A MIXED METHODS APPROACH TO EVALUATING TREATMENT OUTCOMES FOR
AN ECLECTIC APPROACH TO INTENSIVE STUTTERING THERAPY

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The purpose of this study was to evaluate treatment outcomes of the Intensive Clinic for Adolescents and Adults Who Stutter, offered at Bowling Green State University. The study used a mixed methods design to evaluate treatment effectiveness from a user’s perspective within an evidence-based framework. The core method in this mixed methods design was a qualitative, phenomenological approach to recount participants’ experiences at the intensive clinic. Toward this end, the primary investigator engaged in semi-structured interviews with seven participants who had attended the intensive clinic between 2003 and 2008. The study gathered objective clinical data concurrently. Clinical data included archival records and current measures on a variety of assessments to evaluate stuttering severity and attitudes toward communication. All semi-structured interviews were audio-recorded and video-taped. The primary investigator transcribed and analyzed the interviews using thematic analysis to determine major themes within and across participants. Credibility was established by providing participants’ a copy of the analysis to validate, clarify, or question the results. Additionally, two independent investigators recoded all statements from the transcripts. Their codes were compared with the codes generated by the primary investigator to establish reliability. The participants spoke at length about various aspects of the intensive clinic that were either helpful or not helpful to their individual experiences. The major themes generated from participant transcripts included the positive direct effects of: the duration and nature of the program; speech techniques learned and practiced at the intensive clinic; attitude change and counseling techniques used in therapy; and
activities related to desensitization and transfer. The participants also reported positive effects of their personal motivation/readiness to attend the program and clinician attitudes during the program. Participants recommended adding more structure to outdoor activities completed during the program and the inclusion of a structured follow-up program. Clinical data corroborates qualitative themes and indicates that the participants made measurable clinical gains on all measures of stuttering severity and attitude change following the intensive clinic. These changes were maintained at the time of the interview. Future directions for the clinic and related research are discussed in light of the current results.
This dissertation is dedicated to:

My Father, Dr. Aspi J. Irani

My Mother, Pervin Irani

My Sister, Anahita Irani

To People Who Stutter
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This dissertation marks the culmination of five-years of hard work and dedication. A number of individuals have been directly and/or indirectly involved in this process, and I would like to take this opportunity to thank all those that have helped me through this process.

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CHAPTER 1

Introduction

The concept of Evidence-Based Practice (EBP) or Evidence-Based Medicine (EBM) has its origins around the mid-19th century (Ratner & Tetnowski, 2006). This concept has gained great momentum in the United States of America in recent years due to several factors. This includes the growth in managed health care and its consequences, a shift in the locus of clinical decision making from healthcare providers to payers, and the change of the medical-legal mindset from a more defensive to a more offensive clinical practice perspective (Ratner & Tetnowski, 2006).

EBM has most often been associated with the practice of medicine. The most commonly used and cited definition for EBM (Bower, 2003) is the one given by Sackett, Rosenberg, Gray, Haynes, and Richardson (1996). As per their definition,

Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of Evidence-Based Medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. Good doctors use both individual clinical expertise and the best available external evidence, and neither is enough. Without clinical expertise, practice risks becoming tyrannized by evidence, for even excellent external evidence may be inapplicable or inappropriate for an individual patient. Without best current evidence, practice risks becoming rapidly out of date, to the detriment of patients (Sackett et al., 1996; p. 71-72).

Thus, according to Sackett et al. (1996), EBM is an integration of three important elements including individual clinical expertise, the best available evidence from systematic research, and patient values.

The concept of EBP gained momentum in the field of speech-language pathology as well in recent years. This shift is clearly evidenced by the American Speech-Language and Hearing Association’s (ASHA) endorsement and promotion of EBP as a practice model for all members
and affiliates to follow. Toward this end, ASHA published a technical report introducing EBP to communication disorders on August 20, 2004 (ASHA, 2004). In addition, AHSA published a position statement on EBP in communication disorders in January 2005. This position statement clearly states “that audiologists and speech-language pathologists incorporate the principles of evidence-based practice in clinical decision making to provide high quality clinical care.” (ASHA, 2005, pp. 1). ASHA in their 2005 position statement refer to EBP as an approach in which practitioners incorporate high-quality research evidence, clinical expertise, and client preferences and values, in the process of making clinical decisions.

In 2004, ASHA’s executive board convened a coordinating committee in EBP. This committee used a variation of a definition of EBP provided by Sackett and Colleagues (2000). Thus ASHA defines EBP as “the integration of: (a) clinical expertise, (b) current best evidence, and (c) client values to provide high-quality services reflecting the interests, values, needs, and choices of the individuals we serve.” (ASHA, 2004). As per this definition, it is the task of the speech-language pathologist (SLP) to interpret best current research evidence in relation to an individual client, the client’s preferences, values, environment and culture regarding health and well being to make informed clinical decisions. This will involve the dynamic integration of clinical expertise and external research evidence in day-to-day clinical practice (ASHA, 2004).

Thus, in keeping with the original definition of EBM provided by Sackett et al. (1996), ASHA urges all its members to integrate information the latest available research evidence with their own clinical expertise and client preferences/values to select and provide their clients with the best available treatment options. EBP in essence offers a framework and set of tools to systematically improve our efforts to be better clinicians, colleagues, investigators, and
advocates by considering clinical experiences and patient preferences against a background of the highest quality scientific evidence available (Dollaghan, 2004).

The purpose of this study is to use a mixed methods approach to evaluate treatment outcomes for an intensive stuttering clinic offered at Bowling Green State University. The study utilized semi-structured interviews to gain an in-depth understanding of participants’ experiences with the intensive clinic. The study also collected clinical data from participants at the time of the interview, and archival data to determine trends and changes in clinical measures for individual participants and across all participants. The study thus, is an initial step toward evaluating treatment outcomes within an evidence-based framework to help inform future prospective studies on treatment outcomes and treatment directions. The chapters are organized as follows: Chapter 2 provides the reader with a review of relevant literature, the rationale, and specific research questions guiding this study; Chapter 3 provides details of the study’s methods; Chapter 4 provides the reader with both qualitative and quantitative findings of this study, for individual participants and across participants; and Chapter 5 discusses the findings related to the research questions and provides implications and future directions for the intensive clinic and future studies examining treatment effectiveness and outcomes for the clinic.
CHAPTER 2

Review of Literature

The Evidence in Evidence-Based Practice

As mentioned in Chapter 1 and included in the definition, evidence from systematic research is an important and integral part of EBP. As per the EBP framework, clinicians are expected to use the highest quality evidence currently available in addition to their expertise and patient values while making assessment and treatment decisions. This evidence can range from expert opinions to meta-analyses. However, it should be noted that not all forms of evidence are equally persuasive in making a case to use a certain clinical procedure. As described by the definition of EBP, the evidence must be of highest quality and scientific. Thus, evidence is considered more potent if there is greater scientific rigor in producing the evidence (Robey, 2004).

To help practitioners evaluate the rigor of available evidence, several dozen systems for classifying the evidence through a hierarchy of scientific rigor and quality are available (Agency for Healthcare Research and Quality [AHRQ], 2002). These systems for classifying evidence are referred to as levels of evidence or strength of evidence. AHRQ is the recognized authority regarding the assessment of scientific and clinical research in the United States (Robey, 2004). The system utilized by the AHRQ to classify levels of evidence is presented in Table 1. The table above provides a brief outline to help clinicians and practitioners to evaluate evidence for a particular against the available literature. Thus, as per the definition and guidelines of the EBP framework, a clinician is expected to integrate the best, most scientific evidence available with their own clinical expertise and patient values to make an informed decision regarding treatment plans.
Table 1

*Levels of Evidence (AHRQ, 2001)*

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<th>Source of Evidence</th>
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Additionally, ASHA provides its members with four key steps in the process of EBP. The steps include framing the clinical question, finding evidence, assessing evidence found, and finally making the decision. A careful look at the definition of EBP and the steps in the process indicate that clinicians upgrade their knowledge base in response to particular clinical questions (Dollaghan, 2004).

The first step in the EBP process, framing the clinical question, is made easier by the application of a widely used approach known as PICO (Richardson et al., 1995). PICO is an acronym for Population, Intervention, Comparison, and Outcome. Thus, framing a clinical question that addresses all four areas of PICO will help the clinician narrow down the literature search to information applicable and relevant to the particular circumstance faced by the clinician. A guideline such as this helps streamline the EBP process for a clinician making the process more effective and efficient. Schlosser, Koul, and Costello (2007) evaluated the suitability of the PICO template to Alternative and Augmentative Communication (AAC). They proposed a modified template called the PESICO for AAC purposes. PESICO is an acronym for Person (problem), Environments, Stakeholders, Intervention, Comparison, and Outcomes. They added environment and stakeholders to the PICO template since there is a great emphasis placed the individual’s current and anticipated future environments when conducting an assessment or preparing an intervention. Also, in AAC individuals other than the client might hold perspectives that indirectly influence the feasibility of an assessment or intervention, hence the importance of considering the environment and stakeholder perspectives when framing a clinical question for AAC. In light of this investigation by Schlosser et al. (2007), it is important to realize the PICO is a general framework to help a clinician frame a clinical question to guide the EBP process and
the clinician can elect to include or exclude components of the general template to better frame a clinical question that requires EBP.

The second step in the process requires the clinician to find the evidence relevant to the clinical question at the time (Frattali, 2004). Often, evidence-based guidelines that are relevant to the clinical questions may already be developed. When evidence-based guidelines are not available, the clinician must look for systematic reviews of the body of scientific evidence relevant to the clinical question (Frattali, 2004). ASHA provides its members with numerous links to websites where systematic reviews can be found. In the absence of systematic reviews on the particular topic of interest, the clinician can turn to individual studies to seek evidence to help in making treatment decisions (Frattali, 2004). However, publication in a peer-reviewed journal is not a guarantee that the evidence is of scientific quality. Thus, it is important for the clinician to evaluate the available evidence for scientific quality, which forms the third step in the EBP process.

The next step in the EBP process is assessing the evidence one finds. While assessing the evidence, the clinician first needs to determine the relevance of the systematic review or individual study to the clinical question at hand, which calls for the expertise and experience of the individual clinician (Frattali, 2004). For systematic reviews, it is also important to consider who produced the reviews and how positive or negative findings might affect them, i.e. reviewer bias. Individual studies need to be assessed for their level of evidence as per a classification system and the quality of the study. Randomized controlled trials are considered to be the designs least susceptible to bias and are often considered as the highest level of evidence (Frattali, 2004).
The final step in the EBP process is to make a decision (Frattali, 2004). It is at this stage in the process when the clinician will be required to combine her/his clinical expertise with the patient’s perspective, and the available evidence to make a specific clinical decision for a specific client (Frattali, 2004). The clinician needs to first determine the relevance of the available guideline to the specific question and circumstance. Once the relevance has been established, it is important to determine if the available guideline is truly evidence-based. Systems to help a clinician evaluate practice guidelines have been developed. One such prominent tool is the Appraisal of Guidelines Research and Evaluation (AGREE; AGREE collaboration, 2003). In addition to evaluating the practice guideline to be truly evidence-based, the clinician must also consider who wrote the guideline to ensure there is no bias resulting from the effect a positive or negative recommendation might affect the group or committee that wrote the guideline.

In conclusion, the process of EBP would involve framing the right clinical question, finding the relevant evidence, evaluating or assessing the available evidence and finally making the decision to use evidence that is most appropriate for the particular client or circumstance.

*Evidence-Based Practice: Application to Clinical Practice*

The review above provides the reader with a basic definition and framework for the application EBP in clinical practice. However, a few studies have considered certain barriers to the clinical implementation of EBP. Newman, Papadopoulos, and Sigsworth (1998) studied the barriers to implementation of EBP for nurses at an organizational and individual practice level. They found multiple barriers to the implementation of EBP at an organizational level. These barriers included inadequate systems for professional and personal development, problems disseminating, EBP being a low management priority, difficulty managing innovations, and
resource constraints. At the individual practice level, motivation, lack of clarity about roles, and a nursing culture that promotes routine patient care were cited as the primary barriers to EBP. In another study, Gerrish, Ashworth, Lacey, and Bailey (2008) assessed factors that influenced the development of EBP by senior and junior nurses. Their findings suggested that while all nurses felt confident in accessing and using evidence, senior nurses appeared more confident in accessing all sources of evidence and implementing change. Junior nurses were found to perceive more barriers to implementing change. Lack of time and resources was cited as a major barrier to the implementation of EBP. In a similar article, Zeitz and McCutcheon (2003) argue that unless systematic processes are agreed upon and developed to improve clinical practice, EBP is an unrealistic goal. This paper considered the implementation of EBP in the collection of vital signs by nurses in a postoperative general surgical setting. The evidence to support this practice is scant. Zeitz and McCutcheon further argue that it is time to focus on real strategies to that will help achieve best practice as opposed to focusing on EBP as a solution to develop best practice. They describe real strategies to help achieve best evidence as the creation of rigorous relevant evidence, valuing clinical expertise, and changing the culture in which nurses develop and practice.

In the field of speech-language pathology, Brackenbury, Burroughs, and Hewitt (2008) examined the time, effort, and resources required for EBP and the types of results obtained. In this study, Brackenbury et al. followed the principles of EBP outlined by ASHA for three case studies. Clinically relevant questions were framed using the PICO and an extensive search for systematic reviews, individual studies, and other sources were conducted as per the ASHA guidelines. The results of this study indicated that resources required, time involved, and the
availability of relevant information can pose possible barriers to the effective implementation of EBP and make it especially challenging for full-time practitioners.

Overall, EBP has been supported and promoted by most professional organizations including ASHA. EBP is also necessary for effective and ethical treatment (Brackenbury et al., 2008) with most professional organizations providing detailed practice and implementation guidelines to assist practitioners to implement and incorporate EBP in their regular practice. However, a limited number of studies do indicate the presence of barriers that need to be overcome in many health-care professions for successful implementation of EBP.

*Evidence-Based Practice in Stuttering*

The discussion of evidence practice in stuttering treatment is an equally important topic of discussion. Finn (2003) describes an evidence-based framework as steered by three guidelines. The first guideline states that the selection of treatment is based on the best available, most recent, and clinically applicable research evidence; second, the clinician using EBP is a self-directed learner who has a healthy level of skepticism about the knowledge claims (appraisal of evidence); and third, the clinician considers and evaluates the client’s values, concerns, and perspective throughout the treatment process. Thus, a clinician practicing evidence based practice will seek out the best available evidence, assess it for quality before making a clinical judgment, and discuss its application with the client to ensure the selected paradigm addresses the client’s concerns, values, and perspectives on treatment. Finally, this process must be evaluated throughout the treatment process to ensure it is beneficial and resulting in a clinically significant change for the client.

Langevin and Kully (2003) provide a review of the use of EBP for stuttering treatment in a clinical setting. The key questions Langevin and Kully (2003) ask are whether their treatment
program is effective across clients in the short and long term and whether the individual client benefits from the treatment selected or designed in the short and long term. This paper addresses some issues related to clinician expertise. Often, as a clinician practicing EBP, it is difficult to decide what approach(es) might be most beneficial to a particular client. Langevin and Kully (2003) describe routine speech and non-speech clinical measures they collect before treatment for clinical purposes and also for outcome evaluation. This method of assessment and data collection pre-therapy can help a clinician decide what treatment methods to consider while framing the clinically relevant question, which is considered the first step in EBP. This method appears helpful to measure client perspectives, values, and concerns in a more objective and empirical fashion. This method of data collection and outcome measurement is also in keeping with the drive to justify treatment choice on empirical means (Onslow, 2003).

