ABSTRACT: A crucial factor in the process of therapeutic change is the competence of the clinician. A necessary characteristic of the effective clinician is the ability to understand the client's experience. This understanding is essential for making accurate and timely clinical decisions and for validating the effectiveness of our treatment. Can a nonstuttering clinician fully understand the stuttering client's experience? This article advocates for the importance of understanding the phenomenon of stuttering from each client's perspective and suggests ways that nonstuttering clinicians can inform themselves about the experience.

KEY WORDS: clinician, treatment, empathy, effectiveness, outcome

As a student, I never took a course devoted solely to the topic of stuttering. As I matriculated through my master's and doctoral programs some three decades ago, the schedule never seemed to work out. Apparently, I was way ahead of the trend. Beginning in 1993, the American Speech-Language-Hearing Association (ASHA) no longer required students to take a stuttering course. On the other hand, as a person who stuttered since my elementary school years, I had received some intermittent therapy, and following college, intensive treatment. It was not the same as taking a course,

but at least I had a sense of what therapy was about and what it required. And, of course, I also had a good understanding of what it was like to be someone who stuttered.

Over the years, I have often thought that not taking a course on stuttering may have been a positive thing. Depending on who taught the course and the text used at the time, I might have been biased by a particular view or developed a narrow approach to the phenomena of stuttering. I may have proceeded to treat people who stutter (PWS) with a religious zeal reflecting a dogmatic view that I was following ‘The Way’ to think about stuttering, the people who do it, and how to help them.

What I did have was my lived experience and my understanding as I learned to survive on a daily basis as a person who stuttered. I knew about the culture of stuttering, and it helped me understand others who were more or less on the same journey. I knew, for example, the power of denial. I understood all too well the things I would do to hide, avoid, or disguise my stuttering so that it would fail to reach the surface and no one would know. I could be completely fluent for my listeners if I did these things well. I also knew that even the possibility of stuttering influenced my decisions about choosing sounds and words, participating in the classroom, using the telephone, and talking with friends and acquaintances. I had some “street smarts” about my problem. From what I could tell, only other PWS knew such things.

During my brief forays into and out of therapy, I found it surprising that few of my clinicians seemed to understand these aspects of the stuttering experience. Or, if they did, they did not communicate that understanding to me. I was impressed that the clinicians who contacted me seemed to be genuinely nice people who wanted to help. They had a lot of information about stuttering, certainly more than I did. They knew the names of people in the field, the theories, the terminology, and the techniques that were...
popular at the time. They clearly knew the textbook information that I had not been exposed to. In short, they knew a lot about the surface features of the problem.

The clinicians who tried to help me were able to count the moments of my stuttering and place the surface features into categories of repetitions, prolongations, and blocks. They highlighted my avoidance and escape behaviors. They were able to tell me, even once in a while, how to perform certain techniques for improving my fluency. They gave me assignments to practice during the treatment session and at least attempt to do outside the security of the therapy room. On a few occasions, they went with me and modeled these activities. But, most of my clinicians did not seem to understand my experience of stuttering. I felt that I was up against a monumental and intimidating force, and I was not having much success.

Even though the therapeutic techniques that were used with me resulted in speech that sounded and felt even stranger to me than my stuttering, they were sometimes useful. But techniques did not solve my problem. I still felt helpless and alone. I was terribly frustrated because I knew that I had things to say, but I did not know how to communicate those thoughts with any skill or confidence. If others, including my clinicians, had some sense of my predicament, no one was willing or knew how to tell me. Given the advice clinicians received during their academic programs at the time (this was the 1960s), maybe they were fearful of discussing anything that seemed deeper than the obvious, surface features of my problem. Whatever the reasons, because they did not seem to understand my experience, it was easy for me to turn away from therapy, particularly during my teenage years. And, of course, I was not yet desperate enough to face my problem head on.

Later in life, when I was in my early 20s and had graduated from college, I was desperate. I knew I needed help and I was serious about finding it. To my good fortune, I was able to find clinicians who conveyed a better understanding of the stuttering experience and a deeper appreciation of the task I faced. One of the things that hooked me on the treatment process at that point was the way these clinicians conveyed their understanding of my problem and the gauntlet I would be asked to run. It may be that I would have run it anyway, even without their understanding, for I was serious about changing. But, it was wonderful that they were able to demonstrate the empathy (not sympathy) that only comes from such a level of understanding.

In order to have empathy for someone who is in a particular situation, it is much easier if you have been through a similar experience. Empathy has been described as understanding without judgment (Egan, 1998) and has been strongly associated with the ability of the clinician to develop a working alliance with the client (Wampold, 2001). It is not easy to share an unpleasant experience with another. But, the sharing of these experiences (loss of a loved one, divorce, illness, termination of a job) allows for a more natural and intuitive response than would otherwise be possible. An unfortunate but natural part of life is that we will all have many opportunities to involve ourselves in such experiences. Having been on the same or a similar journey as another provides us with a perspective as we try to respond with understanding and support. It is helpful to recognize that on these occasions, it is not our task to fix anything. Often, it is not necessary for us to do or say much. But, what we can do is listen and indicate our understanding.

