayed auditory feedback (DAF) device not only to reduce rate but to heighten awareness of the tempo of speech. Clients do not always like the delayed auditory feedback, but tachylalia (rapid rate) is a prominent feature of this disorder. Many speak too fast relative to their own abilities, as noted by Myers in Chapter 4. Whether the clinician elects to use or not use a delayed auditory feedback device is not important. But, if a rapid rate is part of the overall clinical picture, we believe the client must be made to recognize it.

Vibro-Tactile Feedback

Recent developments now allow us to incorporate the sense of touch or tactile sensation with clutterers. It is now possible to accentuate or heighten a client's tactile sensation electronically with a vocal-feedback device developed at the University of Pittsburgh by George Shames (1989). This device facilitates fluency by placing a transducer on the laryngeal area. The client then "feels" his or her vocal folds vibrating smoothly during speech. Heightening the client's awareness to the tactile modality has much potential. Shames has used this device successfully with stutterers; we have found its use equally effective with our cluttering clients. We believe that every possible modality should be utilized to help clutterers achieve control over their fluency.

Cognitive Training

One of Van Riper's (1975) insightful recommendations to clinicians is that we must deal with more than just the speech of the stutterer. In view of the clutterer's limited awareness problem and often noted reluctance to take therapy seriously, cognitive training is equally necessary for clients who clutter.

Counselling and Attitude Change

In my 25 years as a clinician, I have seen very few adolescent or adult clients who convinced me that they did not care about what listeners thought about their speech. One exception was a salesman sent to me by his employer who complained that prospective buyers reported they could

not understand the man. Even though the employer was willing to pay for therapy, the cluttering salesman quit rather than enrol in treatment.

I am convinced that most people care what other people think, and furthermore that most clients care deeply. Some of our clients have suffered with attention deficits (with or without hyperactivity) for all of their lives. Data from special education specialists (e.g., Wallace & McLoughlin 1988) suggest that as many as one-half of hyperactive youngsters (many of whom have learning disabilities or cluttering-type language and speech problems) do not outgrow their hyperactivity at puberty. They grow up to be hyperactive adults with disabilities. What clutterers with such problems need from speech-language pathologists is our understanding, along with persistence, patience, and a positive attitude.

We believe that one of the clinician's tasks in therapy with clutterers is to help them discover alternate methods of dealing with their problems. First,clients must increase their awareness of themselves. As therapy progresses, we add group sessions to our individual treatments. Group meetings are used to help individual clients take their focus off themselves. Each client is asked to analyze another's speech and to make a positive comment following that person's speaking assignment before the group. We intentionally focus on the positive. At first, some clients cannot think of anything positive to say. Clinicians must learn to remain quiet during these silent pauses in therapy. Some clutterers have become rooted in a negative frame of mind. We believe this attitude must change before any permanent progress will be observed. Complimenting another speaker may seem strange at first; accepting compliments from others is even more difficult for some clients. Actually, when a clutterer does sincerely give or accept a compliment during a group session, we encourage all the other members of the group to applaud. We want to reinforce this new behavior and to let the person know that he or she has just done something significant. Such physical demonstrations as clapping, head nodding, and verbal approvals are necessary for the possibly unattuned cluttering client.

We have reported elsewhere (Daly 1986) that some cluttering clients are compulsive talkers. We need to change their awareness level and reinforce them for turn-taking during conversations. It is not uncommon to hear us say in therapy, "Thank you for listening." For some clutterers, listening skills must be taught. Clinicians who are not familiar with Scott Peck's (1978) book, **The Road Less Traveled**, will find his discussion of the importance of listening most instructive.

Most clients come to us because they are stuck. They want to be rid of the repetitions, slurring, frustration, and tension that accompany many of their speech attempts. They want to speak without the puzzled looks of listeners, who are sometimes amused and confused with their best efforts to communicate. Perhaps even more than his stuttering counterpart, the clutterer needs someone who cares so much that he will continue to seek our help despite his claims that his speech really does not bother him. Clinicians are reminded that counselling is part of what we do. Dyer and Vriend's (1977) book, **Counselling Techniques That Work**, may prove helpful to clinicians who desire more background in this area. During counselling we listen, reflect, clarify, and help our clients identify choices that they may wish to make. Wise clinicians know that it is the client who must make the decision. As Shames and Florance (1980) so aptly suggest, every time we make a decision for a client, we deprive him or her of the opportunity for growth. Therapy is about growth.