At the individual practice level, this may not directly relate to EBP as the methods largely used for stuttering treatment are more anecdotal or authority-based (Onslow, 2003) than evidence-based, relying heavily on expert opinion and recommendations. Bernstein Ratner (2005) expands on this concept of anecdotal or authority-based for the type of evidence referred to as anecdotal or authority-based by Onslow (2003) and Bothe (2003). The evidence in question can be considered as a powerful form of evidence since the clinician is both the gatherer and applier of this evidence and should thus be distinguished from anecdotal evidence associated with the authority of peers or other respected professionals. It should be realized that expert opinion comprises the lowest level of evidence as per the AHRQ and ASHA guidelines. However, considering the dearth of published evidence (Ingham, 2003), use of clinical expertise and systematic record keeping to inform ongoing treatment decisions will make the treatment empirically driven, measurement based, and client-sensitive (Finn, 2003) thus contributing to
EBP. As Onslow (2003) points out, EBP is not about the clinician, it is about the clients getting better. Thus, use of systematic data collection to guide treatment in a clinical setting would translate to EBP. This process of gathering evidence and using that data to inform treatment direction can also be considered an explicit fifth step in the EBP process (Bothe, 2003). The following section will review available research on treatment effectiveness and efficacy for stuttering.

Andrews, Guitar, and Howie (1980) completed a meta-analysis of treatment outcomes studies published, recent books, periodicals, and proceedings of conferences held before 1979. Any report that provided an account of treatment applied to three or more People Who Stutter (PWS) and contained pre- and post-treatment measures were included in this study. Thus a total of 42 studies met the inclusion criteria. These reports included studies of 756 PWS, which allowed for the computation of 116 effect sizes. For the purpose of this meta-analysis, Andrews et al. (1980) calculated an effect size for each outcome measure and coded the features of each study for author characteristics, principal treatment, ancillary treatment, format of treatment, and characteristics of outcome measurement. The effect sizes were used as dependent variables whereas the other features were used as independent variables in the meta-analysis. Overall, the authors had appraised all outcome studies used in this meta-analysis for quality and the possibility of bias.

The results of this study indicated that the most frequently used treatments in the 42 studies analyzed included prolonged speech, rhythm, and attitude therapy. On average they found treatment duration to be 80 hours completed within a period of eight weeks, including transfer activities. Overall the results of this meta-analysis indicated that prolonged speech and gentle onsets appear to be the strongest treatments in the short- and long-term. In general,
Stuttering therapy was found to be effective with an average effect size of 1.3 standard deviations.

St. Louis and Westbrook (1987) reviewed stuttering treatment outcome studies published in major journals and books from 1980 to 1987 using guidelines similar to those used by Andrews et al. (1980). The results of this analysis further confirmed that prolonged speech as a method used with adults was currently the treatment of choice with adults who stutter. Their results also found a significant effect for rate control. They found that treatment methods involving the modification of a stuttering moment and the use of desensitization were seldom mentioned in the treatment literature reviewed. It should be noted that the meta-analysis by Andrews et al. (1980) did not find sufficient studies outlining the clinical benefits of stuttering modification approaches, which are widely recommended in major textbooks (Cordes, 1998). St. Louis and Westbrook also indicated that a mix of two therapy models, intensive and non-intensive maintenance programs might be the most effective as opposed to one treatment model alone. The results of this study indicate that intensive therapy appears to be highly effective in helping PWS achieve fluency early in the process, however, problems with relapse arise when PWS are dismissed immediately following an intensive program. Overall, the results of this analysis indicate that PWS benefit from speech analyses, however, the problem of relapse needs to be addressed.

Blood (1995) used a single subject multiple baseline across subjects design to evaluate the efficacy of a program that utilized a computer-assisted biofeedback program, Computer-Aided Fluency Establishment Trainer (CAFET; Goebel, 1988), and a relapse management program (Power²; Blood, 1995). Four adult males participated in this program that comprised 46-55 hours of intensive treatment using the computer-assisted biofeedback program over a course
of three weeks and 50-minute extended treatment sessions held three times a week for approximately six to eight months. The purpose of these extended treatment sessions was to promote carryover and transfer and relapse management. Training for relapse management, attitude change, problem solving, self-esteem, self-responsibility, and coping skills was done using the POWER² program. Follow up sessions were continued at 6 and 12 months intervals after termination of the extended treatment sessions.

Blood (1995) measured treatment efficacy of this program by measuring speech behaviors, feelings (affective), and thinking (cognitive) measures. Speech behaviors were measured using percentage of stuttered syllables per minute (%SS), rate of speaking in syllables per minute (SPM), and use of the Stuttering Severity Instrument-SSI (Riley, 1980). The affective or feelings component was measured using two self-administered scales: Personal Report of Communication Apprehension-PRCA (McCroskey, 1978) and Assertiveness Scale (Rathus, 1973). The Self-Efficacy Scale for Adult Stutterers-SESAS (Ornstein and Manning, 1985) and the Erickson S-24 Scale (Andrews & Cutler, 1974; Erickson, 1969) was used to measure the thinking or cognitive component. All measures were gathered at baseline (before the start of treatment), at the end of the intensive program, following the extended treatment sessions, and at 6 and 12-month follow-up intervals. Results of this study indicated that the program effectively reduced stuttering behavior and augmented positive changes in attitudes and feelings, which were maintained over the 12-month follow up period. While this study does indicate the benefit of a holistic treatment approach that targets the behavioral, affective, and cognitive components of stuttering the results cannot be generalized because of the small sample population. The study does, however, support the use of a combination of intensive and non-intensive follow-up treatment as suggested by St. Louis and Westbrook (1987).
Hancock et al. (1998) reported two- to six-year clinical effectiveness data for 3 different stuttering treatments for children and adolescents who stutter using a controlled trial. This study was a follow-up from Craig et al. (1996) reporting 12-month follow-up data on treatment effectiveness of the three treatment approaches. The initial study recruited 97 participants and divided them in groups for each treatment program, and one group with no treatment (control group). Treatment effectiveness was reported for the use of intensive smooth speech, parent-home smooth speech, and electromyographic feedback approaches with children and adolescents who stutter between the ages of 9 to fourteen years. The three treatment approaches were compared to each other, as well as a no treatment control group. Initial results reported by Craig et al. (1996) at 12-months follow-up indicated no significant differences between the 3 treatment groups in terms of treatment efficacy and a significant difference between the 3 treatment groups and the no-treatment control group. This initial result indicates that treatment of stuttering in children and adolescents is efficacious and better than no treatment. The 2- to 6-year controlled trials outcome study by Hancock et al. (1998) found no significant differences in mean clinic conversation %SS scores 2 to 6 years post treatment, indicating long-term effectiveness and maintenance of gains made in treatment. It should also be noted that a large majority of the parents (71%) reported that their children’s stuttering was cyclical, something that the objective data did not show. This emphasizes the need to collect objective and subjective (qualitative data) simultaneously while assessing treatment effectiveness or efficacy. These results also did indicate that children in the treatment groups reported more positive communication attitudes and reduced anxiety in the long-term as compared to children with no treatment.

Cordes (1998) reviewed stuttering treatment literature from 1965 to 1996 to identify treatment procedures that report positive outcomes and to identify issues within this literature.
that deserve further research and review. This chapter follows an earlier conference presentation discussing the current state of stuttering treatment literature by Ingham (1996). The previous search of literature indicated a lack of the application of basic scientific approaches that should have formed the basis of establishing treatment efficacy. The current review by Cordes (1998) overlooked basic methodological concerns and only considered what treatment procedures were reported to have reported good outcomes. For the current review, all articles related to stuttering treatment efficacy/outcomes research and published in peer-reviewed journals between 1965 and 1996 were included. Articles published before 1965 were excluded from this review to allow for a review of articles published after the advent and use of Delayed Auditory Feedback (DAF) in stuttering therapy.

Results of the literature search resulted in two subgroups identified as the research subgroup and the recommended stuttering treatment subgroup. The research subgroup comprised 64 published papers reporting investigations of 81 different treatment procedures. A large majority of treatments reported in the research subgroup comprised operant procedures using time-out, reinforcement, or a combination of time-out and reinforcement of fluency. The recommended subgroup placed an emphasis on cognitive or cognitive-emotional treatment procedures. Also, the recommended subgroup had no mention of airflow or regulated breathing therapies that were included in the research subgroup. A careful review of both the research and the recommended subgroups indicated that treatments most often cited in the recommended subgroup were not treatments that had been most comprehensively researched. Another important finding of this review is that stuttering treatment research in general did not report maintenance data. The difference between the recommended and research subgroups appears to be of concern due to a lack of comprehensive scientific research to prove effectiveness of the
recommended treatment procedures and the fact that the more comprehensively researched
treatment procedures are the least recommended. This indicates a need to fill the gap and study
the more recommended treatment procedures for effectiveness.

Yaruss (1998) conducted a retrospective study to report treatment outcomes data to
evaluate the adult stuttering treatment program developed by Gregory and colleagues at the
Northwestern University (NU). The particular approach evaluated in this study had been in use at
NU for thirty years and has also been described and recommended in books on stuttering
treatment and taught at workshops around the world jointly sponsored by the Stuttering
Foundation of America (SFA) and NU (Yaruss, 1998). The unifying framework for evaluating
and treating stuttering as proposed by the WHO in the ICIDH (Yaruss, 1998), which was utilized
to evaluate treatment outcomes for this program. A five stage plan for documenting treatment
outcomes was utilized when conducting this retrospective study and included: (1) describing the
nature of the treatment program in detail; (2) defining success clearly; (3) operationalization of
clinical decision making such that treatment goals are easily measurable; (4) measuring treatment
outcomes with measures taken before, during, and after treatment; and (5) reporting all changes,
positive and negative, as a result of treatment objectively. A retrospective study of this nature
does not allow for establishment of cause-effect relationships between treatment and outcome,
and difficulty establishing reliability of the data gathered by multiple clinicians over a twenty-
five year period. Thus, the purpose of this study was to carefully observe and document the
changes that have occurred for clients during the course of treatment and thereby operationalize
the treatment process. Participants in this study included adult clients who were enrolled in the
program at NU between 1975 and 1996. Data gathered included a detailed review of clients’ files
developed during the therapy process and a follow-up questionnaire mailed to the clients at the
time of this study. The follow-up questionnaire mailed to the clients’ requested detailed information about speech fluency, reactions to stuttering, success with modification techniques, satisfaction with treatment, and occurrence of relapse since their dismissal from therapy.

Findings of this study by Yaruss (1998) were reported in terms of: (1) changes in speech fluency; (2) use of modification techniques; (3) changes in affective and cognitive reactions; and (4) follow-up data. Results indicated that participants experienced a reduction in the production of both typical and less typical types of speech disfluencies as a result of treatment. Speech disfluencies were not eliminated as a result of treatment, however, that was also not a goal of the treatment program being evaluated. Archival data from the clients’ files also indicated that the participants mastered some but not all of the modification techniques. Yaruss (1998) reports that this data is rather difficult to interpret due to the difference in clinician ratings of mastery of the modification techniques. Changes in affective and cognitive reactions were not clearly documented in the archival records and thus could not be interpreted and reported in this study. Participant responses on the follow-up questionnaire indicated that they perceived improvements in speech fluency and related attitudes and a decrease in avoidance behaviors as a result of treatment. Clients reported that they noticed these improvements in their communication abilities despite not using modification techniques as frequently as they did immediately following treatment. Thus, the use of retrospective data has drawbacks in terms of the information that can be gathered and the reliability of the data collected, however, it does provide one with an initial first step to evaluate and document treatment effectiveness. Further, this provides one with knowledge to design better prospective studies to gather relevant data to tract treatment progress and effectiveness.
Ingham et al. (2001) reported efficacy for a stuttering treatment program known as Modifying Phonation Intervals (MPI), which is a computer-based program that trains PWS to reduce the frequency of relatively short phonation intervals across speaking tasks and situations during connected speech. A multiple-baseline single-subject experimental design was used with 5 adult males who stutter. Treatment evaluation was based on a time series evaluation. The researchers collected data before the start of treatment, during treatment, immediately post-treatment, and at a twelve-month follow-up. The results of this study indicated that all participants achieved stutter-free and natural-sounding speech, as measured by Treatment Evaluation Speaking Tasks (TESTs) within- and beyond-clinic, at the completion of the maintenance phase of treatment and twelve months after completion of the maintenance phase. Ingham et al. (2001) also reported “all participants provided personal testimony that the treatment led to major positive lifestyle changes” (p. 1241) however, the researchers did not administer any formal tools to measure change in attitudes and/or lifestyle.

Webber, Packman, and Onslow (2004) conducted a laboratory investigation of the use of self-modeling on stuttering rate in adolescents and adults who stutter using a single-subject withdrawal design. A total of three participants were recruited for this study and comprised two adult males and an adolescent boy. The study comprised three phases, including a baseline, treatment phase, and withdrawal phase. Treatment effectiveness was measured collecting objective speech data including %SS and syllables per minute (SPM). In addition to this objective data, the investigators also conducted exit interviews for each participant. The results indicated that stuttering reduced under the treatment condition for only one of the three subjects. Participants reported in the exit interviews that they noticed some reduction in their stuttering severity during the introduction of the treatment phase and a rise in stuttering severity during the
withdrawal phase. The results of this study indicate that self-modeling as a technique for stuttering therapy could have some effectiveness; however, the current results cannot be generalized due to the low sample size and lack of significant efficacy data.

Armson, Kiefte, Mason, and De Croos (2006) investigated the effect of the SpeechEasy device on stuttering frequency in a laboratory setting for thirteen participants. The participants for this study comprised 2 females and eleven males between twenty-one and fifty-four years of age. To evaluate efficacy of the device in the laboratory, speech measures (%SS) were gathered for a total of four conditions: two baseline and two experimental conditions. All thirteen participants completed each condition. The initial baseline %SS was gathered before the participants were given the device. The first experimental condition was called the device only condition and the participants were asked to wear the device and not provided any instructions. The second experimental condition labeled as the device plus condition involved providing participants with instructions to prolong vowels and the beginning of each breath group. This experimental condition was consistent with the SpeechEasy fitting protocol. A second baseline was conducted after the two experimental conditions, similar to a withdrawal design.

Results of this study indicated a statistically significant reduction in group means of %SS in both experimental conditions as compared to the first baseline condition. Stuttering frequencies were found to have increased during the second baseline condition that followed the two experimental conditions, but were lower than the stuttering frequencies measured during the initial baseline, indicating some carryover effect of the experimental condition. It should also be noted that the most significant reduction in stuttering frequency during the experimental phase was found for a reading task and less benefit was recorded for monologue and conversational tasks. The investigators also reported great individual variability on the effects on the
SpeechEasy device on stuttering frequency. While this study does report a significant effect of the SpeechEasy device on stuttering frequency, it is tested in a controlled environment with a limited number of participants. Additionally, the study does not consider client values and preferences.