The understanding that results from living a similar experience is a handy thing to have in a helper’s repertoire. Of course, most speech-language pathologists do not stutter and therefore do not have this shared experience. So it is entirely possible that a client who stutters will challenge you by saying something that I wish I would have said to some of my clinicians: “You don’t stutter so you don’t understand!” Will they be correct? How will you respond when someone you are trying to help says that to you? Your response is what this commentary is about.

---

**NOT EVERYONE UNDERSTANDS**

Nearly everyone who is not a professional speech-language pathologist is likely to have naïve and sometimes negative views of stuttering and PWS (e.g., Craig, Hancock, Tran, & Craig, 2001; Collins & Blood, 1990; Klassen, 2001; St. Louis & Lass, 1981; Van Borsel, Verniers, & Bouvry, 1999). This is not surprising because unless the listener personally knows someone who stutters, he or she is unlikely to have any experience with the phenomenon. Some lack of understanding about stuttering may even be reasonable for clinicians who specialize in other communication disorders. For example, I know very little about dysphagia or literacy. But, if you want to work with and help PWS, particularly if you want to specialize in the area, it is essential to understand the phenomenon. Unless you do, it will be difficult to make timely and useful clinical choices.

It is possible, I believe, for a clinician who does not have an extensive understanding about stuttering to help someone who stutters. Assuming that the clinician possesses basic clinical skills and is desensitized and unafraid of stuttering, the clinician is likely to provide help to a preschool child. Although less likely, clinicians who do not possess a particularly deep or sophisticated understanding of stuttering can successfully assist adults who are not dramatically impacted by their stuttering. For example, the clinician can show such individuals how to decrease their patterns of avoidance, increase their ability to produce speech in a more efficient and fluent manner, and smooth their patterns of stuttering. Sometimes, that is all it takes. But many children and most adolescents and adults who stutter will require considerably more understanding and help.

Based on more than 30 years of interacting with people and programs around the country as a clinician, researcher, author, and site visitor, I believe that there are people providing clinical service, and in some cases conducting research and writing about stuttering, who do not fully understand the phenomena. There are a variety of ways that individuals communicate this lack of understanding. They may suggest that they have “the answer,” often a
reasonably simplistic one, about the cause of stuttering. Even more likely, they tend to state that they know how to “fix” stuttering, again, often with a simplistic approach (e.g., talk like this, breathe like this, wear this device). They may suggest that their “method” will result in success for the vast majority of people who sign up for their approach. They may imply, often not so subtly, that others are mistaken in their views, and that other approaches are obviously ineffective. They tend to use assessment measures that focus exclusively on the surface features of the problem, particularly the frequency of stuttering events without regard, for example, to the quality or form of the stuttering. I offer these examples because, in my opinion, there is no simplistic or single explanation for the cause of stuttering. There is no one approach that works equally well for all individuals. It takes time, and often some focused effort, to normalize speech fluency and to facilitate the necessary cognitive changes that take place. The frequency of stuttering, while sometimes important, is but one feature and often far from the most central one.

On the other hand, clinicians and authors who understand stuttering tend to say things like the following: “I’m not certain what causes stuttering, but I can suggest many helpful responses.” “I don’t know how fluent you can become but, together, we can find out.” “Yes, we want to help you alter the frequency of your stuttering, but that is only one aspect of the changes we want to help you make.” “I have many suggestions that may be helpful to you, but you are the best judge of whether treatment is helpful.” “An increase in the frequency of your stuttering may actually be a good indicator if it coincides with a decrease in your avoidance behavior.” “It is possible to stutter and be an extremely good communicator.”

THE QUALITY OF INSTRUCTION

I suppose it is heretical to say so, but not all instructors have an acceptable level of understanding about the nature of stuttering and those who do it. Students may gain some understanding of the stuttering phenomena in spite of unsophisticated instruction, but, more likely, they will be mystified and turned off. This problem is not a new one, and there are many studies over the years that indicate the poor level of preparedness that many of our students have in the area of fluency disorders (Brisk, Healey, & Hux, 1997; Kelly et al., 1997; Mallard, Gardner, & Downey, 1988; St. Louis & Durrenberger, 1993; Yaruss & Quesal, 2002a). For example, Yaruss and Quesal surveyed 159 ASHA-accredited graduate programs and found that nearly one quarter of programs (22.6%) allow students to graduate without course work in fluency disorders. Of the 152 programs responding to practicum requirements, just less than two thirds permit students to graduate without any clinical diagnostic (63.3%) or treatment (64%) experiences with individuals who stutter. Yaruss and Quesal summarized their overall findings by reporting “a trend toward fewer required classes taught by less experienced faculty, fewer clinical hours guided by less experienced supervisors, and a greater likelihood that students will graduate without any academic or clinical education in fluency disorders” (p. 58).