Relaxation and Mental Imagery

Our experience suggests that some clutterers, but more often clutterer-stutterers, exhibit signs of stress and frustration. As with stutterers, such clients frequently benefit from instruction and practice with relaxation techniques. Herbert Benson (1976) offers a simple, yet most informative discussion of stress reduction in his book, **The Relaxation Response.** Although some sections are somewhat technical, we recommend that many of our adolescent and adult cluttering clients read it. For those clients who appear to be too impatient to read it, or they do not think that such information applies to them, we go over the information during therapy. We use examples from successful business people or sports celebrities described by such authors as Porter and Foster (1986) who report great success using relaxation exercises during their work day or before important sporting events.

We instruct our clients on breathing exercises and verbally instruct them to feel themselves relax. We take a few minutes during therapy to assist our clients in assuming a comfortable sitting posture. We ask our more tense and stressful fluency clients to maintain a period of "stillness" during the five minutes or so when we guide them into a more calm, relaxed state. During these instructions we suggest that more relaxation may be experienced if the client separates his teeth slightly, as it is difficult for anyone to relax while clenching the teeth. Exact scripts which clinicians may

read aloud to clients while they attempt to relax their breathing and muscles may be found in Benson's (1976) book and in our therapy program for stuttering clients (Daly 1988). As in other aspects of therapy with clutterers, repeated practice is important.

For many clients, we tape record the first relaxation session. The primary purposes of the cassette tape are 1) to guide them into a more relaxed frame of mind and 2) to help them relax within a relatively short period of time, usually about five minutes. Later the client continues to practice with his relaxation tape at home. Eventually the goal is for the client to learn to relax himself independently without listening to a tape. Then, whenever the client has a few minutes and feels the need to relax, he is able to do so. Many clients report lowering their stress levels (and their rate of speech) by using relaxed breathing or calm relaxation during activities which previously heightened tension. Moreover, the ability to relax is critical in order that maximum benefit from the next segment of cognitive training, mental imagery, be realized.

Waitley (1983) has conducted research with hundreds of highly successful athletes, business executives, POWs and scientists. He discovered that one of the characteristics these successful people had in common was an ability to mentally rehearse events before they happened. They had learned to "pre-play" their future successes before they occurred. These people reported practicing visually imaging themselves achieving their goals long before they actually happened. Maltz (1960) described this phenomenon 30 years ago in his classic book, **Psycho-Cybernetics**. He presented strong evidence to indicate that people who really want to change, must first see themselves in a new role before they could accomplish the change. Lazarus, who first gained prominence as a behavioral psychologist (Wolpe & Lazarus 1966), later wrote, "behavioral methods alone are often insufficient to produce durable results" (Lazarus, 1971, p 11). In his 1984 book, **In The Mind's Eye**, Lazarus emphasized that the person who wishes to accomplish something in reality must first picture himself or herself achieving it in the imagination.

We have observed that clutterers often imagine themselves failing. We frequently hear comments such as, "I can never say that word; it has four syllables," "Slowing down doesn't make any sense," or "I hate to read aloud; people say they can't understand me." Clutterers frequently can see themselves speaking and reading aloud in the future clearly enough. The problem is that they pre-play failure, and then they execute the self-fulfilling

prophecy. Our task is to help the clutterer see himself speaking more intelligibly and fluently. Clients must believe in the possibility that they can succeed. They must realize that mentally rehearsing positive outcomes does effect future results. Daly et al (1985) reported on the successful use of imagery techniques with an adult clutterer. We have incorporated such cognitive procedures with both clutterers and stutterers for several years and find them essential components of our complete therapy program.

Training in Positive Self-Talk and Affirmation Exercises

Behavioral researchers maintain that humans talk to themselves at rates well over 1,000 words per minute (e.g., Helmstetter 1986). That is impressive when we recall that humans speak at rates of less than 200 words per minute typically around 140-160 words per minute (Fairbanks 1960). Equally amazing is the assertion by some authorities (Helmstetter 1986) that about 75% of what we think is negative and actually works against us. Negative self-talk leads to negative self-images which eventually leads to learned helplessness. Positive self-talk is a relatively new strategy that has been gaining acceptance by psychologists and leaders of the neurolinguistic programming approach (Bandler 1985; Robbins 1986; O'Connor & Seymour 1990). Meichenbaum and Cameron (1974) were among the first researchers to use these techniques, and they reported good results by helping clients modify what they say to themselves. Helmstetter (1986, 1987) presents more recently designed, easy-to-learn, practical procedures for changing a person's self-talk.