Bothe, Davidow, Bramlett, and Ingham (2006) completed a systematic review of behavioral, cognitive, and related treatments for developmental stuttering published between 1970 and 2005 that met trial quality assessment of the treatment procedures. An initial literature review of published articles yielded 162 articles that were then assessed on five methodological criteria and 4 outcomes criteria using a written data extraction instrument. Following the assessment of the 162 articles found on the methodological and outcomes criteria, only 39 articles were found to meet trial quality standards that met all criterions. Results of this systematic review suggest that a large majority (80%) of literature reviewed used research designs that are known to be at risk of obtaining spuriously positive results and fewer than half the articles provided beyond-clinic data. They found no evidence of the effectiveness of many treatment types and evidence of the ineffectiveness of many treatment types. Overall, they found that the results are ultimately positive and many of the studies; including prolonged speech type procedures and self-management for adolescents and adults, and response-contingent treatments for preschoolers resulted in reduced stuttering or improvement in Social, Emotional, or Cognitive (SEC) variables.

Bothe, Davidow, Bramlett, Franic, and Ingham (2006) completed a systematic review of all trial quality research on pharmacological treatment of stuttering published between 1970 and 2005. A total of 31 articles were reviewed to meet methodological and outcomes criteria similar to the ones used by Bothe, Davidow, Bramlett, and Ingham (2006). None of the 31 articles
reviewed met more than three of the five methodological criteria. Overall, results of this systematic review suggest that none of the pharmacological tested report improvement in either stuttering frequency or relevant SEC variables and question the use of current pharmacological agents for stuttering.

Reviewed above are some of the larger all-encompassing meta-analyses and systematic reviews of treatment outcomes in stuttering, as well as several treatment outcome and efficacy studies. A common theme that can be seen across all the published reviews of treatment outcomes in stuttering is the fact that most published articles are methodologically unsound, they do not meet outcomes measurement criteria, and suggestions that the more rigorously researched treatment procedures are not recommended as often or as much as treatment procedures that have not been proven effective by rigorous and scientifically sound research (Cordes, 1998).

In evaluating the evidence to support stuttering therapy, it should be noted that a large majority of this evidence has been produced and evaluated by proponents of the fluency shaping approach. Thomas and Howell (2001) critically addressed measurement issues, treatment integrity, design issues, and tests of treatment outcomes in their assessment of the efficacy of stuttering treatment. Thomas and Howell highlight a growing concern about the reliability and validity of clinic-based perceptual measures of stuttering including frequency counts that have been used to assess treatment effectiveness in most published studies, meta-analysis, and systematic reviews. This issue of reliability is very important in treatment efficacy studies, especially when the main variable used to determine treatment outcomes is stuttering frequency, because perceptual ratings of speech are filtered through a complex system of human perception. This perception is subject more often to error and bias that more objectively collected data (Thomas & Howell, 2001). They further address design issues such as measuring long-term
maintenance of gains made during the course of therapy and the use of untreated control groups held in pre-treatment baselines.

Though the use of randomized untreated control groups is suggested in most studies of treatment efficacy, there are important issues to consider for fields such as ours. Swinkles, Albarran, Means, Mitchell, and Stewart (2002) point out that the implementation of components of Randomized Control Trials (RCTs), often considered the gold standard (Ingham, 2003), may not be possible for fields such as physical therapy, education, social work, and speech-language pathology (Bernstein Ratner, 2005). Bernstein Ratner (2005) further argues that we cannot necessarily view a RCT within a discipline as superior to all other forms of evidence related to treatment efficacy being gathered concurrently.

Thus, even the treatments that appear to be the best for treating stuttering, as indicative of meta-analyses and systematic review may not necessarily bring about a clinically significant change. A good example of this is the use of prolonged speech, while shown to be most effective (Andrews et al., 1980; Cordes, 1998; and St. Louis & Westbrook, 1987) in bringing about large, quantifiable differences in stuttering frequency, the resulting stutter-free speech has often been judged as unacceptable in terms of speech quality (Onslow & Ingham, 1987). The use of a 9-point speech naturalness scale in treatment to normalize unnatural-sounding speech in treatment (Ingham & Riley, 1998) has been used effectively since and is described as a good example of the scientific underpinnings of an evidence-based framework (Finn, 2003). However, what this also demonstrates is the importance of triangulation of multiple data sources to guide treatment. The conclusion that prolonged speech often results in unnatural-sounding speech was based on laboratory evidence collected by Ingham and Packman (1987) and clinical anecdotes (Finn, 2003).
Finn (2003) further argues that clinically significant change for PWS, or any person seeking professional help, is a change in the behavior that prompted the individual to seek professional help. He further adds that self-measurement serves as the basis to determine the clinical significance of change from a client perspective. Also, it is important to consider what notion or concept the evidence gathered has been designed to inform (Bernstein Ratner, 2005). In the case of stuttering, limiting evidence to the surface behaviors of stuttering such as frequency counts might not be sufficient when considering a more broad-based framework for the disorder. The International Classification of Impairments, Disabilities, and Handicaps (ICIDH) framework includes not only the surface behaviors of stuttering or the impairment, but also includes a description of difficulties a speaker might experience in daily communication (disability) and the overall consequences this disability could have on the speaker’s life experiences (handicap) (Yaruss, 2007). Often, stuttering has been described as involving multiple cognitive and emotional responses associated with speaking difficulties as evidenced by personal accounts of individuals’ experiences with stuttering (Yaruss, 2007).

This more broad-based framework of stuttering, as ascribed by the ICIDH, is further supported by reports of the lack of long-term maintenance of gains made in therapy (Bloodstein, 1995; Cordes et al., 1998; Craig, 1998; St. Louis & Westbrook, 1987). Critchton-Smith (2002) report that speech management strategies taught in therapy are employed variably across different situations with a distinct possibility that the client’s original strategies of avoidance and escape might reoccur leading to the possibility of relapse. The study by Critchton-Smith (2002) looked at communicative experiences and coping strategies used by 14 adults who stutter via in-depth qualitative interviews. Although the results might not generalize to a general population of PWS, it is important to realize that certain mechanism, beyond the surface behaviors of stuttering
can influence treatment outcomes and could possibly lead to relapse or a loss of treatment gains made over a period of time. Similarly, Klompas and Ross (2004) investigated life experiences of 16 PWS from South Africa using a qualitative framework to explore the impact stuttering had on their quality of life. The results of this study indicated that most participants reported negative effects of stuttering on their self-esteem and self-image that had evoked strong emotions in them. In another study, Stewart and Richardson (2004) investigated the effects of therapy from a patient perspective by interviewing 13 PWS who had received group therapy between 1995 and 1999 that comprised a combination of speak more fluently and stutter more fluently approaches grounded in a client-centered and personal construct therapy. The results of this study indicated that most clients did benefit from the therapy program; however, they also felt the need for continued support following discharge from therapy.

Yaruss, Quesal, Reeves, Molt, Kluetz, Caruso, et al. (2002) surveyed members of the National Stuttering Association (NSA) to learn about their experiences in support groups as well as their experiences in speech therapy. The results of this study indicated that most individuals who responded had received speech therapy several times in their lives. Responses suggest that individuals who had received fluency-shaping treatments were more likely to experience relapse as opposed to individuals who received stuttering modification or a combination of approaches.

The studies discussed regarding the perceptions that PWS report regarding their treatment are grounded in more descriptive and qualitative methodologies and treat the client as an experiential expert (Stewart & Richardson, 2004). Approaches to studying treatment effectiveness are not traditionally considered as scientific and contributing to a high level of evidence as per the EBP guidelines ascribed to by ASHA. This type of evidence often referred to as anecdotal evidence (Bernstein Ratner, 2005) can be powerful when the clinician gathers it to
inform treatment directions (Langevin & Kully, 2003). Also, considering the complexity of stuttering and its impact on the individuals functioning and quality of life, considering only empirical evidence and limiting ourselves to questions which lend themselves to designs involving (RCTs) might diminish our ability to interpret the ecological validity of evidence (Kovarsky, 2008). Large-scale quantitative studies that generally comprise the higher levels of the EBP framework provide us with some knowledge of outcomes (Stewart & Richardson, 2004), often related to overt symptoms of stuttering. Quantitative studies provide us with none or minimal understanding of how these changes relate to the individual client or how the clients make sense of these experiences after the therapy process has ended (Stewart & Richardson, 2004). Qualitative methodologies, such as those used by the aforementioned studies (Critchton-Smith, 2002; Klompas & Ross, 2004; Stewart & Richardson, 2004) can help us gather rich data based on the client’s personal knowledge and experience of the treatment process as a consumer. As Onslow (2003) rightly points out, “evidence-based treatment is not about clinicians; it is about their clients getting better” (pp. 240). Keeping that in mind, and the complex nature of stuttering (Bernstein Ratner, 2005; Yaruss, 2007) it is important to assess therapeutic effects from the client’s perspective.

**Need for this Study**

The purpose of this study is to evaluate treatment effectiveness from a user’s perspective within an evidence-based framework. Keeping ecological validity in mind, it is important to collect rich data within a multi-method framework to analyze the short-term and long-term effectiveness of various procedures used in therapy (Kovarsky, 2008). Certain methods and procedures employed within a therapeutic framework, such as intensive therapy, have been shown to have short-term effectiveness (St. Louis & Westbrook, 1987). However, evaluation of
long-term effectiveness requires regular follow-up in a non-intensive framework. The use of cognitive-emotional counseling techniques, personal construct methods, and external support in the form of support groups have also show to help with long-term maintenance of therapeutic benefits (Crichton-Smith, 2002; DiLollo, Neimeyer, & Manning, 2002; Klompas & Ross, 2004; Plexico, Manning, & DiLollo, 2005; Stewart & Richardson, 2004; Yaruss et al., 2002).

Further, this study also proposes to determine the meaning of objective measures of treatment outcomes, including stuttering frequency (% syllables stuttered), type of disfluency, duration of disfluency, secondary behaviors, severity, and attitude questionnaires, to the individual client to help define treatment effectiveness from the client’s perspective. The following research questions will guide this study:

1. What factors do clients report as contributing to treatment effectiveness?
2. What therapeutic procedures do clients report as helpful in the long-term maintenance of treatment benefits?
3. What changes in objective measures of stuttering are noted after therapy?
4. What is the relationship between clients’ self-reports of treatment effectiveness and objective clinical measures of treatment outcomes?
CHAPTER 3

Methods

Design

A mixed method research design was used in this study. Morse (2003) defines mixed methods design as,

The incorporation of various qualitative or quantitative strategies within a single project that may have either a qualitative or quantitative theoretical drive. The imported strategies are supplemental to the major or core method and serve to enlighten or provide clues that are followed up within the core method (p. 190).

The decision to select a mixed methods approach was to allow triangulation of objective clinical data with clients’ reports of treatment effectiveness. As discussed in the review of literature, studies have either evaluated treatment effectiveness from an objective standpoint utilizing articulatory rate, SSI-3 (Riley, 1994), speech naturalness ratings, and attitude questionnaires as a measure of successful treatment outcomes or a qualitative approach treating the client as a experiential expert. Studies utilizing a quantitative framework to evaluate treatment outcomes often fail to include the client’s perspective on what has been helpful and what was not helpful. Studies utilizing a qualitative approach to evaluate treatment outcomes and successful management of stuttering are often accused of not meeting the scientific rigor required to be included within an evidence-based framework. Therefore, a mixed methods design can offset some disadvantages of both qualitative and quantitative methods (Tashakkori & Teddlie, 2003). Thus, this study used a mixed methods approach to evaluating treatment outcomes in stuttering.

A qualitative framework using a phenomenological approach comprised the core method used for this study. Quantitative measures of behavioral (speech), affective, and cognitive aspects of stuttering for both the participants’ present status and review of archival
records of treatment progress was gathered concurrently. These data were then be triangulated with the qualitative data obtained from the interviews to help explain relevant themes and perspectives better. Triangulation is a process where the researcher uses multiple and difference sources, methods, and theories to provide corroborating evidence. The process typically “involves corroborating evidence from different sources to shed light on a theme or perspective” (Creswell, 1998; p. 202). Thus, a concurrent transformative design (Creswell, Plano Clark, Gutmann, & Hanson, 2003) was utilized to inform the analysis and interpretations of results obtained from the qualitative and quantitative perspective.

Denzin and Lincoln (1994) define qualitative research as,

> Multimethod in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them. Qualitative research involves the studied use and collection of a variety of empirical materials – case study, personal experience, introspective, life story, interview, observational, historical, interactional, and visual texts – that describe routine and problematic moments and meaning in individuals’ lives (p. 2).

Thus, qualitative research primarily focuses on participants’ perspectives and the meaning of a particular experience for the individual and involves asking participants to describe their everyday lived experiences (Creswell, 1998). Considering the purpose and nature of the research questions, it was important to utilize a framework that considered the client’s perspective and experiences to answer the research questions.

This study employed a phenomenological approach that “describes the meaning of the lived experiences about a concept or the phenomenon” (Creswell, 1998; p. 51). The purpose of this study was to evaluate treatment effectiveness from a user’s perspective and gain a deeper and richer understanding of factors that contribute to successful management of stuttering. The study also proposed to analyze the correlation between objective clinical data
including stuttering frequency counts and speech rate with the speakers’ subjective reports of satisfaction and perceived benefits from therapy. Toward this end, the researcher obtained participants’ perspectives and the meaning of their lived experiences about this phenomenon.

To better answer the third and fourth research questions, the researcher concurrently gathered objective clinical data from the participants. These objective data gathered included speech samples in different environments, similar to data gathered pre- and post-therapy to measure treatment outcomes (Langevin & Kully, 2003). Additionally, archival records were also accessed to measure treatment progress.

Participant Selection

In a phenomenological study, according to Creswell (1998), the participants must be individuals who have experienced the phenomenon being explored and are able to articulate their conscious experiences. Thus, for the purpose of this study, participant selection was done through maximum variation sampling (Miles & Huberman, 1994). This method requires the investigator to deliberately select participants based on both similarities and differences across certain characteristics or experiences shared (Maxwell, 2005). Additionally, it is recommended that a long interview protocol be completed with up to ten people (Creswell, 1998.) Access to participants was limited to finding individuals who have experienced the phenomenon first hand and it is convenient for the researcher to obtain people who are easily accessible.

Selection of participants using the maximum variation selection method, according to Maxwell (2005) is intended to achieve four primary goals:

1. The first goal of this method was to establish a representative population by selecting participants who are known to either exhibit a particular characteristic or experience a
particular phenomenon. For this study, the primary investigator selected adults with
developmental stuttering who had attended a multi-faceted intensive stuttering clinic
offered at Bowling Green State University (BGSU).

(2) The second goal was to achieve heterogeneity. Thus, participants for this study varied
across race, gender, age levels, social backgrounds, personal experiences, educational
experiences, and vocational experiences. Also, stuttering affects more males than females
by a ratio of 4:1 (Bennett, 2006; Bloodstein, 1995), the gender ratio of the participants
reflected this ratio as closely as possible.

(3) The third goal of maximum variation selection was to explore cases that are pertinent to
the phenomenon under investigation. Thus, participants were recruited from individuals
who had attended the multi-faceted intensive stuttering clinic during different years. This
procedure was used to ensure heterogeneity of participants based on the type of therapy
experience (depends on the year they attended the intensive clinic), follow-up therapy
received, and the duration since they last received therapy.

(4) The fourth goal was to select participants for the purposes of making comparisons and
illuminating differences. The current participant criterion allowed the primary investigator
to compare immediate benefits with more long-term benefits of an intensive program
alone, and an intensive program coupled with a non-intensive follow-up therapy
experiences.

A total of 7 adult participants who had attended the Intensive Stuttering clinic for
Adults and Adolescents at BGSU were recruited for this study. The program was requested to
share a copy of the client’s files to allow the first author to access archival records of the
participants in this study. The first author then personally contacted clients who agreed to
participate in this study and conducted an in-depth interview with each participant. Following the interview, the first author also recorded samples of the participants’ speech in various settings (clinic, outside, reading in the clinic, and phone calls) for objective clinical data.