Exacerbating the problem is the increasing shortage and difficulty in recruiting tenure-level faculty. According to the Joint Ad Hoc Committee on the Doctoral Shortage, Council of Academic Programs in Communication Sciences and Disorders (Oller, 2002), there were 50 unfilled tenure-line positions in 1998 and nearly twice as many in 1999 and 2000. Although there are no data specifically for faculty positions in fluency disorders, the fact that students are not required to take courses or clinical work in stuttering, combined with the ever-expanding scope of practice in our field, makes it less likely that instructors will be hired in the area of fluency disorders. Many of the best academic programs no longer have doctoral-level faculty teaching and specializing in fluency disorders. This is not to say that individuals with a master’s degree cannot teach outstanding courses on fluency disorders—and there are many who do. But, it is the doctoral faculty who direct student research and mentor new faculty. Although there are many wonderful instructors in the area who are knowledgeable and passionate about their work, there are far too many who are not.

Let me provide an example. A couple of years ago, I presented a workshop at another university. The faculty member who had taught stuttering at this program had retired that year and I had an opportunity to meet the person who had been hired as the new instructor. She told me that her degree was in a field other than speech-language pathology and thus did not know much about stuttering. Naturally, I assumed that she would take advantage of the opportunity and attend at least a portion of the 1½-day workshop. Well, she never showed up, and I cannot imagine what she is telling her students about stuttering. I hope that she is using a good book. Even so, she is undoubtedly turning students off to the opportunities for helping PWS. She is most likely spending a lot of class time talking about theories of etiology, which, while important, tends to make stuttering appear esoteric and mysterious. And, she is likely making the students inhibited about helping. I hope that she is not saying things like “Don’t spend your time working with people who stutter, work with people you can help,” as more than one of my students have reported being told by instructors during their undergraduate programs.

A PLACE TO BEGIN:
UNDERSTANDING THE PHENOMENA

Many instructors are adept at conveying the essential nature of the stuttering experience and thus set the stage for insightful clinical decision making by their students. There are also other sources of information about the stuttering experience. The classic, autobiographical account by Wendell Johnson (1930), Because I Stutter, was one of the first in-depth descriptions about how even the possibility of stuttering can influence one’s decision making throughout life. More recently available are Our Voices: Inspirational Insights From Young People Who Stutter (Bradberry &
Reardon, 1999) and Living With Stuttering: Stories, Basics, Resources, and Hope (St. Louis, 2001). These books provide accounts of people who, with and without professional help, have achieved happy and successful lives. Each of these and other publications are imbedded with important insights for clinicians. On the Internet, The Stuttering Home Page (http://www.mankato.msus.edu/comdis/kuster/) is the single best source for information about stuttering. This site provides research presentations (particularly from the Annual International Stuttering Awareness Interactive Computer Conference that takes place each October), clinical experiences, and historical and current clinical information, as well as links to a variety of other informative and helpful sites. Another source of information are the discussion groups found on the Internet (Stutt-L, Stutt-Help, Stutt-X). Following the discussions on these groups provides a way for anyone who is interested to understand the culture of stuttering. Not all of the messages you will read on these sites are positive, or healthy, or insightful. But, visiting these discussion groups provides a view that will enable you to develop some “street smarts” about what PWS experience, think, and feel.

Looking through these and other sources, you will find such things as the presentation by Starkweather during the 1999 International Stuttering Awareness Day Online Conference (http://www.mnsu.edu/comdis/isad6/isadcon6.html). Dr. Starkweather, an accomplished teacher, writer, researcher, and clinician, explained his understanding of “the experience of stuttering.” He suggested that stuttering and nonstuttering speakers are distinguished not so much by behavioral features that are often so apparent, but by the nature of the internal experience. He stated:

The nonstutterer typically does not even notice his disfluencies. He does not experience them at all, unless some oddity calls them to his attention. But for the stutterer they are salient above all else at the moment. A source of fear, frustration, shame, loathing, and anger, they loom larger than anything else, huge, swollen, a figure of such magnitude that it can block out all other experience. For many stutterers, at the moment of the stuttering block nothing else is important. The reaction is nothing less than catastrophic. So, it seems evident that the reaction of stutters to disfluency is the major distinction between the disorder and the normal phenomenon. Indeed, it is all about experience. (pp. 1–2)

Starkweather suggested that “of course those of us who don’t stutter can never really know [what it is like to stutter].” I don’t think that has to be the case. Dr. Starkweather does not stutter and he unmistakably understands the experience. I know many people who are researchers, clinicians, and instructors who do not stutter but who clearly understand the depth of what it is like to be someone who stutters. They indicate their understanding by the diagnostic protocols they use and the way they measure the success of their intervention. They show that they understand by the way they interact with PWS. They show their understanding when they take the time and effort to attend support group meetings. They show their understanding by the research questions they investigate.

On the other hand, I agree with Starkweather when he suggests that we can never really know all the details and the depth of another person’s story. How can we know the entire story of something we are not (e.g., a person from a different gender, race, or culture)? Nevertheless, as Starkweather recommends, it is critical that we develop the ability to ask the right questions and listen to these people. We do not need to know or understand every last detail, but we can learn enough so that we can begin to provide timely and necessary assistance that will help people begin to move forward with their speech and with their life. We can help them move from being a victim of stuttering to taking action and making helpful changes.