We have been utilizing relaxation, mental imagery, positive self-talk, and affirmation training with both children and adults with fluency disorders for the past several years. Our clinical impression is that these cognitive strategies are most useful. First, we increase clients' awareness of their negative internal self-talk. Next, we help them substitute positive self-talk for their old negative patterns. Basically, this is accomplished by having our clients practice aloud and silently specific phrases and sentences that we have prepared together. Finally, we follow Van Voorhees' (1987) recommendation of teaching them to write their own affirmation statements and to practice reading them aloud three times a day.

An affirmation is a sentence or statement of truth which typically is not true when it is written, but rather is something one wants to be true in the future. Writing affirmations is like writing goals for the future. The

difference is that the affirmation is worded in such a way that it appears to be true in the present. The objective of writing affirmations is to convince the subconscious mind through repeated readings of the affirmation that the statement is already true.

We help our cluttering clients write specific sentences on index cards. They are written in the first person, present tense, using positive language. Some examples are:

> "My eye contact with listeners is good. It feels good to keep my speech moving forward smoothly by remembering to use just the right amount of air, voice, and movement."
>
> "I enjoy using slower, smooth starts when I initiate speech inclass. I really like being understood because I concentrate on my articulation and fluency."
>
> "Each day I express my ideas more clearly. I know that I can speak clearly in any speaking situation by being in control of my speech."

What people think is influenced by the words they use. Whenever we hear a client make a self-degrading statement, we stop him and ask him to rephrase the statement into a more positive fashion. Furthermore, the clutterers read the positive statements aloud a minimum of three times a day with as much emotion as possible. The goal of this technique is to have the new positive oriented statements imprint into the mind. Repetition is important, but researchers (e.g., Van Voorhees 1987) maintain that the stronger the emotion, the more likely the client's subconscious mind will work to make the statement come true.

It is important to note that some clinicians may feel uncomfortable using the aforementioned cognitive procedures. I have studied these techniques and have been using them for the last several years with many disfluent children and adults. I am very impressed with the clinical outcome and highly recommend them in dealing with clutterers. The question which arises is "How much time should the clinician devote to cognitive training?" The best answer seems to be, "It depends on the client and where we are in therapy." For some, who warrant it, I may provide counselling as a part of nearly every therapy session. For others who understand the rationale for

the procedures, my role is similar to that of a coach: to instruct, support, and reinforce correct responding. I provide information and encouragement when it seems appropriate. For other clients, I first provide instruction and modelling, and then I get out of their way. My use of counselling techniques depends on the outcome of our sessions, that is, whether the clutterer is making progress towards our goals. Sometimes such decisions have empirical or logical rationales; other times, they resemble clinical hunches or intuition. I always try to ask myself the question Van Riper (1975) framed many years ago, "What does this client need from me right now?"

The amount of relaxation a clinician may choose to emphasize in therapy also depends on the client. Knepflar (1986) reported use of relaxation with fluency clients whose neck muscles had increased their neck size two inches because of tension. Others may appear to need a minimum of relaxation procedures. The rate of their speech and the amount of tension observed throughout the body are good signs. Another way to determine the amount of their tension is to ask them directly. But, if relaxation procedures are considered, then we suggest daily practice until the technique is mastered. The relaxation exercise we employ take five to seven minutes. It is long enough to effect a good response, and it is short enough to realistically use on a daily basis. We remind our clients of Waitley's (1983) data indicating that successful people he studied used the relaxation response daily to help them maintain a high level of performing.

Maintaining a Daily Routine

Positive self-talk and affirmations should be conscientiously practiced several times a day. As noted above, we recommend three times a day; once early in the morning, once sometime during the day, and once more just before retiring. Nevertheless, conditions do not always permit strict adherence to our schedules. We have found that guilt provoking is not good therapy. When a client confides that he has not been able to practice as frequently as was agreed, we restate the goals and the rationale for practice and accept that interfering events do occur. We simply agree to start again and to follow the plan, reminding the client that successful people "plan their work, then they work their plans."

Summary

Clinicians must deal with the multi-faceted nature of cluttering. We believe that treatment should address whatever deficits are identified. This chapter has focused on the three cardinal symptoms of cluttering; excessive repetitions, short attention span, and lack of complete awareness. Our clinical experience suggests that direct treatment procedures attacking all aspects of the problem are most effective. Clinicians must emphasize strategies which heighten the clutterer's awareness to therapy goals. The advice the older, proficient minister gave to the young minister planning his sermon seems pertinent here. First, tell them what you are going to tell them, then tell them, then tell them what you just told them. Finally, the importance of repetition and persistence when working with cluttering clients cannot be overstated.