Table 2 provides demographic information for each participant who engaged in the semi-structured interview. This includes information about the year the participant attended the Intensive Clinic (years if the participant attended more than one offering of the clinic) and whether any follow-up therapy was received. Follow-up therapy was provided in the form of weekend intensive workshops, regular non-intensive therapy, or via telepractice. Telepractice is defined by the American Speech-Language-Hearing Association (2005) as, “the application of telecommunications technology to deliver professional services at a distance by linking clinician to client, or clinician to clinician for assessment, intervention, and/or consultation” and has been deemed an appropriate model of service delivery for SLPs. The position statement by ASHA (2005) further states that telepractice, which is a synonym for telehealth, may be used to overcome barriers to access of services including distance. For the purpose of the Intensive Clinic, distance has been the primary barrier to providing regular follow-up services. The use of telepractice as a means of regular follow-up to the intensive clinic was started in 2008. Pseudonyms have been used in Table 2 to ensure participant confidentiality.
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<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Occupation</th>
<th>Year(s)</th>
<th>Follow-up</th>
<th>Type of Follow-up</th>
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<td>Student</td>
<td>2008 &amp; 2009</td>
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</tbody>
</table>
The participant demographic data indicates that all participants in this study had attended different offerings of the Intensive Clinic. The participants also differ from each other in the type of follow-up therapy was received; if any. Thus, the interviews from individual participants revealed similar themes that capture the basic tenants of the program offered at BGSU, but allow comparison between the different experiences of the individual participants. It should be noted that the Intensive Clinic was first offered in the year 2003; thus the data collected in this study provides information from each offering of the intensive clinic. The clinic was not offered in the year 2007; hence there are no participants from that year. It should also be noted that follow-up via telepractice was offered for the first time in the year 2008. Lastly, the intensive clinic offered in the year 2009 was a nine-day program as opposed to the tradition three-week program offered in the previous years. Two of the seven participants attended the nine-day and three-week program and hence provide a comparison between the two variations of the intensive program.

_Nature of the Therapy Program_

Bowling Green State University’s Intensive Stuttering Clinic for Adolescents and Adults (Gabel et al., 2005; Gabel et al., 2008) is a 15-day intensive therapy program conducted during the summer at the BGSU Speech and Hearing Clinic. The clinic utilizes both fluency shaping and stuttering modification approaches. Therapy was conducted at the BGSU Speech and Hearing Clinic and in a “real world” environment, thus limiting the ability to control the setting and selection of clients. The sessions lasted from five to seven hours a day and included both group and individual sessions. Therapy is typically provided by five to seven graduate students and the clinic is staffed by a Board Recognized Specialist in Fluency Disorders (BRSFD), and several clinicians who hold ASHA’s Certificate of Clinical Competence (CCC).
The therapy was divided into four distinct but overlapping phases. The first Phase of this program helped the participants increase their awareness of their stuttering behaviors. The clinicians guided the participants in identifying all the behaviors related to their stuttering. These behaviors included disfluencies, secondary physical reactions, negative emotional reactions, and negative communication attitudes.

The second phase of the program aimed at guiding the participants through a process of reducing the severity of their stuttering. The clinicians encouraged the participants to stutter openly using techniques such as pseudo stuttering to assist in learning to stutter easily and reduce anxiety related to their stuttering (Van Riper, 1982). They also gave speeches during group therapy sessions and participated in a variety of conversations with unfamiliar listeners both inside and outside of the clinic.

The third phase involved teaching participants techniques to modify stuttering and improve fluency. The modification techniques included pull-outs and cancellations (Van Riper, 1982). Fluency shaping behaviors taught included easy onsets, deliberate phonation, airflow management, and reduced rate of speech. Initially, these behaviors were taught using very slow speech rates, which were gradually increased to more normal rates of speech. Delayed auditory feedback was used initially to assist the participants in producing these behaviors. Both types of techniques were first used in controlled contexts (clinical setting) and then in real-life situations (talking to strangers, completing phone conversations, giving speeches, etc.)

The fourth phase of the therapy program was focused on developing a personalized maintenance program for each participant. The maintenance programs, when present, have been described in the demographics section above.
Procedures

Semi-Structured Interviews

According to Creswell (1998), “for a phenomenological study, the process of collecting information involves primarily in-depth interviews with as many as 10 individuals.” (p. 122). All interviews were conducted via webconferencing using Webex software (Cisco Systems, http://www.webex.com). The software utilized to enable the online webconference interviews uses a secure server that is certified by Web Trust and SAS 70 and each session will be encrypted (http://www.webex.com/what-is-webex/technology-at-a-glance.html) to assure security and confidentiality. Webex also allows users to audio- and videotape interviews online in real time to review later for transcription purposes. The software was selected keeping security and ease-of-use in mind. The primary investigator of this study purchased a license for the software and can schedule meetings online at a time convenient to each participant. Participants were sent an email invitation to the online meeting. The email contained a link to the virtual meeting room with a secure password specific to that meeting. Webex functions across all platforms including Windows, Macintosh, Linux, and Unix and requires minimal to no technology support to function.

Few studies have utilized videoconferencing and webconferencing technologies as a medium for qualitative interviews (Chapman & Rowe, 2002; Sedgwick & Spiers, 2009). The use of this technology allows interviews to be conducted from a place and time convenient to both the interviewer and interviewee. There is also a significant cost reduction in conducting interviews using this technology in comparison to in-person interviews (Chapman, 1999). Sedgwick and Spiers (2009) used videoconferencing technology to conduct semi-structured interviews online and found that the use of this technology provided a rich medium that
allowed them to gather multiple verbal and nonverbal cues from their participants, use natural language, and immediate feedback allowing participants to express personal feelings and emotions. Thus, they found that videoconferencing allowed them to preserve more of the features found in in-person interviews. Sedgwick and Spiers (2009) also reported that the use of videoconferencing allowed them to establish rapport with all participants and proceeded through the stages of apprehension, exploration, cooperation, and participation as reported by Dicicco-Bloom and Crabtree (2006). Finally, none of the participants in this study (Sedgwick & Spiers, 2009) reported or verbalized any concerns with the technology. Disadvantages reported with the use of videoconferencing include the inability of the interviewer to use open body language to communicate acceptance and support of the participants, quality of call speed, and the availability of technology (Sedgwick & Spiers, 2009). During a pilot using the Webex software, it was found that video quality might have been slightly compromised depending on the internet connection speed. The delay however, was found to be negligible and it did allow flawless communication between participants. The use of software such as Webex did eliminate the need for technical support required for videoconferencing and helped reduce costs. Availability of the technology was another significant concern when using video/webconferencing technologies to conduct interviews. The software used to conduct interviews for this study required only a computer with a webcam and an internet connection to function. Participants recruited for the study were required to have their own internet connection. Webcams and headsets required to conduct the interviews were shipped to each participant by the primary investigator of this study. Participants were also emailed an illustrative guide to help them set up and use the webtechnology effectively (see Appendix B).
Before the start of the interview, each participant was emailed a consent form. Participants were asked to respond to the email with the words “agreement confirmed” in the subject line to indicate consent to participate in the study. Following consent, participants were asked to complete a demographic questionnaire designed to systematically gather information about the participants’ age, gender, educational background, family history, personal history of stuttering, and history of therapy received. The demographic questionnaire was uploaded to a websurvey using Survey Monkey (www.surveymonkey.com, 2009) to allow systematic and timely collection of data and reduce paper and mailing costs. The information gathered on the demographic questionnaire was used to make comparisons across participants for the qualitative analysis of data gathered during the interview and comparison of qualitative data with objective clinical data gathered. After agreeing to participate in the study and completing the demographic questionnaire, the primary investigator described the purpose of the study to the participant and then interviewed the participant according to the guidelines for a semi-structured, phenomenological interview (Creswell, 1998). The interviews lasted approximately 30 to 60 minutes and were conducted by the primary investigator. The researcher used an interview protocol (see Appendix A) to guide the interview. All questions asked in the interview were open-ended and asked in a conversational manner. The interviewer engaged in a dialogue with the participant instead of asking questions in a serial manner to attempt to elicit responses to the questions of interest. Follow-up questions were asked if any clarifications were needed, or if the participants failed to address a particular issue of interest. Participants were encouraged to speak at length about each question and their personal views and perspectives were sought. All interviews were audio- and/or video-taped and transcribed verbatim for data analysis purposes.
**Objective Clinical Data**

The second step in this process was the collection of objective clinical data from the participants at the time of the interview. The data collected at the time of the interview was done to match the participant’s archival data to allow for direct comparisons between archival data and current status. The information included below is a general description of data collected at the time of the interview and not representative of individual participants.

*Feelings and Attitudes toward Stuttering.* Objective clinical data included questionnaires that assessed the participants’ feelings and attitudes toward speech and communication. These questionnaires included:

(1) Locus of Control of Behavior Scale (LCB) (Craig, Franklin, & Andrews, 1984) which assesses the extent to which a client believes he can control his behavior and has been shown to predict long-term outcomes (Guitar, 2006) with lower scores on the LCB indicating decreased danger of relapse (Craig & Andrews, 1985; Craig, Franklin, & Andrews, 1984);

(2) Erickson S-24 Scale of Communication Attitudes (S-24; Andrews & Cutler, 1974) is used to obtain information about a client’s communication attitudes and has been normed on both People Who Stutter (PWS) and People Who Do not Stutter (PWDS). Research indicates that if communication attitude, as measured by this scale, does not change during treatment there is an increased likelihood of relapse within 12 to 18 months post-therapy (Andrews & Craig, 1988; Guitar & Bass, 1978); and

(3) Overall Assessment of Speakers’ Experiences of Stuttering (OASES) (Yaruss & Quesal, 2006) is a comprehensive measurement instrument that takes the totality of the stuttering disorder within the widely accepted ICF framework that can be used in daily treatment and in treatment outcomes research. This instrument has a total of four sections: I –
General Information; II – Your Reactions to Stuttering; III – Communication in Daily Situations; and IV – Quality of life. Impact ratings for each section and the overall impact stuttering has on the person’s life will be reported in this study.

*Speech Sample.* In addition to the attitudinal questionnaires, the interviewer also gathered and recorded the participants’ speech in various conditions. These conditions included conversations, monologues, phone calls, and reading samples in the interview room. The samples thus gathered and audiotaped were analyzed for:

1. **Frequency** of stuttering reported as percentage of syllables stuttered (%SS). This measure has been found to be highly correlated with stuttering severity (Young, 1961);

2. **Type** of stutters was counted in addition to the frequency to determine the predominant type of disfluency;

3. **Duration** of the longest block has been known to provide important information about how much stuttering may interfere with communication (Van Riper, 1982). In accordance with common practice, the average duration of the three longest stutters in each speech sample were calculated (Myers, 1978; Preus, 1981; Riley, 1994; Van Riper, 1982);

4. **Secondary Behaviors** are most often escape type behaviors used to break out of a stutter after it starts or avoidance type behaviors used to keep from stuttering (Guitar, 2006). These vary from individual to individual and can take the form of physical movements or changes in the way speech is produced. Secondary behaviors are often signs that stuttering has progressed to a more advanced stage and need to be included in a thorough assessment of stuttering severity (Guitar, 2006);
(5) Severity of stuttering, suggested as the clinically most relevant assessment of overt stuttering behaviors (Guitar, 2006), is also a very important measure of treatment outcomes. Stuttering severity was measured using the Stuttering Severity Instrument- Third Edition, (SSI-3; Riley, 1994).

Data Analysis

Qualitative

Each semi-structured interview was audio and video recorded to allow for transcription and analysis of the data. The data obtained from the semi-structured interviews was analyzed for common themes both within and across the participants’ accounts of their experiences with therapy and coping skills/strategies used when not in therapy. Categorizing strategies including coding and thematic analysis were used to analyze the transcribed interviews (Maxwell, 2005.) The primary investigator utilized the following procedure, as outlined by Creswell (1998), to guide the analysis of data obtained from the interviews:

1. Interviews were transcribed verbatim. The transcription included both the interviewers’ and the participants’ statements (McLellan, Macqueen, & Neidig, 2003).

2. All transcripts were read in full by the primary investigator.

3. Each line in the participant’s transcript was reviewed using the concept of treatment effectiveness as the “lens” for analysis and then assigned a short code that summarizes the statement (LaPelle, 2004).

4. Following the generation of a list of codes, the primary investigator looked at the complete list and determined which codes are meaningful to the participant’s experiences. Themes were determined on observed
commonalities across the participant’s therapy experience and coping skills/strategies used during and after therapy. These themes were then further grouped in categories.

This process was completed for each participant, and following the independent analyses of all transcripts, major themes for the group were determined by looking across codes and individual themes for each participant.

*Reliability.* To enhance reliability of this analysis, two external reviewers, naïve to this particular study, were recruited to recode all of the responses. Both external reviewers are assistant professors in communication disorders and teach undergraduate and graduate level courses in fluency disorders at their respective universities. Thus, the external reviewers although naïve to this particular study, are well versed with stuttering literature and can be considered as experts on the topic. A Pearson’s Correlation and t-test was conducted to examine inter-judge reliability of the themes. Results of this analysis between the primary investigator and first judge indicate a positive correlation, significant at the 0.01 level ($r = 0.979$). Results of this analysis between the primary investigator and the second just yielded a positive correlation, significant at the 0.01 level ($r = 0.997$). A t-test comparing means for all judges was conducted. The results indicate no significant differences between means for the primary investigator and the first judge ($t = .163; p = .880$), and the second judge ($t = .000; p = .923$) thereby establishing inter-judge reliability.

*Credibility.* In qualitative research, credibility or correctness of a description, conclusion, explanation, interpretation, or any other sort of account by the researcher is the same as validity in quantitative research. The use of this term does not imply the existence of an objective truth or gold standard to which data collected and analyzed in qualitative
research can be compared. A key concept for credibility however, is a credibility threat that can be conceptualized as alternative explanations. These threats to credibility are particular events or processes that can lead to invalid conclusions rather than variables that can be controlled for.

Two broad types of threats to credibility include researcher bias and the effect of the researcher on the environment or individuals studied. Thus, credibility comprises strategies used by the qualitative researcher to identify and attempt to rule out threats to credibility (Maxwell, 2005). Clarifying researcher bias (Creswell, 1998, pp. 202) is another important credibility check employed at the outset of the study to clarify the researcher’s position, his past experiences with the topic, and any biases and assumptions that may impact the inquiry. This process is often referred to as “bracketing” (Maxwell, 2005) and was employed as a credibility check for this study. The researcher addressed his personal and professional biases regarding stuttering and what findings may be expected before analyzing the interviews. The primary investigator in this study has a Master’s degree in communication sciences and disorders and is currently enrolled in a PhD program in communication sciences and disorders. He has six years experience working with PWS, including three summer intensive clinics at the multi-faceted program for adults and adolescents who stutter. He is also an active member of the local NSA chapter and a member of the International Fluency Association (IFA). The primary investigator thus, from the outset of the study, commented on past experiences, biases, prejudices, and orientations that could possibly shape the interpretation and approach to this study (Creswell, 1998). The primary investigator made notes about his experiences with therapy for PWS and his beliefs about what is effective for long-term management and coping with stuttering (Appendix B). This process helped the researcher identify his own biases and increased his
awareness, thus reducing the effect these biases had on interpreting the qualitative data obtained in this study.