How might instructors communicate their understanding of the stuttering experience to students? How do clinicians communicate their understanding to the person they are trying to help? Perhaps one useful strategy for achieving understanding is to ask the experts, the people who live the experience. They are the best judges of their problem and the best people to ask about what they need and want from treatment. The more experience I gain, the more convinced I am that the best source of information about stuttering is the interpretation of the phenomena by the person who is experiencing it. What clients who stutter say (as well as how they say it) will change as the process of therapy gets underway and they gain insight. Nevertheless, throughout the process, we need to listen carefully, in spite of their stuttering, to what these people have to say. When we do so, we will hear the following:

At some point in my childhood, maybe the first time I tried to speak and the only sound out of my mouth was an unintelligible stutter, I lost the ability to laugh, even to smile, without conscious thought or effort. I was judged by my words or, rather by my inability to produce them in the way that others did. From then on, I learned to trust no one and to speak only when absolutely necessary. As far as I was concerned, trusting led to betrayal and pain, and speaking was an unbearable horror. Words were my enemy. (Rabinowitz, 2001, p. 189)

My hands were trembling as I began…. I felt very much alone. So great was my fear that I seemed to go into a trance. It was a kind of out-of-body experience: a fluent person seemed to be speaking out of my mouth. I heard his words, but they did not come from me. When I was finished, the teacher complemented me for my fluency and for my courage. I think the class may even have applauded—not in sarcasm but in appreciation for my triumph and also, I imagine, in relief. My feeling of success was fleeting, however, as at my Bar Mitzvah, I had somehow been fluent. But my fluency mystified me. There was no way to remember how I felt being fluent, because my fluency did not seem to come from me. I was beginning to fear fluency. I knew myself when I was stuttering. But I felt estranged from myself when I was fluent. Fluency meant trouble. It created expectations I knew I could not meet. (Jezer, 1997, p. 108)

I could not find a speech pathologist that knew what to do with me because I was very fluent in an interview process and in a therapy room….. So it was very hard for me to convince them that I was indeed in a lot of pain and a lot of distress. (treatment transcript)

Such descriptions are vivid and, to the uninformed, may suggest that PWS have serious psychological problems—a view that many people have anyway and one that is more or less promoted by actors who portray PWS in movies and on television. Many of the behaviors we see in PWS are strange and dramatic. They are indeed neurotic and
compulsive in the sense that they appear to be irrational and detract from their ability to communicate successfully. As the research repeatedly demonstrates, however, PWS are no different psychologically from the general population of nonstuttering speakers. They are responding and attempting (often not very adeptly) to respond to the fact that they happen to stutter. They do what appears to be irrational things to keep from stuttering or to escape and get unstuck when they find that they are stuck. In some ways, watching a speaker stutter is similar to watching someone who is drowning. It can look like that because it can also seem that way to the person who is stuttering. You cannot get your breath. You are stuck and helpless. You reach for whatever you can to escape, rational or not, to save yourself. As long as you think you may escape from the helplessness, it is worth reaching for. The strength of that link between being helpless and the desire to save yourself from stuttering may be difficult for the nonstuttering clinician to appreciate. But, just as the drowning person feels that he or she has no choice, the person who finds him- or herself helpless in the experience of stuttering feels that he or she has no choice but to do what, on many occasions, has resulted in escape before (greater effort, a movement of the extremities, whatever it takes). It is important for the clinician to understand the strength of that association and appreciate what it is going to take to change that linkage, particularly in speaking experiences where failure has been the rule rather than the exception.

### IMPLICATIONS FOR HOW WE CAN HELP

As the clinician comes to understand the nature of the stuttering phenomena, particularly how an individual has experienced stuttering, there are obvious implications for our choices when conducting diagnostic and treatment activities. We diagnose stuttering from many perspectives, but most basically by how the person speaks and what they have to say about their experience. We generally begin by considering the overt or surface speech (and nonspeech) behaviors that noticeably differentiate PWS from those who do not. On occasion, this can be a lengthy process of discovery. That is, some speakers demonstrate a wide variety of unique and interesting behaviors, and we are not likely to see all of these behaviors in one or even several meetings. Under greater levels of communicative or emotional stress (these forms of stress frequently overlap for individuals who stutter), we will note avoidance and escape behaviors that may not have been used for months or years. Helping the speaker to map these surface behaviors is fundamental for our understanding of each person’s stuttering as well as for planning strategies to help the speaker to vary and modify them.

Just as important is our ability to listen to what these behaviors have to say about the speaker’s experience with stuttering. As we go beyond the surface behaviors and begin to understand the client’s interpretation of his or her problem, we may find out that it is not what we assume it to be. Our listening will enable us to demonstrate our understanding of the speaker’s experience. To the extent that we demonstrate our understanding, we are more likely to connect clients with the process of change. We will be more likely to adjust the content and the timing of what we do in therapy to meet their needs. More importantly, we will be more likely to develop a working alliance that has been shown as central for facilitating change (Wampold, 2001).

We assume, and often it is true, that the primary reason clients come to us for help is that they desire to cease or decrease their stuttering. And, of course, we typically do just that. We help them understand how speech is produced, and we help them to coordinate the parts of their speech system so that things run smoother. We help them self-evaluate their speech in order to produce fluency that is spontaneous and increasingly natural. We help them problem-solve and improve their ability to communicate so that they enjoy speaking with others. We help them achieve insight and understanding about the stuttering experience so that they are less likely to respond reflexively with embarrassment and shame when they do happen to stutter. These are all worthy therapy goals. But we will also have people come to us who have other requests, as described by Jezer (1997).

Speaking slowly and with great expression she told how she grew from a “shy, lonely, isolated little girl who never fit in” into a confident woman who was not afraid to speak in public. “We all know what stuttering is”, she said, “and the blocking is only a very, very minor part. Stuttering is the isolation, pain, fear, and low self-esteem that must be relieved. And when they are relieved, I will be cured of my stuttering.” (cited in M. Jezer, p. 242)

The above statement clearly suggests that the client is often in the best position to determine appropriate goals in therapy. Of course, this requires that the clinician, at least to a degree, relinquish his or her role as expert. Certainly it would argue that we should no longer grasp the role of expert with a dogmatic and autocratic view of what must occur in therapy and how this person we are trying to help should speak and live his or her life.

People often come into therapy wanting to be “normal” speakers. Actually, many “normal” speakers are not particularly good at it and do not communicate very well, regardless of their fluency level. The communicative ability of most “normal” speakers is far from idyllic, a value that many PWS assign to them. On the other hand, many of our clients find out, or sometimes know at the outset, that more suitable therapeutic goals are to (a) not be handicapped by their stuttering, (b) feel OK about who they are even if they stutter, (c) be able to take risks with their speech and their lives, or (d) communicate well despite some stuttering. These are goals that I would not necessarily be satisfied with. But the fact is, some people are and that is their choice, not ours.

Society, and some clinicians, think that PWS should become at least as fluent as everyone else, and sometimes that happens. There are a number of people who have stuttered severely who are able to go well beyond the norm and become far better than average speakers (Hillis & Manning, 1996). But not everyone who comes to us for
help will define success as zero stuttering, or even less than 2% stuttering. People have varying degrees of ability to produce fluent speech (Boberg, 1986; Cooper, 1987; Moore & Haynes, 1980; Neaves, 1970; Perkins, Kent, & Curlee, 1990; Zimmerman, 1980, 1981), just as they have varying degrees of ability to do just about everything else that humans do. And, of course, we need to provide evidence that whatever changes the client desires take place.

HOW TO A CHOOSE A TREATMENT

Beginning in the 1980s, it has often been recommended that clinical researchers in our field in general, and in fluency disorders in particular, provide evidence that treatment makes a meaningful difference (e.g., Blood, 1993; Bothe, 2003; Conture, 1996; Conture & Guitar, 1993; Conture & Wolk, 1990; Ingham & Costello, 1984). Furthermore, it is commonly suggested that we follow a medical model in demonstrating the efficacy of treatment (Ingham, 2003). The recommended procedure for demonstrating empirical support for treatment approaches is randomized clinical trials where the benefit of a specific protocol (typically requiring a manual to standardize treatment) is shown to produce “a beneficial result under ideally controlled conditions when administered or monitored by experts” [italics added] (Thomas & Howell, 2001, p. 312). For many reasons (including health maintenance organizations and third-party payers), it is important to demonstrate that we are helping PWS according to what we do “in therapy.” However, there are many good reasons why clinical trials and the medical model in general are inappropriate and biased for answering this question.

Fortunately, the field of psychology began dealing with the issue of empirically (or evidence) based treatment during the middle of the last century. A recent book on this topic by Wampold (2001) sheds some well-researched, empirically based comments on the issue. Because it is not the purpose of this article to provide a detailed explanation of why the medical model and associated criteria for empirically validated treatments does a poor job of explaining treatment outcomes, we will present only a few of Wampold’s findings that speak to the issue of the help we provide to PWS. Of course, one may propose that what (psycho)therapists, counselors, and social workers do is not what we do as clinicians when we help PWS. But, as many experienced clinician–researchers have indicated, there are many more similarities than differences (Bloom & Cooperman, 1999; Cooper, 2003; Crowe, 1997; Gregory, 2003; Manning, 2001). Using the powerful statistical technique of meta-analysis that is designed to aggregate similar studies and allow testing of hypotheses, Wampold found the following:

• There are consistent findings across studies using many different treatment approaches that psychotherapy is remarkably efficacious. In this case, we are talking about absolute efficacy (treatment compared to no treatment). Measures of effect size—an index of how much a dependent variable (the outcome of treatment in this case) can be controlled, predicted, or explained by an independent variable (treatment or no treatment in this case) (see Snyder & Lawson, 1993)—were found to average .80. This is considered to be a large effect in the social sciences.

• Across more than 250 distinct psychotherapy approaches described in more than 10,000 books, there is strong evidence that treatments are uniformly efficacious. Effect sizes for different treatments reached a maximum of .20, a difference that is inconsequential theoretically or clinically. These measures of relative efficacy (comparisons of different treatments) appear to be inflated by the differences in the effectiveness of the clinicians delivering the therapy.