It has been recommended that intensive interviews enable the researcher to collect “rich” data (Maxwell, 2005). In order to gather rich data for interview studies, it is recommended that the researcher transcribe the entire interview instead of taking notes on what the researcher feels is important. Data collection in this study involved audiotaping in-depth interview with each participant. The primary investigator for purposes of data analysis transcribed the audiotaped interviews.

Respondent validation, often referred to as member checks (Bryman, 1998, pp.78-80; Lincoln & Guba, 1985), includes “systematically soliciting feedback about your data and conclusions from the people you are studying” (Maxwell, 2005, pp.111.) This method has been further described as the single most important way to rule out the possibility of misinterpretation of participants’ accounts by the researcher. To help avoid misinterpretation of participant accounts, the researcher mailed a copy of the interview transcript with his conclusions to the participants and sought their feedback. All participants read over the conclusions made by the primary investigator and responded back via email. All participants’ were in agreement with the initial conclusions drawn by the primary investigator and did not request any changes or additions to the transcript.

Clinical Data

Current Status. Objective clinical data in the form of feelings and attitudes toward stuttering measured using attitude questionnaires including the LCB, S-24, and OASES; and speech sample analysis for frequency, type, duration, secondary behaviors, and severity were analyzed after the completion of the semi-structured interview with each participant. All data
gathered was analyzed individually for each participant following the guidelines outlined above in the procedures section. Additionally, group means for the following tasks: S-24; LCB; SSI-3; and %SS in conversation, reading, and phone calls were calculated to determine trends in clinical data. The group means were calculated for scores gathered at baseline (pre-intensive clinic), at the completion of the intensive clinic (post-intensive clinic), and at the time of the interview for all seven participants.

Archival Data. Archival data gathered from client files obtained from BGSU’s Intensive Stuttering Clinic for Adolescents and Adults who stutter was analyzed for changes reported on the attitude questionnaires, stuttering severity (SSI-3), and speech sample analysis prior to the initiation of intensive therapy and following the completion of the intensive therapy program for each participant. For the attitude questionnaires, the OASES was not administered for participants attending the intensive clinic in 2004. Hence, OASES results will be reported for all other participants.

Treatment Outcomes. Treatment outcomes were measured based on changes reported on the attitude questionnaires and speech sample analysis prior to the start of the intensive therapy and at the end of the intensive therapy program. Further, long-term treatment outcomes were measured by comparing archival data with the objective clinical data measured at the time of the interview. Thus there were a total three points of comparison for the final analysis: (1) pre-treatment; (2) immediately post-treatment; and (3) six months to seven years post-treatment.

Triangulating the Data

Following the data collection and analysis phase of this study, results from the qualitative phase and the quantitative phase was compared to look for similarities between
themes obtained from the qualitative analysis and patterns observed in the objective clinical data, both current and archival. This process will be transformative and further directions for understanding this data and future research will be informed by the results obtained from the individual data sets in this mixed methods study.

Application to an Evidence-Based Framework

ASHA defines EBP as, “the integration of: (a) clinical expertise, (b) current best evidence, and (c) client values to provide high-quality services reflecting the interests, values, needs, and choices of the individuals we serve.” (ASHA, 2004). Thus, the results obtained from the qualitative phase of this study addressed client values and preferences. Results obtained from the objective clinical data and the therapy plans addressed the clinical expertise piece of EBP and help produce current evidence evaluating the effectiveness of various treatment paradigms from a clinical and client perspective to determine the current best evidence. Hence, the use of a mixed methods design allowed us to incorporate clinical expertise with patient values to produce evidence for or against certain procedures used in stuttering therapy.
CHAPTER 4

Results

The purpose of this study was to use a mixed-methods design to determine treatment effectiveness from a client perspective. The study further sought to determine the correlation of objective clinical data with client’s reports of satisfaction and benefits from therapy. This study was guided by the following research questions: (1) What factors do clients report as contributing to treatment effectiveness; (2) What therapeutic procedures do clients report as helpful in the long-term maintenance of treatment benefits; (3) What changes in objective measures of stuttering are noted after therapy; and (4) What is the relationship between clients’ reports of treatment effectiveness and objective clinical measures of treatment outcomes?

The first two research questions in this study are answered by data collected and analyzed from the semi-structured interviews. The third research question for this study is answered by the objective clinical data gathered at the time the participant attended the intensive clinic, and at the time of the interview. The fourth research question is answered by comparing objective clinical data with relevant themes generated from the semi-structured interviews.

Results from the data collected are reported in this chapter. This chapter is further divided in two sections. The first section presents relevant themes generated from qualitative data across participants and clinical data averaged across all participants. The purpose of the first section is to provide the reader with an overall summary of qualitative data gathered across all participants and clinically measured objective changes in stuttering severity and attitudes toward communication. The second section provides data from each participant. The purpose of this section is to provide the reader with qualitative themes relevant for individual participants and
objective clinical data for each participant. This section includes additional themes generated from individual semi-structured interviews that were not replicable across all participants.

The data for both sections in this chapter will be presented in tables and quotes from individual interviews. The quotes used to support each theme in this chapter were selected based on the specificity of information provided.

Section 1: Overall Summary Across Participants

The purpose of this section of the chapter is to provide a summary of data gathered across participants. This section first highlights qualitative themes relevant across all participants. The section also presents trends in objective clinical measures gathered before the intensive clinic (pre), at the conclusion of the intensive clinic (post), and at the time of the interview (current). The objective data presented in this section is an average across all seven participants and provides the reader with a general overview of changes in objective data reported as a result of attending the intensive clinic and maintenance of changes made during the intensive clinic. In addition to the objective clinical data, the qualitative themes generated from the interviews have been categorized and relevant themes from each category will be presented below. A description of the categories and relevant themes will be supported by specific quotes from individual interviews. In this section, themes that were generated for more than half the participants are presented. Additional relevant themes from individual participants based on their personal experiences will be presented in the second section of this chapter.

The major categories and themes for this section are presented in Table 3.
Table 3

*Categories and themes across participants.*

<table>
<thead>
<tr>
<th>Category</th>
<th>Theme</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Effects</td>
<td>Duration and nature of Program</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Speech Techniques Learned</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Attitude Change and Counseling</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Desensitization and Transfer of Skills</td>
<td>6</td>
</tr>
<tr>
<td>Indirect Effects</td>
<td>Motivation and Readiness</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Clinician Attributes</td>
<td>5</td>
</tr>
</tbody>
</table>


**Direct Effects**

This category is used to summarize themes from individual transcripts that discuss the positive or negative effects of various aspects of therapy. This category includes a total of five themes that describe how participants found various aspects of the program beneficial. The relevant themes from this category are discussed below.

**Duration and Nature of Program.** Statements indicating the positive impact of the nature of the intensive clinic were coded using this theme. This includes statements about the overall structure and execution of the intensive clinic, including the duration of the clinic. Examples of this theme are:

*Daniel:* First, I was staying in the dorms with a few other people who stutter and I am still friends with two of those people who I went through the clinic with so it’s been positive in that respect and I think that going through an intensive clinic with other people who you’re rooming with I think you get a different aspect of therapy from the clinic just by being around those people all 24/7 and its sort of like a small family that you are sort of thrown in to, that is very helpful. So that was one aspect that was helpful.

*Cody:* The first time I went I think I made the most progress, I think also because I had no real speech therapy before that but yeah just focusing on my speech that intensively and thinking everything out like that and then using all the techniques to sort of learn how to speak again kind of I think that helped me out a lot.

*Nicole:* Something that was new and different for me that stood out from any other experience was actually being with other people that stuttered and meeting with them and talking with them, I had, there was one guy in my high school who stuttered but we sort of ran in different friend groups so we really didn’t have any contact but I just knew of him and so it was just an awesome thing to see that I’m not the only one like this that other people have this issue. That is something that really stood out for me that was just different from what I have done before and then obviously the amount of therapy stood out as being different. It was an all day sort of thing as opposed to an hour one day per week.

These statements from the participants can be construed as a perceived benefit of the overall setup of the intensive clinic. The intensive clinic has been offered as a 15-day residential program and most participants were housed in dormitories on campus. Thus, participants
attended the program and lived with others attending the program for a three-week period. All seven participants found this aspect to be helpful. They all perceived a benefit from living on campus with other participants’ and the amount of time they had to focus on working on their speech with other PWS in a group and individually with their clinicians. The residential nature of the intensive program, the amount of time devoted to working on speech, and the idea of being in a “cohort” or “family” appears to have a positive effect on clients’ perceptions of treatment effectiveness.

*Speech Techniques Learned.* Statements indicating that learning various strategies to manage or modify stuttering moments such as easy onsets, slow prolonged speech, pull-outs, etc were helpful to the participant as part of therapy were coded with this theme. This theme highlights the importance of using an eclectic approach and providing participants with multiple strategies from fluency shaping and stuttering modification approaches to manage the behavioral component of stuttering. Selected examples from this theme are:

**Mike:** They taught me how to actually get through blocks where you slow down your words. So if there is a word like a w-word and I’m having a problem with you can kind of slow it down to get in to words. They actually taught me how to think a little bit slower you know to prepare yourself when you are speaking so if you are about to start a conversation, start it slower and then slow in to the word a little bit more and I use some of that stuff now.

**Teddy:** Slowing down your rate is really helpful. And also do different techniques at the start of a sentence has been helpful for me. So those techniques were helpful for outside of the intensive clinic.

**Rick:** I still find voluntary stuttering, pullouts and cancellations useful but seems like when I do that stuff it makes my stuttering seem more severe and I don’t get as good of a response from the listener as I do just by trying to talk smoothly and getting through the stuttering moments as soon as possible but they really make talking a lot easier in situations when I am able to use them. Actually, before therapy at BG I generally found talking absolutely miserable and even when I didn’t have that much stuttering but when I am really able to manage my speech I actually enjoy talking.
These statements were made in repose to questions about what specific activities/techniques participants found helpful. As can be seen from statements coded with this theme, all participants felt like they did benefit from learning a variety of fluency shaping and stuttering modification techniques. As cited by previous studies, participants’ in this study reported a preference for the use of slow prolonged speech to help move to silent prolongations more effectively. All participants’ acknowledged that it is difficult to effectively use techniques in all speaking situations, but it is important to know how to use them and practice using them in a variety of settings. Thus, it appears that the intensive nature of the program allowed participants’ to practice using these techniques in a more focused manner over an extended period of time. It can be argues that the duration of the program allows participants to transfer skills learned in therapy, but also practice fluency shaping and stuttering modification techniques to an extent where it reaches a level of automaticity that allows them to use the techniques more effectively with reduced mental effort. Another important theme, attitude change and counseling, discussed below appear to be essential to the effective use of fluency of modification techniques learned in therapy.

**Attitude Change and Counseling.** This theme reflects statements that describe the positive impact of counseling strategies used in therapy. This also includes statements about the positive effect of changing attitudes toward self and stuttering have on the participant’s ability to manage stuttering and approach feared situations. Selected examples from this theme are:

Nicole: Oh yeah, like I think that changed a lot. A big thing for me is I’m a perfectionist and I have a really big fear of failure and especially in high school with my parents I was always fear of not being perfect for them or letting them down and I think I knew in the back of my mind that my stuttering would never just go away and I think that my mom was thinking; and I have no idea if this is how she thought or not or just is just how I perceived that she was thinking. I just had this idea that she thought that I’m gonna send her to therapy and then this problem will fix itself but I think I knew that it was never going to be completely fixed so I was too scared to even try because what if I actually
tired and put effort and then it didn’t get fixed like my mom was expecting it to. So it was easier to just not to try because I knew that the outcome would not be this perfect fix whereas I was saying at the clinic having that attitude of like we are not here to fix you we are here to make your life as enjoyable and successful as you want so there was just sort of this attitude of we’re just going to make you as fluent and under control of it as you want and so that was just like a much more, so much more safe to want to try because I knew that the end result that was being expected of me was just that I was happy with the result. So with that in mind all I need to do is improve to the point where I am happy and satisfied as opposed to I have to continue to fix it until my speech is completely fluent like it was just so much easier to actually go into it because I wasn’t scared of the failure.

Yolanda: Ok so I remember one of the handouts I think that was some statement about stuttering and I don’t remember exactly but like stuttering is not something that happens but something that I do; something like those taught me to be responsible and another thing is that whether I stutter or not the listener is not going to know or how did it go, something like a time thing avoiding to stutter because it is not about the listener but about the way I feel. Learning about the process of attitude and feeling.

Cody: Things that helped were mainly things that I would do like controlling emotions you know like I think we did this in speech therapy but not to try to block emotions like nervousness you know but like to use like extra energy to maybe focus more on a technique or yeah like to have more control over the situation will help. Also the techniques we did in speech therapy like the pull-outs but those only work when you seem to control your emotions and you can handle the situation better but like you can’t be like the same like for all of them, it gets harder.

These statements from the participants are reflecting of the perceived benefits of using strategies such as CBT and motivational quotes. Six of seven participants reported that they feel like they benefitted a lot from exploring their own attitudes toward communication and stuttering and it in many ways set the foundations for using fluency shaping and stuttering modification techniques learned in therapy more effectively. As Cody explicitly stated, “Also the techniques we did in speech therapy like the pull-outs but those only work when you seem to control your emotions.” A big part of understanding and changing one’s attitudes toward communication also includes desensitization to feared speaking situations and learning to transfer skills practiced in
the therapy room to the outside. The theme, desensitization and transfer of skill, discussed below, further corroborate this.

Desensitization and Transfer of Skills. This theme was used to code statements that indicate a positive impact of completing activities that require the participant to go outside his or her comfort zone and talk in feared situations. These include activities completed outside the clinic and help with transferring speech strategies learned during therapy in the clinic. Selected examples of this theme include:

Rick: It was actually really nice to just go outside of my comfort zone like during the stuttering surveys or going to administrative offices on campus to ask questions, that’s something I have never done for any therapy.

Teddy: Doing phone calls and listening back to them was also really helpful for me to recognize what I was feeling and I also like going around campus and talking to random people. That helped me to desensitize and also my fear of stuttering in public.

Daniel: The other thing that was helpful was just pushing me to do things outside of my comfort zone and really, I mean there was some hand holding that was involved but some pushing too like you just need to do this no matter what. I guess one example that stands out the most is that I have always been very fearful of approaching strangers and just talking to them. That’s something that I used to hate doing, I mean I’m still not fond of doing that but it was a lot scarier for me back then and before the clinic I would always have severe blocks in doing a situation like that or it was just real though so doing that situation, I think it was the first few days of clinic.

Statements coded under this theme capture the perceived benefits of completing activities that push participants outside their comfort zone to address their attitudes toward communication and their ability to transfer new motor skills learned during therapy to typically feared speaking situations. Participants’ statements indicate that they feel completing activities of this nature contribute to treatment effectiveness and help with addressing their attitudes toward communication and effectively managing their situation in a variety of situations. The themes on this category indicate that the four components of the intensive program discussed; including the
nature and duration, teaching fluency shaping and stuttering modification techniques, use of CBT, and desensitization activities work as a package and have overall influence on treatment effectiveness for a majority of the participants’ attending the program. These four components appear to be essential to treatment effectiveness and appear to overlap with each other to provide participants’ with a well-rounded program that helps make clinical measurable gains in both speech related measure and attitudinal measures. Further, one can argue that the exploring and modifying personal attitudes toward communication and stuttering can be beneficial to the individual’s ability to effectively use fluency shaping and stuttering modification techniques in a variety of speaking situations.