• The consistent findings of uniform efficacy across treatments provide indirect evidence that specific ingredients associated with treatment approaches are not responsible for the benefits of (psycho)therapy.

• The medical model implies that there are specific therapeutic ingredients necessary for the remediation of a disorder. That is, specific ingredients are assumed to be responsible (necessary) for the client to change or progress toward therapeutic goals; thus, the development of manuals specifying clinician adherence to the ingredients.

• There is little support for the medical model for explaining treatment outcomes because specific ingredients account for only 1% of the variance in outcomes. Placebo effects (containing some but not all factors common to many treatments) account for 4% of the variability.

• Relative efficacy studies have shown that the use of manuals does not increase the benefits of psychotherapy. There are indications that strict adherence to a treatment protocol may have detrimental effects because it tends to suppress the effect of clinician competence.

• Relative efficacy studies also suggest that training therapists to adhere to a manual can result in deteriorating interpersonal relations between the therapist and client.

• It does not appear that treatments administered in clinical contexts are inferior to treatments delivered in strictly controlled clinical trials. Adherence to a treatment protocol is not related to the outcomes produced by the treatment, a phenomenon that indicates that specific ingredients are not critical to the success of psychotherapy.

• There are many factors that are common across treatment approaches that do much better in accounting for variance in treatment outcome. Among these are the working alliance between the client and the clinician, accounting for 5%, and clinician allegiance to the treatment protocol (whatever the treatment), accounting for up to 10%. Perhaps most critically, the quality of the therapist accounts for up to 22%.
The contextual model of psychotherapy stipulates that there is a common set of factors across treatments that result in a successful treatment outcome. The model is less dogmatic than the medical model concerning specific ingredients. The contextual model allows eclecticism as long as there is a rationale that underlies and that rationale is cogent, coherent, and psychologically based. The healing context and the meaning attributed to it by the participants (both therapist and client) are critical.

A reading of Wampold’s (and others) work comparing absolute efficacy (treatment compared to no treatment) and relative efficacy (a comparison of two or more treatments) provides a convincing argument that there are no appreciable differences across well-organized and rational treatments for psychotherapy. This is likely to be the case in the area of fluency disorders, and we are in need of studies that would investigate whether or not this may be true. All clinicians should be able to provide a rational explanation for their clinical decisions and also provide evidence that they are indeed helping. The contextual model appears to offer a considerably better and more comprehensive explanation for the process of change and successful outcome than does the medical model for psychotherapy, and very likely for therapies used for PWS. Critical to understanding provided by the contextual model are the effectiveness of the clinician and the working alliance between the client and the clinician.

INDICATORS OF CHANGE AND SUCCESS

For the clients we are helping, it may be that the best measure of successful change and eventual outcome is indicated by whether or not we understand the client’s story and whether or not we meet the client’s goals rather than our own. If we identify these goals and show that they are met, it is likely that we are helping the speaker to move in the right direction (see, for example, Baer 1990; Conture, 1996). The particular treatment that we use is not the issue. Successful help is not a treatment versus treatment issue (see Wampold, 2001). For example, Bloodstein (1987) and Conture (1996) concluded that treatment is effective across many forms of intervention in approximately 7 out of 10 cases. The issue is whether treatment helps and what data provide evidence of that help. In most instances, a single measure such as percentage of syllables stuttered (%SS) is not a particularly convincing indicator of decreased severity of the disability or successful outcome. On the face (or surface) of it, a decrease in the frequency of stuttering would be the holy grail of success for an individual who did not understand the phenomenon (as with the typical listener). Of course, we can and should obtain data concerning surface features of the problem. In most cases, particularly with adolescents and adults, we also need to understand the cognitive features. In spite of opinions to the contrary (Ingham, 2003), there are measures that can be used for indicating cognitive change and quality of life (Blood, 1993, 1995a, 1995b; Hillis, 1993; Langevin & Kully, 2003). Other measures are being developed or modified from areas of psychology (e.g., DiLollo, Manning, & Neimeyer, 2003; Yaruss, 2001; Yaruss & Quesal, 2002b). Of course, not all clinicians or researchers agree on what these should be—just as not everyone agrees that certain behavioral measures should be used or that %SS is always a particularly valid measure of severity or success.

In addition to prescribed measures, individuals will inform us of important cognitive changes by the way they describe themselves and their speech. Listen as PWS change from describing themselves as victims or pawns to people who are:

- achieving insight about themselves and their choices
- decreasing their anxiety and fear so that they are no longer overwhelmed by the experience of stuttering
- taking risks, decreasing avoidance behavior, and extending their ability to communicate in broader and more difficult speaking situations beyond the treatment setting
- creating distance and separation from stuttering to the point of being able to respond with a humorous interpretation of their situation
- demonstrating agency where they act for themselves and become the origin rather than the receiver of action (see Monk, Winslade, Crocket, & Epston, 1997)
- moving from being readers of a story that has been dominated by the theme of stuttering to becoming the authors of a new story that is composed of many themes
- identifying themes of success in their lives that run counter to the once-dominant stuttering theme

We need to recognize these victories so that we (and others) can highlight and reward this success. These changes will be available to us in statements such as:

- “I can do this, I’m not helpless and I have good choices.”
- “For the first time in my life at age 25, I approached other students and asked directions to the dorm. I didn’t even stutter much, but that doesn’t matter.”
- “You know I stuttered as much as I always have talking to her, but as I walked away, I wasn’t embarrassed as I have always been in the past.”
- “I hadn’t expected to stutter as I ordered my coffee, but when I stuttered on the word ‘decaf,’ my wife and I both began laughing and could hardly stop.”
- “Ninety-five percent of the time or more, stuttering is not an issue. It’s there, I know it’s there, and it’s part of who I am, but it’s not an issue in terms of decisions I make or in terms of what I’ve achieved. It just doesn’t play a major role in my life.”
- “Today I would have to say the stuttering that I suffered from has turned into one of my biggest assets and I think it has served me well. It truly has become a gift for me.”
- “As negative as I viewed it for so many years of my life, if anybody would have said to me ‘Well Mike, at
the age of 18 or 19 how is (stuttering) positive and how does stuttering impact your life in a positive way?’ I would have said, ‘Are you kidding? I can’t imagine stuttering having any positive influence on my life.’ But it has. It has made me more sensitive to other peoples’ needs and other people’s differences.”

Although it may sound strange to hear people describe their stuttering in this manner, these comments are remarkably similar to those of other individuals who have successfully confronted life-threatening problems.

Nobody would ever choose to have this [Parkinson’s disease] visited upon them. Still, this unexpected crisis forced a fundamental life decision: adopt a siege mentality—or embark upon a journey. Whatever it was—courage? Acceptance? Wisdom—that finally allowed me to go down the second road (after spending a few disastrous years on the first) was unquestionably a gift—and absent this neurophysiological catastrophe, I would never have opened it, or been so profoundly enriched. That’s why I consider myself a lucky man. (Fox, 2002, p. 5)

What if I relapsed and the cancer came back? I still believe I would have gained something in the struggle, because in what time I had left I would have been a more complete, compassionate, and intelligent man, and therefore more alive. The one thing the illness has convinced me of beyond all doubt—more than any experience I’ve had as an athlete—is that we are much better than we know. We have unrealized capacities that sometimes only emerge in crisis. (Armstrong, 2000, p. 267)

Comments such as these often provide direct indication of fundamental, individual change. It is possible that cognitive change will follow the mastery of behavioral modification techniques. That is, as people successfully modify their speech to smooth their stuttering or to elaborate and expand their fluent speech, they may subsequently begin to alter their view of themselves. For others, self-interpretation will change only with more direct efforts in the form of counseling, modeling, and experimentation with alternative constructs about stuttering, fluency, and how the individual interprets him- or herself.

Regardless of how an individual alters his or her constructs, such changes are part of a successful therapeutic process. For example, it is not uncommon to find that speakers are unable to do what we ask of them, particularly when we ask them to use newly learned techniques or targets outside of the security and support of the clinic setting. People are resistant to speaking in a different way or using new techniques because they do not believe they can. They do not yet have the self-efficacy (a measure of an individual’s confidence that he or she can successfully perform activities necessary to produce a particular outcome) (Bandura, 1977) or personal constructs (Kelly, 1955) that allow them to experiment and stay with the task long enough for things to begin to change. Their lack of (or minimal) success in the past has shown them that they are not likely to be successful now. It may be that an important initial step in our intervention is to begin to understand why this is so for each person we are helping.

As undesirable as stuttering may be, if someone has lived as a person who stutters for a decade or two, stuttering is likely to be one of the person’s core characteristics or constructs. Although the person wants to separate from stuttering and become “normal,” to do so is to invalidate what you have been for years or decades. It will take time to adjust to new constructs of yourself and the expectations of others. Here is the way a professional writer describes it:

The potential for stuttering, the fact that we might stutter in the next sentence even though the sentence we are speaking is perfectly fluent, is why so many of us who stutter think of ourselves as stutterers even when we are not stuttering. It would seem, then, that part of our problem lies in how we perceive ourselves as speakers more than in how our listeners react to us when we speak. A stutterer who isn’t stuttering may not be a stutterer to the people listening to him, especially if they don’t know him. But a stutterer who isn’t stuttering often still feels that he is a stutterer, because he knows that fluency is fleeting and stuttering may happen the next time he opens his mouth. (Jezer, 1997, p. 18)

Just as I’m uncomfortable in changing the style of my clothes, I’m unable to get out of my skin and imagine myself as a different personality. (Jezer, 1997, p. 120)

I cannot play-act or assume a new identity. I believe that this has something to do with my stutter. I interpret any effort to get out of myself, even if only to be playful, as a rejection not only of what I am but of my stutter. Tempted to be smooth and stylish, I hear an inner voice (it must be my own voice, for I can’t identify it as belonging to either of my parents) making a sardonic comment. “Watsamatter, you’re not satisfied with who you are?” To which I instantaneously and defensively respond, “I am satisfied! I am satisfied! I don’t want to be anyone but me!” (Jezer, 1997, p. 120)

Once we understand the story of PWS, we can suggest and model new attitudes and behaviors showing them alternative hypotheses about their situation with which they can experiment. The techniques we suggest will remain simply techniques until they are practiced enough to become part of the person. The new speaking techniques (be they stuttering modification or fluency shaping) will sound and feel strange because they are more unique and unnatural than the stuttering. It takes time and much practice until the new way of speaking (or stuttering) becomes acceptable and familiar. As techniques are overlearned and become resistant to stress, the speaker will begin to trust him- or herself to use them. Gradually, the techniques become integrated into the person’s problem-solving response. Only when the person is able to master these new responses to an old problem will he or she open the door to new levels of communication. Regardless of how we approach these changes, our clients generally need to alter the ways they have been considering themselves as well as their behavior.