**Indirect Effects**

This category is used for themes generated from participant interviews that reflect on factors not directly related to the therapy program that have had a positive impact on the effectiveness of the program and the participant’s perceived benefits from the program. The themes under this category appear to be an essential part of the program and can have an impact of the treatment outcomes and the client’s perceived benefits from the program. These are statements that reflect positive coping with stuttering and a better sense of control in a variety of difficult speaking situations. There are two relevant themes presented related to this category.

**Motivation and Readiness.** Statements coded with this theme reflect the impact the participants’ personal motivation to attend the program and readiness to commit to the program had on their perceived effectiveness of the program. These statements also include those comments suggesting the negative impact a lack of motivation and/or readiness can have. From a few participant reports, it appears that the nature of the therapy program and the clinician’s
attitude could possibly have an influence on motivation and readiness for making changes in therapy. Selected examples from this theme include:

Nicole: I think my issue was I was still in denial and I was not either at the age or maturity level to talk about it in a open way and be honest with him and to really accept that this was an issue that I had and now I needed to work on how to fix it. He was definitely the first sign of hope but I didn’t think that myself at that age where I was at, I was not prepared for that.

Daniel: Well, leading up to the Bowling Green intensive clinic I was, I would call myself a pretty severe stutterer back then. And so my stuttering really affected me at my job as a speech-language pathologist. I mean I was able to carry out my job pretty well but there were times where it was really difficult to talk. So that gave me the motivation to go through the intensive clinic and to get as much from that clinic as I possibly could. I would say I was a 10 of 10 as far as being motivated for that clinic so that was helpful.

Cody: I think speech therapy in the school, I don’t think I was very much into it. The only thing we would do was to look at the characters of Winnie the Pooh and all of them had a different way of handling stuttering something or like rather than handling it, like I think it was Tigger that spoke slowly or and then some other character spoke fast and some other ones spoke in the XXX voice but the owl spoke in the preferred way, he would breathe in and then breathe out a little bit and start speaking on your exhale. There was some name for it forgot that. Then we would just do sounds, or have to repeat words that started with sounds that I was having trouble on and then I would just mainly talk a lot at the therapy. There was no real focus on the mental aspect of it and how to handle situations or controlling most, it was just the outer aspects.

These statements are reflective of the participants’ personal motivation to attend the therapy and how that had an impact on their perceived benefits from the program. Most participants reported that they were very motivated to attend the program for various personal or professional reasons and were determined to make the best of it and gain the most of it. Some participants’ statements also indicate that the direct effects of the program had an influence on their motivation and resolve to gain the most from this program. Thus, it is important to remember that a highly motivated client will benefit from the program provided the program is to their liking and the methods used in therapy help the client maintain a high level of
motivation. Another major factor affecting the client’s motivation is the relationship they have with their clinician. This is another important theme discussed below as clinician attributes.

**Clinician Attributes.** This theme codes statements from the transcripts where the participants indicate how the clinician’s responses and demeanor can have a positive or impact on the therapy experiences and perceived benefits from therapy. The statements can also be interpreted as the advantage of a good client-clinician relationship where the client can trust the clinician when entering difficult situations. The main component of the statement reflecting this theme has been italicized. Selected examples from this theme are as follows:

**Mike:** When I was with speech therapist that didn’t give you a strange frown or what are you saying or anything like that I started speaking much better where you know, I started to actually not stutter at all because there wasn’t anything in my mind where you know it was a blockage saying like “ah man what’s going on”. It wasn’t a strange look or it wasn’t like what are you saying again; I didn’t hear that – I didn’t understand that. So I actually, I think we spoke a lot better because they were there basically saying stutter – we want you to stutter and I started to not stutter that much anymore. I think that it gave me a comfort level that I was not used to.

**Daniel:** So she pulled me to the side and she was like ok so what’s wrong. So I told her what I was experiencing inside and so she listened to me which was helpful and then she showed techniques that she thought might help me in this situation. So she suggested just doing some voluntary stuttering to get me going for a conversation and just try to maintain the eye-contact. So I did that and it was the first time that I can remember that I approached a stranger using voluntary stuttering and at the same time maintaining eye contact. So that was a big success for me and something that I had to be pushed to do because I would never do that by myself.

**Rick:** It was nice that they didn’t tell me I stuttered so severely that they could never possibly help me, it’s just something I have heard several times.

These statements reflect the importance of a good clinician-client relationship on the perceived benefits from therapy or treatment effectiveness. This theme was consistent across five of the seven participants’ interview for this study. One of the major factors participants reported as influencing their motivation and perceived benefits from treatment was their overall
relationship with the clinician as well as their perception of the clinician’s competency. They reported that past therapists were often not invested in therapy and did not benefit much from previous therapy because of their lack of faith in the clinician’s competence. This is an important factor to consider when evaluation treatment effectiveness or treatment outcomes, because the clients’ motivation to benefit from the program could depend a lot on the clinician’s competence and the clinician-client relationship.

*Other Relevant Themes*

This sub-section of the first section describes other relevant themes from individual interviews that were not included above because they were not replicated across a majority of the participants. This includes themes that were specific to a particular year the program was offered and were not experienced by all the participants. There are a total of two themes that appear to be relevant to participants’ therapy experiences that are discussed in this sub-section. The themes discussed here are: (1) Follow-up; and (2) Effect of program duration.

*Follow-up.* This theme was selected as relevant to discussion in this section of the results chapter because a large majority of the participants who received follow-up therapy after the intensive clinic indicated that it was beneficial. Additionally, the participants who did not receive follow-up services after the intensive clinic recommended that follow-up be offered in the future to make the program stronger. Selected examples from individual transcripts that reflect this theme are as follows:

- **Daniel:** I still had quite a bit of trouble with the carryover part though, incorporating those strategies or different ways of thinking in my everyday life that was still missing but

- **Mike:** I would probably say that probably would/could be improved about the program is probably to do more individual follow-up where it was more closely aligned to you. But it is hard because a lot of people were graduating and going into their own careers. I would probably say that with the addition of video and webcams you could probably do
that. You can actually do an individual therapy session as a follow-up for a few months if you could set it up where each person has a webcam. Do follow-up to check and see progress. I think that can be added to the program pretty easily. Maybe possibly have it where it is possible where the person went straight from the clinic back into therapy just to make sure that they are actually doing the techniques and to brush up on the techniques if one gets a little lapse on it. I would say that those would be some of the individual improvements that I would suggest.

Teddy: I really like how we still have contact with the clinicians after therapy is over because as everyone says the hard part is once you leave the clinic and go to the real life. So it was extremely important to have that support system of the telepractice and having someone to talk to and share. So that was really a big part of what I gained from that therapy.

The theme of follow-up discussed above indicates the importance of an intensive program to provide clients with the option for regular structured follow-up. It appears that clients who did receive regular non-intensive follow-up perceived a benefit and for clients who did not receive the follow-up services, they reported that as a piece that was missing and they wished they had contact with their clinicians after returning home from the intensive clinic.

*Effect of program duration.* This theme was used to code statements describing the effect the length on the intensive program had on participants’ perceived effectiveness of the program. This theme is replicated in interviews from two participants who had the opportunity to attend the longer 15-day intensive clinic and the shorter nine-day intensive clinic offered in 2009.

Selected statements from this theme are:

Rick: I actually thought the longer clinic in 2006 was better just from having more time and spending more time on just working on techniques.

Teddy: Yeah, I participated in the 15-day and then the 9-day clinic. I personally thought the 15-day was a lot more helpful for me. There was a lot more time to work on the techniques and I really liked that we had take home activities to do too.
**Data Triangulation**

The themes above reflect that all seven participants’ in this study found the intensive clinic effective in general and highlighted various aspects of the clinic that made it a beneficial experience for them. The qualitative themes relevant to this have been discussed above. Another purpose of this study was to provide objective clinical data about the effectiveness of the intensive program and triangulate these objective measures with participant reports of treatment effectiveness. Figures 1 and 2 present average scores for all seven participants on clinical measures of stuttering severity (SSI–3), communication attitudes (S-24 and LCB), and percent disfluencies recorded in a variety of tasks (conversation, reading, and phone calls). Impact ratings on the OASES for four participants that completed the scale are presented in Table 6. Two of the participants attended the intensive clinic in 2004 and hence did not complete the OASES. One participant, Rick, was 16 years old when he first attended the intensive clinic, hence completed the adolescent version of the scale (ACES; Yaruss, 2003). The data for the ACES will be reported in section 2 with the individual participant summaries. The data presented in the figures 4 and 5 is an average across all participants’ in this study (n = 7) and presents overall trends across participants attending the intensive clinic. The data presented includes baseline data gathered before the start of the intensive clinic, treatment effect gathered at the end of the intensive clinic, and maintenance data gathered at the time of the interview. The objective clinical data for stuttering severity (SSI–3; Fig. 4) indicates that participants demonstrated measurable clinical gains as a result of attending the intensive clinic and maintained these gains following conclusion of the intensive clinic. Objective data for participants’ attitudes toward communication and stuttering as measured on the S-24 (Fig. 4) indicate that client’s reported measurable clinical change at the end of the intensive clinic but this change was not maintained
post-therapy. The score for the S-24 gathered at the time of the interview however, were lower than scores reported at baseline. The objective data on the LCB (Fig. 4) indicates positive clinical change at the conclusion of the intensive clinic; however, current data indicates the scores similar to baseline score. It should be noted that all scores indicate an internal locus of control and are hence positive. This measure indicates that participant’s were not able to maintain changes related to locus of control over a period of time as seen with measures of stuttering severity and communication attitudes. The objective data for four participants who completed the OASES (Table 6) also reflects a similar theme with measurable gains made as a result of attending the intensive clinic. Lastly, clinical data indicating %SS gathered for three different speaking situations (Fig. 5) indicates that on an average participants’ demonstrated clinically measurable gains in this measure during the intensive clinic. Current data indicates that participants’ continued to make positive changes in their fluency.

The objective data thus appears to corroborate participants’ reports of treatment effectiveness. One of the main themes that all seven participants reported was that they perceived a benefit from the nature and duration of the intensive program. The objective clinical data for stuttering severity and attitude change indicates that participants demonstrated clinically measurable change at the end of the intensive clinic. Participants’ were able to maintain these positive changes on most clinical measures between one- to seven years after the intensive clinic and showed mild positive changes on measures of %SS. Individual participant summaries and clinical data is discussed in section 2 below.
Figure 4. Average Scores on the S-24, LCB, and SSI-3
Figure 5. Average %SS for Conversation, Reading, and Phone Calls
Table 6  

*OASES impact rating for four participants*  

<table>
<thead>
<tr>
<th>Participant</th>
<th>OASES</th>
<th>Pre-intensive</th>
<th>Post-Intensive</th>
<th>Current (2010)</th>
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<tbody>
<tr>
<td>Cody</td>
<td>Moderate/Severe</td>
<td>Mild/Moderate</td>
<td>Moderate</td>
<td></td>
</tr>
<tr>
<td>Teddy</td>
<td>Moderate/Severe</td>
<td>Moderate</td>
<td>Moderate</td>
<td></td>
</tr>
<tr>
<td>Nicole</td>
<td>Moderate</td>
<td>Mild/Moderate</td>
<td>Mild/Moderate</td>
<td></td>
</tr>
<tr>
<td>Yolanda</td>
<td>Moderate</td>
<td>Mild/Moderate</td>
<td>Mild/Moderate</td>
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Section 2: Individual Participant Summary

The purpose of this section of the chapter is to provide a summary of data gathered from individual participants. This section highlights themes relevant to individual participants’ experiences in addition to individual participant profiles. The qualitative themes discussed in this section will be additional themes that are specific to the participants and not already summarized in Section 1 above. This section will also provide the reader with objective clinical data related to stuttering severity measurements and measures of attitude change for each participant.

Participant 1: “Daniel”

Daniel is a 38 year-old male who attended the intensive clinic in 2004. He received follow-up in the form of weekend intensive workshops in the fall of 2004 and 2005. Daniel also pursued regular follow-up therapy with a private speech therapist in his area. He is currently a doctoral student in speech language pathology and teaches college level courses. Clinical measures reported for Daniel include speech related measures of % SS for a conversational sample, a reading passage, and three phone calls; and stuttering severity as measured on the SSI-3. Attitudinal measures include scores on the S-24 Scale of Communication Attitudes and the LCB. These measures are reported for Daniel at the time when he first attended the intensive clinic (pre-intensive); at the conclusion of the intensive clinic (post-intensive) in 2004; and at the time of the interview completed in 2010. Changes in clinical data over a period of six years are reported in Table 7. As can be seen from the data presented in the table below, Daniel made some measurable gains in speech related and attitude measures as a result of attending the intensive clinic. It is important to note that these changes were maintained over a period of 6 years. Daniel reported a number of factors in his interview that were crucial to making- and maintaining these changes in objective clinical measures. For Daniel the theme “Life Events”
discussed below appears to be a major contributing factor in the maintenance of gains made during the intensive clinic.
<table>
<thead>
<tr>
<th>Clinical Measure</th>
<th>Pre-Intensive</th>
<th>Post-Intensive</th>
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</tr>
</thead>
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<tr>
<td>S-24*</td>
<td>16</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>LCB*</td>
<td>22</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>SSI-3</td>
<td>36</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>%SS Conversation</td>
<td>22%</td>
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<tr>
<td>%SS Reading</td>
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<td>%SS Phone</td>
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</table>

* Lower scores indicate more positive attitudes
Table 8

*Categories and Themes for Daniel*

<table>
<thead>
<tr>
<th>Category</th>
<th>Themes</th>
</tr>
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<td>Direct Effects</td>
<td>Duration and Nature of Program</td>
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<tr>
<td></td>
<td>Identification/Awareness of Stuttering Behaviors</td>
</tr>
<tr>
<td></td>
<td>Speech Techniques Learned</td>
</tr>
<tr>
<td></td>
<td>Attitude Change and Counseling</td>
</tr>
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<td>Desensitization and Transfer of Skills</td>
</tr>
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<td>Follow-up</td>
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<td>Indirect Effects</td>
<td>Motivation and Readiness</td>
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<td>Life Events</td>
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<td>Clinician Attributes</td>
</tr>
<tr>
<td>Recommendations</td>
<td>Use of External Aids</td>
</tr>
<tr>
<td></td>
<td>Follow-up</td>
</tr>
</tbody>
</table>
A detailed analysis of the transcript generated from the interview with Daniel revealed 11 themes that fit in three categories. Categories were determined for themes based on participant reports of what aspects of therapy were helpful and what aspects of therapy were not helpful. All themes have been outlined in Table 8.

A total of three additional themes were generated from the interview with Daniel. The themes are discussed below with relevant quotes from the transcript.

Identification/Awareness of Stuttering Behaviors. This theme was used to code statements that indicate the participant perceived a benefit from activities during therapy that helped increase awareness of his own stuttering behaviors. This includes but is not limited to tallying disfluencies with the clinician. Examples of such statements include:

Daniel: I had never done the identification stage before where you identify what you are doing with your speech what you’re thinking and then tallying I had never done that before so that was really helpful for me that was a big positive so I would say what I have said so far have been the biggest positives for me

Life Events. This theme includes statements that reflect the positive impact certain life events had on the participant’s ability to cope with stuttering. These events are not related to therapy or a part of therapy and are hence categorized as indirect effects. Any information in the transcript that might reveal the identity of the participant and risk participant anonymity has been replaced by “XXXX.” Examples of these include:

Daniel: Going through school XXXX was helpful or helping me continue to alter how I thought about my stuttering and I think what helped was supervising in the intensive clinic and just going over everything that I went through as a client and seeing it from a different perspective as a clinician that was helpful and then having successes in doctoral school was helpful for my confidence piece for example teaching a college class for the first time was the scariest thing I had ever done but probably the most rewarding too for me from a confidence standpoint with my fear.