CONCLUSION

Can you understand the stuttering experience if you do not stutter? How will you prepare for the inevitable question from a client? “How can you understand? You don’t stutter!” Here is a summary of some suggestions.

• Listen closely to your clients so that you can understand their story. Listen to the potential they show in
their abilities and to their past successes. Listen for themes that run counter to the often dominant theme of helplessness and avoidance forced on them by the fact that they stutter. Help them to create a story that is different, possibly counter to the one they brought with them.

- Consider using a “telling your story worksheet” developed by St. Louis (2001), which provides some contextual information for facilitating and developing a client’s story.

- Listen to their stuttering, not necessarily for the purposes of counting and cataloguing the number of times and the way that they stutter. But, listen also to what the stuttering tells you about their efforts to avoid stuttering and to struggle with great effort. Stuttering with less effort is a wonderful step in the right direction.

- Listen to the quality of your client’s nonstuttered speech for speech that, while technically nonstuttered, is not stable, natural, or spontaneous. Such “talking on thin ice” may be an indication of attempts not to stutter and minimal control or confidence.

- Leave the therapy room and the clinic and enter the field with them to experience what they are experiencing, if necessary entering their world as a companion who also stutters. Take the risks you are encouraging them to take by taking your turn in the world of listeners who will respond in a variety of interesting ways. Do what you ask them to do.

- Attend a self-help meeting of PWS such as the annual meeting of the National Stuttering Association, Friends, Speak Easy International, Speak Easy Canada, or the Canadian Association of People Who Stutter. Listen to the stories of courage, success, acceptance, and support regardless of how much stuttering occurs.

- Visit the Stuttering Home Page Web site and immerse yourself in the culture of stuttering by reading the presentations from the International Stuttering Awareness Day conferences—the stories, suggestions, and comments. Follow the links to other sites.

- Stress the importance of balancing cognitive changes with mastery of behavioral techniques. The techniques will have to be practiced thousands of times in a variety of progressively more difficult speaking situations before they will become incorporated into the response and style of the person. Realize that it will take even longer for cognitive changes to occur.

- Consider becoming a specialist in fluency disorders (BR-FD), an indication to the public that you are willing to go beyond the minimum requirements associated with the Certificate of Clinical Competence.

- Continue to be a student throughout the life of your career. Continue to work at sharpening your knowledge and skills by taking part in all manner of continuing education activities. Learn as many treatment approaches and associated techniques as you can that seem to you to be “congenial and convincing” (Frank & Frank, 1991). Find one or more approaches to treatment that coincide with your world view. You will be better delivering a treatment that you enjoy rather than trying to use an approach that is not congruent with who you are. It will be impossible for you to adhere to a treatment protocol that you do not truly believe in and that prevents you from developing a working alliance with the person you want to help. As Wampold (2001, p. 217) wisely stated, “Slavish adherence to a theoretical protocol and maniacal promotion of a single theoretical approach are utterly in opposition to science.”

All that said, I will end (perhaps I should have begun) by saying that, like everyone, my views are biased (perhaps a better word is filtered) by my experiences, including the fact that stuttering was once a dominant theme in my life. Our reality is influenced by our culture, gender, family, education, and opportunities—or the lack of them. This is true for even the most objective of us, and this includes clinicians and scientists.

Scientists often strive for special status by claiming a unique form of “objectivity” inherent in a supposedly universal procedure called the scientific method.... This image may be beguiling, but the claim is chimerical, and ultimately haughty and divisive. For the myth of pure perception raises scientists to a pinnacle above all other struggling intellectuals, who must remain mired in constraints of culture and psyche. (Gould, 1995, p. 148)

All of us, especially in our role as students of our profession, need to keep this in mind as we hear pronouncements from authorities no matter what the topic. Trust your instincts, especially as you gain experience and, hopefully, wisdom. As you continue to learn and apply information, you will discover ideas and approaches that resonate with who you are. Experiment with these ideas and techniques. Adopt those that (at least for a time) are useful and feel right. Ask your clients to do the same because some of the ideas will resonate with them more than others. Along the way, gather evidence that what you are doing is making a difference. Provide alternatives that you truly believe in but, to the extent possible, avoid placing yourself in the role of expert about the lives of the people you are trying to help. Although we can develop insight about the phenomena of stuttering and how to help, it is their journey.

REFERENCES


Contact author: Walt Manning, Memphis Speech and Hearing Center, 807 Jefferson Avenue, Memphis, TN 38105. E-mail: wmanning@memphis.edu