Daniel: I think on average its gradually been getting better over time each semester from 2006 until now which is 2010 and I think a lot of that is due to achieving various goals like supervising graduate clinicians, doing a lot of direct therapy with clients, teaching a
lot of college classes. I think each of those successes helps somebody who stutters, I mean gradually over time it helps.

Daniel: Achieving goals has been very helpful for me in developing a more positive or helpful attitude toward my stuttering and also something that I forgot to mention is just not being afraid to take risks whether it’s stuttering or something else. Something that you really want to do just go ahead and do that even though it might seem very dangerous from a stutterer’s perspective still do it and still try anyway and that’s been very helpful too. Because back when I was a more severe stutterer I would not try I would not take risks and so I think too well for me anyway too for me progress with my stuttering I just sort of put myself out there and take more risks with my speech and learn how to not feel so negative about my stuttering.

Use of External Aids. This theme is used to code statements from the interview transcript that indicate the client did not perceive as beneficial during the intensive clinic. As reported during the interview, the participant did not perceive much of a benefit from using the Delayed Auditory Feedback (DAF) device for an entire day during the intensive clinic. The participant had previous experience with the use of DAF and reported that it had been helpful for a short duration in the past. Thus, this theme might be a result of participant bias from previous experiences with the device. The reader must use caution when drawing conclusions from this theme. An example of the participant’s report is as follows:

Daniel: I wasn’t enjoying it but when I went through the 2004 clinic we spent about I think it was close to a whole day using the DAF machine so yeah we just spent the whole day talking very slow either reading or having a conversation with our clinician but just going very slow and I remember just hating that and I don’t feel like at the end of the day I really got anything from that. So I wasn’t too happy about that.

Overall, Daniel reported positive outcomes from attending the intensive clinic. Daniel mentioned a number of factors during the semi-structured interview that he felt contributed to the effectiveness of the program and the same is reflected in the objective clinical data both current and archival. As can be seen from the data available for Daniel, both direct and indirect factors influenced his perception of benefits from therapy. He mentioned that he had received a lot of
therapy in the past, but he was very motivated to make changes when he attended the intensive clinic in 2004. Further, he found the nature of the program and living with other PWS like a family for the duration of the program very appealing and felt that contributed to his overall success in the program. Working on his stuttering with other PWS is something his previous therapy experiences had not given him the opportunity to do, and this is something he really found beneficial about this program. He also reported that positive and caring attitude of his clinicians during the program is something that helped him through more difficult situations and increased his motivation and confidence in his ability to make changes reflected in the clinical data.

Participant 2: “Cody”

Cody is a 22 year-old male who first attended the intensive clinic in 2005. Since then, Cody attended an eight-hour intensive weekend workshop in the fall of 2005; attended the intensive clinic in 2006 and 2008. Cody then received regular non-intensive follow-up via telepractice for two-hours per week during the fall of 2008 and one-hour per week during the spring of 2009. Cody was discharged from therapy at the end of spring 2009. He is currently a senior in college.

Clinical measures reported for Cody included speech related measures of % SS for a conversational sample, a monologue, a reading passage, and three phone calls; and stuttering severity as measured on the SSI-3. Attitudinal measures include scores on the S-24 Scale of Communication Attitudes, the OASES, and the LCB. These measures are reported for Cody at the time when he first attended the intensive clinic (pre-intensive); at the conclusion of the intensive clinic (post-intensive) in 2005; at the end of the intensive clinic in 2006; end of the intensive clinic in 2008; at the time of discharge from therapy in 2009; and at time of the
interview completed in 2010. Changes in clinical data over a period of five years are reported in Table 9 for all measures except the OASES. Impact ratings for the OASES and each section are reported in Table 10. As can be seen from the data presented in the Tables 9 and 10, Cody made some measurable gains in speech related and attitude measures as a result of attending the intensive clinic. Further, Cody has been able to maintain the gains made on all objective clinical measures to a level below the beginning of therapy in 2005. Similar to the qualitative themes generated from Cody’s interview, making and maintaining these changes has been a process and there is a need to continue working on maintaining these changes by “practicing” speech techniques learned in therapy and completing feared speaking situations.
Table 9

*Clinical Data for Cody*

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<td>10.09%</td>
</tr>
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*Lower scores indicate more positive attitudes*
Table 10

*OASES impact ratings for Cody*

<table>
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<td>Moderate</td>
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<tr>
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<tr>
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### Table 11

*Categories and Themes for Cody.*

<table>
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<tr>
<th>Categories</th>
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<tbody>
<tr>
<td>Direct Effects</td>
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<tr>
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<td>Speech Techniques Learned</td>
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<td></td>
<td>Attitude Change and Counseling</td>
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<td>Desensitization and Transfer of Skills</td>
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<td>Indirect Effects</td>
<td>Motivation and Readiness</td>
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<td>Clinician Attributes</td>
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<tr>
<td>Recommendations</td>
<td>Use of External Aids</td>
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<tr>
<td></td>
<td>Techniques Learned</td>
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</table>
A detailed analysis of the transcript generated from the interview with Cody revealed eight themes. Themes generated from the interview with Cody are categorized similar to themes Daniel’s. All categories and themes have been outlined in Table 11. The additional themes generated from the interview with Cody are discussed below.

**Use of External Aids.** This theme is used to code statements from the interview transcript that indicate the client did not perceive as beneficial during the intensive clinic. As reported during the interview, the participant did not perceive much of a benefit from using the Delayed Auditory Feedback (DAF) device for an entire day during the intensive clinic. This theme is similar to the theme generated from the interview with Daniel and has been categorized as “Recommendations.” An example of the participant’s report is as follows.

**Cody:** Number one I think it would maybe the DAF because it, I understand like why we didn’t use that afterward because it sort of just gives expectation or it was just, you can’t/don’t want to talk like that either.

**Techniques Learned.** This theme was used to code statements from the transcript that indicate certain techniques taught and practiced during the intensive clinic that the client did not perceive as beneficial for himself. Statements reflecting this theme include:

**Cody:** Well, I didn’t feel like the cancellations were that helpful because you can’t really do that. It’s like kind of weird if you do that in feel like you know just speaking with someone it’s not that practical but I also think that it was a little counterproductive because it may be rewarding fluency that just speaking you know because or I guess it’s how you take it because if I would say it again I would try to be more fluent but I guess you may have been supposed to say it as easy as possible but I would still try to be fluent because I wouldn’t want to say it again you know.

**Cody:** Yeah, then I think the cancellations stuff. It feels like pretty much everything else helped me out in some way. Yeah.

Overall, Cody perceived the most benefit from the intensive clinic the first time he attended it. He felt he would have benefitted more from follow-up intensive clinics he attended if
there were a stronger emphasis on practicing fluency shaping and stuttering modification
techniques and less emphasis on the affective and cognitive aspects of stuttering. This is an
important factor to take into consideration for client’s returning to the intensive clinic. Cody did
report benefitting from the clinic and the objective data corroborates his story.

Participant 3: “Teddy”

Teddy is a 23-year old male who first attended the intensive clinic in 2008. He received
follow-up therapy via telepractice for a year before attending a second offering of the intensive
clinic in 2009. The intensive clinic in 2009 was a nine-day clinic as opposed to the 15-day clinic
offered prior to 2009. In his interview, Teddy compares the two intensive clinic models and
states a preference for the 15-day intensive clinic he attended in 2008. He has been receiving
regular non-intensive follow-up in person. Teddy is currently a graduate student in a speech-
language pathology program.

Clinical measures reported for Teddy included speech related measures of % SS for a
conversational sample, a monologue, a reading passage, and three phone calls; and stuttering
severity as measured on the SSI-3. Attitudinal measures include scores on the S-24 Scale of
Communication Attitudes, the OASES, and the LCB are reported in Table 12. Impact ratings for
the OASES are reported separately in Table 13. These measures are reported for Teddy at the
time when he first attended the intensive clinic (pre-intensive); at the conclusion of the intensive
clinic (post-intensive) in 2008; at the end of the intensive clinic in 2009; and at time of the
interview completed in 2010. Changes in clinical data over a period of two years are reported in
Tables 12 and 13.
Table 12

*Clinical Data for Teddy*

<table>
<thead>
<tr>
<th>Clinical Measure</th>
<th>Pre-intensive</th>
<th>Post-intensive</th>
<th>2009</th>
<th>Current (2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>S-24*</td>
<td>19</td>
<td>9</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>LCB*</td>
<td>31</td>
<td>24</td>
<td>10</td>
<td>22</td>
</tr>
<tr>
<td>SSI-3</td>
<td>40</td>
<td>26</td>
<td>19</td>
<td>23</td>
</tr>
<tr>
<td>%SS</td>
<td>23.24%</td>
<td>12.46%</td>
<td>6.7%</td>
<td>5.7%</td>
</tr>
<tr>
<td><strong>Conversation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%SS Monologue</td>
<td>22.58%</td>
<td>16.77%</td>
<td>4.7%</td>
<td>3.7%</td>
</tr>
<tr>
<td>%SS Reading</td>
<td>8.75%</td>
<td>1%</td>
<td>0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>%SS Phone</td>
<td>21.14%</td>
<td>16.7%</td>
<td>11.3%</td>
<td>11.4%</td>
</tr>
</tbody>
</table>

*Lower scores indicate more positive attitudes*
Table 13

*OASES impact ratings for Teddy*

<table>
<thead>
<tr>
<th>OASES Section</th>
<th>Pre-intensive</th>
<th>Post-intensive</th>
<th>2009</th>
<th>Current (2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>Moderate - Severe</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>I</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>II</td>
<td>Moderate - Severe</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>III</td>
<td>Moderate - Severe</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>IV</td>
<td>Moderate</td>
<td>Mild - Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
</tbody>
</table>
As can be seen from the data presented in Tables 12 and 13, Teddy made measurable clinical gains on all objective clinical measures. Teddy made the most significant gains during the intensive clinic in 2008. Since then, he has maintained gains made on all clinical measures. As seen from the data, Teddy continued to make positive changes in speech related measures. Measures of attitude toward speech and stuttering have been more variable and at the time of the interview, were slightly higher than measured at the end of the intensive clinic in 2008. However, the score on attitudinal measures have remained below the scores obtained before Teddy attended the intensive clinic in 2008 indicating that he has maintained these attitude/cognitive changes with continued therapy in a non-intensive format. These results corroborate themes from Teddy’s qualitative data.

A detailed analysis of the transcript generated from the interview with Teddy revealed nine themes that fit in two categories. Themes generated from Teddy’s interview were categorized similar to the previous interview. Teddy did not have any themes categorized as “Indirect Effects.” All categories and themes have been outlined in Table 14.
Table 14

*Categories and Themes for Teddy.*

<table>
<thead>
<tr>
<th>Major Themes</th>
<th>Minor Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Effects</td>
<td>Duration and Nature of Program</td>
</tr>
<tr>
<td></td>
<td>Identification/Awareness of Stuttering Behaviors</td>
</tr>
<tr>
<td></td>
<td>Speech Techniques Learned</td>
</tr>
<tr>
<td></td>
<td>Attitude Change and Counseling</td>
</tr>
<tr>
<td></td>
<td>Desensitization and Transfer of Skills</td>
</tr>
<tr>
<td></td>
<td>Home Assignments</td>
</tr>
<tr>
<td></td>
<td>Follow-up</td>
</tr>
<tr>
<td>Recommendations</td>
<td>Group Therapy</td>
</tr>
<tr>
<td></td>
<td>Need for Structure</td>
</tr>
</tbody>
</table>
Additional themes generated from the interview with Teddy are discussed below.

**Identification/Awareness of Stuttering Behaviors.** This theme was used to code statements that indicate the participant perceived a benefit from activities during therapy that helped increase awareness of his own stuttering behaviors. According to Teddy, this was one of the most helpful aspects of therapy that helped him eliminate secondary behaviors and “laid the foundation” for everything else he gained from the therapy experience. This includes but is not limited to tallying disfluencies with the clinician. Examples of such statements include:

Teddy: I thought that it was really helpful for me especially doing the videos and watching myself stutter so I could see the type of disfluencies I have. That was really helpful, just knowing my stuttering helped me know how I could go about and reduce it.

Teddy: Yeah, the playback of the video recordings was a crucial thing. Then tallying my disfluencies was also really helpful. Also listening back to recording of the phone calls that I made.

Teddy: It all came in stages really but the main thing for me was looking back at the video of me speaking and tallying, so because a lot of my disfluencies were interjections so once I became aware of that and also aware of my secondary behaviors I was able to work on them and get down to the core behaviors. Yeah so I would say that the most important thing was eliminating secondary behaviors and just having core behaviors. That really laid the foundation for everything else that I did.

**Home Assignments.** This theme codes statements from Teddy’s transcript that indicate home assignments helped make the entire therapy experience more beneficial for him and helped instill confidence that he can use skills learned in therapy outside in the real-world even without the presence of a clinician. Examples of this theme include:

Teddy: A very important thing was the take home assignments we had to call businesses because that really helped, I guess to generalize more of what we learned.

Teddy: There was a lot more time to work on the techniques and I really liked that we had take home activities to do too. I think that that was an important part for me - the take home activities of calling businesses and recording all the experience of doing that to the clinician the following day.
**Group-Therapy.** This theme is used to code statements from the interview transcript that indicate the client did not perceive as beneficial during the intensive clinic. The client felt that large group education sessions were helpful and beneficial as indicated by his comment, “Yeah, yes like not the discussions that we had at the end of the day with XXXX. I thought that those were helpful.” The client also worked in a group with two to three other clients attending the program and their clinicians. Teddy felt that working in smaller groups was not very helpful because his goals were very different from those of the other clients. This theme indicates that individual therapy would be more beneficial unless all other clients are working on the same or similar goals. Examples of the participant’s reports are as follows.

**Teddy:** I think that, what I can think of as the least helpful would be having the group therapy so having 3 more people and working on fluency. We were all very different level and were on a different level and working on different techniques. So I thought that more time could have been devoted for me than watching someone else doing therapy.

**Teddy:** There were sometimes during the day that we would like. I remember playing a board game during a group setting and working on a technique so that is what I am talking about.

**Need for Structure.** A second theme in this category, “Need for Structure” reflects statements from the transcript that indicate the need for more structure and effective planning of all activities, especially the activities completed outside. Teddy felt that more effective planning of outside activities could have been beneficial and allowed more time to work on desensitization and practicing techniques in high pressure situations. His statement reflecting this theme includes:

**Teddy:** I guess that the day that we go downtown, could have been done in a more efficient way. There was a lot of time wasted in that so I felt that we talked to relatively few people for the amount of time that we were down there.
Teddy too found the program to be effective and felt it was “one of the best programs he has attended.” As can be seen from the objective data, Teddy did make clinically measurable gains on all measures of stuttering severity and attitude change. He mentioned that he enjoyed the experience and benefitted from it a lot overall, but also reported that he would have liked more structure and efficient planning from the program. This is an important point for all clinicians providing therapy and for the program as a whole to consider. Further, Teddy attended two variations of the intensive program, a 15-day and a nine-day variation. He stated a preference for the 15-day program as he felt it allowed extra time to focus on and practice fluency shaping and stuttering modification techniques. He also reported that receiving follow-up therapy via video telepractice was effective and helpful for him personally. This is an area that needs further research. Lastly, Teddy talked about the importance of homework assignments for his progress in the program. That was one of the other reasons why he preferred the 15-day program. The benefit of home assignments for clients’ is another area that needs to be researched further.

Participant 4: “Mike”

Mike is a 43 year-old male who attended the intensive clinic in 2004. He did not receive any follow-up therapy after the initial intensive clinic. Mike currently works as a residential specialist.

Clinical measures reported for Mike include speech related measures of % SS for a conversational sample, a reading passage, and three phone calls; and stuttering severity as measured on the SSI-3. Attitudinal measures include scores on the S-24 Scale of Communication Attitudes and the LCB. These measures are reported for Mike at the time when he first attended the intensive clinic (pre-intensive); at the conclusion of the intensive clinic (post-intensive) in
2004; and at the time of the interview completed in 2010. Changes in clinical data over a period of six years are reported in Table 15. As can be seen from the data presented in Table 15, Mike made measurable gains in speech related and attitude measures as a result of attending the intensive clinic. It is important to note that these changes were maintained over a period of 6 years. Mike reported a number of factors in his interview that were crucial to making- and maintaining these changes in objective clinical measures. For Mike, it appears that speech techniques taught, and desensitization activities played a major role in making these changes during the intensive clinic. Following the intensive clinic, it appears that his career choice and resulting life events appear to be major contributing factors in maintaining gains made during the intensive clinic.
Table 15

*Clinical Data for Mike*

<table>
<thead>
<tr>
<th>Clinical Measure</th>
<th>Pre-intensive</th>
<th>Post-intensive</th>
<th>Current (2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>S-24*</td>
<td>17</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>LCB*</td>
<td>29</td>
<td>32</td>
<td>28</td>
</tr>
<tr>
<td>SSI-3</td>
<td>26</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>%SS Conversation</td>
<td>17%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>%SS Reading</td>
<td>2%</td>
<td>0.6%</td>
<td>0%</td>
</tr>
<tr>
<td>%SS Phone calls</td>
<td>30%</td>
<td>6%</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

*Lower scores indicate more positive attitudes*
As can be seen from the clinical data presented in Table 15, Mike made measurable gains in speech related measures and maintained these gains over a period of six years. Mike however, did not report any changes on the attitude measures immediately following the intensive clinic. His score on the S-24 scale of Communication Attitudes appears to have reduced at the time of the interview.

A detailed analysis of the transcript generated from the interview with Mike revealed seven themes that fit in a total of three categories. The themes generated from Mike’s interview have been categorized similar to the previous participant’s themes. All categories and themes have been outlined in Table 16. Additional themes generated from the interview with Mike are discussed below.
Table 16

*Categories and Themes for Mike.*

<table>
<thead>
<tr>
<th>Major Themes</th>
<th>Minor Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Effects</td>
<td>Duration and Nature of Program</td>
</tr>
<tr>
<td></td>
<td>Speech Techniques Learned</td>
</tr>
<tr>
<td></td>
<td>Attitude Change and Counseling</td>
</tr>
<tr>
<td></td>
<td>Education About Stuttering</td>
</tr>
<tr>
<td>Indirect Effects</td>
<td>Life Events</td>
</tr>
<tr>
<td></td>
<td>Clinician Attributes</td>
</tr>
<tr>
<td>Recommendations</td>
<td>Follow-up</td>
</tr>
</tbody>
</table>
Education about Stuttering. This theme was used to code statements that indicate the positive impact that learning about famous people who stutter, and general information about stuttering had on Mike’s attitude toward stuttering and approach to speaking situations. An example of a statement reflecting this theme is:

Mike: I never did do that but if somebody asks me now I think that I am more prouder of actually opening because I see that there is nothing wrong with being a stutterer and from getting evidence and seeing a lot other people that stutter I didn’t know that James Earl Jones stutters but I discovered James Earl Jones and there is other people that are really famous and stutter too. This I didn’t know until I went there and it gave me an opportunity to just truly realize the fact that there is nothing wrong with stuttering.

Life Events. This theme codes statements that reflect the positive impact certain life events had on the participant’s ability to cope with stuttering. These events are not related to therapy or a part of therapy and are hence categorized as indirect. Examples of these include:

Mike: I would say that the big thing that helped me was that I actually worked in a retail business. I actually worked in about 4 or 5 jobs in retail and different types of retail and that made me talk. You had to talk to customers. You couldn’t just stand there and watch customers because they would ask you for help you had to explain, so it was a lot for one-on-one interaction.

Mike: Another thing that helped me was in school – the speaking class. Actually my major was communication so you had to do all these interpersonal and small group communication. You had to take effective speaking and basically that is the speeches. One thing is that I was really nervous thinking about talking in front of the class. I was the only one basically that did speeches with no notes, no guidelines, It was just all stuff that I remembered in my head and I was shocked to see that I got an A in the class and I actually got through it.

Mike too reported an overall benefit from attending the intensive program and the clinical data corroborates his story. For Mike, he found the overall atmosphere of acceptance and living with other PWS during the program very beneficial. He reported that the program would have been stronger if follow-up services were provided via telepractice or a referral to a fluency
specialist in his area was made. He reported that it was difficult to practice techniques and it is easy to get “lazy” with practicing techniques when contact with the clinician is lost.

Participant 5: “Nicole”

Nicole is a 25-year old female who attended the intensive clinic in 2003. She received follow-up therapy on a weekly basis until December 2006 after she attended the intensive clinic. She was discharged from therapy in December 2006 and has not received therapy since.

Clinical measures reported for Nicole include speech related measures of % SS for a conversational sample, a monologue, a reading passage, and three phone calls; and stuttering severity as measured on the SSI-3. Attitudinal measures include scores on the S-24 Scale of Communication Attitudes, the OASES, and the LCB. These measures are reported for Nicole at the time when she first attended the intensive clinic (pre-intensive); at the conclusion of the intensive clinic (post-intensive) in 2003; at the time of her discharge from therapy in 2006; and at time of the interview completed in 2010. The data between the times of conclusion of the intensive clinic to the time of her discharge in 2006 was not consistent and has not been reported here as a result. Changes in clinical data over a period of seven years for all measures except the OASES are reported in Table 17. Impact ratings for the OASES are reported separately in Table 18. As can be seen from the data presented in Tables 17 and 18, Nicole made measurable clinical gains on all speech related and attitude measures at the end of the intensive clinic. Nicole appears to have been able to maintain this progress over a period of seven-years. Most clinical measures reported at the time of discharge and at the time of the interview, are slightly higher than what was reported at the end of the intensive clinic. This appears to be a general trend with most participants and could possibly be a result of the nature of the intensive program. It is important to note that Nicole reported higher scores on the S-24 scale and the LCB at the time of the
interview when compared with the scores reported prior to the intensive clinic. These measures appear to be in contrast with what themes were reported during the interview.
Table 17

Clinical Data for Nicole

<table>
<thead>
<tr>
<th>Clinical Measure</th>
<th>Pre-intensive</th>
<th>Post-intensive</th>
<th>December 2006</th>
<th>Current (2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>S-24*</td>
<td>7</td>
<td>5</td>
<td>Not available</td>
<td>11</td>
</tr>
<tr>
<td>LCB*</td>
<td>23</td>
<td>15</td>
<td>24</td>
<td>30</td>
</tr>
<tr>
<td>SSI-3</td>
<td>27</td>
<td>4</td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td>%SS</td>
<td>9</td>
<td>2</td>
<td>6.33</td>
<td>2.3</td>
</tr>
</tbody>
</table>

Conversation

| %SS Monologue   | 10            | 3              | 7             | 5              |
| %SS Reading     | 11            | 4              | 5.45          | 0.3            |
| %SS Phone Calls | 18            | 4              | 10.67         | 5.5            |

*Lower scores indicate more positive attitudes*
Table 18

*OASES impact ratings for Nicole*

<table>
<thead>
<tr>
<th>OASES Section</th>
<th>Pre-intensive</th>
<th>Post-intensive</th>
<th>December 2006</th>
<th>Current (2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>Moderate</td>
<td>Mild/Moderate</td>
<td>Mild/Moderate</td>
<td>Mild/Moderate</td>
</tr>
<tr>
<td>I</td>
<td>Moderate/Severe</td>
<td>Mild/Moderate</td>
<td>Mild/Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>II</td>
<td>Moderate</td>
<td>Mild/Moderate</td>
<td>Mild</td>
<td>Mild/Moderate</td>
</tr>
<tr>
<td>III</td>
<td>Moderate</td>
<td>Mild</td>
<td>Mild/Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>IV</td>
<td>Moderate</td>
<td>Mild-Moderate</td>
<td>Mild/Moderate</td>
<td>Mild/Moderate</td>
</tr>
</tbody>
</table>
Table 19

*Categories and Themes for Nicole.*

<table>
<thead>
<tr>
<th>Categories</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Effects</td>
<td>Duration and Nature of Program</td>
</tr>
<tr>
<td></td>
<td>Speech Techniques Learned</td>
</tr>
<tr>
<td></td>
<td>Attitude Change and Counseling</td>
</tr>
<tr>
<td></td>
<td>Desensitization and Transfer of Skills</td>
</tr>
<tr>
<td>Indirect Effects</td>
<td>Motivation and Readiness</td>
</tr>
<tr>
<td></td>
<td>Clinician Attributes</td>
</tr>
<tr>
<td>Recommendations</td>
<td>Need for Structure</td>
</tr>
</tbody>
</table>
A detailed analysis of the transcript generated from the interview with Nicole revealed seven themes that fit in three categories. The seven themes generated from the interview with Nicole have been categorized similar to the previous interviews. All categories and themes have been outlined in Table 19. Additional themes generated from the interview with Nicole are discussed below.

*Negative Direct Effects.* This theme was used to code statements reflecting the participant’s sentiment that the activities were beneficial to her overall success in the program, but could have been structured differently or better. These comments were made in conjunction with the benefits of desensitization activities including talking to strangers and making phone calls. Examples of this theme include:

Nicole: but something that I absolutely hated was to be able to like give me these opportunities to talk on the phone I had to create these situations of why I would need to call and like that whole idea like I’m trying to think of some situations that were created I think one was maybe like calling a car repair place and trying to get some information about how much a car repair would be or calling the library and seeing if they had a certain book in stock; you know just like creating these situations where I didn’t actually need to make that phone call and I just hated like bothering these people with this phone call that I didn’t really need that information and I hated being like put on the spot to create these questions and create this situation of why I would need to call someone

Nicole: So I don’t wanna say don’t do it but I would say it needs to be rethought of how it’s played through and that was we just went up to like strangers on the street and would ask them like do you know someone who stutters? Do you think that it’s a problem? Do you think, are there any jobs that PWS cannot have? I don’t know if that still goes on or not but like I think I really gained some valuable information as far as what people really thought so like that to me was helpful getting this information of how these complete strangers would answer these questions but sometimes when the complete strangers didn’t have the nicest things to say about PWS like that was heart breaking. I guess the things that rank bottom would be the ones I already said of being forced to like give that survey to people and then standing there when they gave me some possibly bad news or comment that were not positive and then being having to create these situations of calling on the phone.
The interview with Nicole and her clinical data support that she benefitted from the intensive clinic and follow-up therapy. The qualitative data from her transcripts indicate that she valued and perceived a benefit from the desensitization time activities; however, she wished they were more structured and “controlled.” It is important to keep differences in participants’ level of sensitivity and training student clinicians to be more flexible with clients for individual tasks.

Participant 6: “Rick”

Rick is a 20-year old male who attended the intensive clinic in 2006. He received follow-up services on a non-intensive schedule from the fall of 2007. He also attended the intensive clinic in 2009 before continuing to receive non-intensive follow-up. He is currently a junior in college and continues to receive non-intensive follow-up therapy. Similar to Teddy, Rick also attended the 15-day offering in 2006 and the 9-day offering of the intensive clinic in 2009. During the qualitative interview with Rick, he stated a preference for the 15-day clinic and felt the extra time was helpful. This theme is consistent with what Teddy stated during the interview.

Clinical measures reported for Rick include speech related measures of % SS for a conversational sample, a reading passage, and three phone calls; and stuttering severity as measured on the SSI-3. Attitudinal measures include scores on the S-24 Scale of Communication Attitudes, the *Assessment of the Child’s Experience of Stuttering* (ACES; Yaruss, 2006) OASES, and the LCB. It should be noted that rick was 16-years old when he attended the intensive clinic in 2006; hence the ACES was used as a measure of the impact stuttering has on his life till 2008 when the OASES was administered. These measures are reported for Rick at the time when he first attended the intensive clinic (pre-intensive); at the conclusion of the intensive clinic (post-intensive) in 2006; at the end of the first year of non-intensive follow-up in 2008; at the end of the second year of follow-up in 2009; and at time of the interview completed in 2010. Please see
Table 20 for clinical data recorded and reported for Rick. ACES/OASES impact ratings are reported in Table 21. As can be seen from the data presented in Tables 20 and 21, Rick made measurable clinical gains on most measures related to stuttering severity and attitude change as a result of attending the intensive clinic in 2006. Rick continues to make progress to this day and maintain most of the progress made during the intensive clinic. As seen from the clinical data, Rick’s reports on the attitude scale tend to fluctuate and have remained higher than the scores reported at the end of the intensive clinic in 2006. Other measures related to severity, especially %SS for all contexts has been maintained or further reduced since the intensive clinic in 2006. His score on the SSI-3 was the highest at the time of the interview in 2010. A possible reason for this could be the fact that Rick had a stuttering disfluency (a part-word repetition) during a phone call that lasted over 60 seconds in duration, affecting his SSI-3 score negatively.

A detailed analysis of the transcript generated from the interview with Rick revealed six themes that fit in two categories. These themes were categorized similar to the previous interviews. All categories and themes have been outlined in Table 22. The interview with Rick did not generate any additional themes that were not discussed in Section 1 above.
Table 20

*Clinical Data for Rick.*

<table>
<thead>
<tr>
<th>Clinical Measure</th>
<th>Pre-intensive</th>
<th>Post-intensive</th>
<th>2008</th>
<th>2009</th>
<th>Current (2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>S-24*</td>
<td>20</td>
<td>2</td>
<td>Not available</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>LCB*</td>
<td>9</td>
<td>10</td>
<td>Not available</td>
<td>Not available</td>
<td>29</td>
</tr>
<tr>
<td>SSI-3</td>
<td>36</td>
<td>27</td>
<td>20</td>
<td>25</td>
<td>30</td>
</tr>
<tr>
<td>%SS</td>
<td>25</td>
<td>18</td>
<td>4.3</td>
<td>16.51</td>
<td>11</td>
</tr>
<tr>
<td>Conversation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%SS Reading</td>
<td>75</td>
<td>31.5</td>
<td>1</td>
<td>0.01</td>
<td>0.3</td>
</tr>
<tr>
<td>%SS Phone calls</td>
<td>19.39</td>
<td>33.3</td>
<td>11</td>
<td>29.35</td>
<td>15.7</td>
</tr>
</tbody>
</table>

*Lower scores indicate more positive attitudes*
Table 21

**ACES/OASES impact ratings for Rick**

<table>
<thead>
<tr>
<th>ACES/OASES Section</th>
<th>Pre-intensive</th>
<th>Post-intensive</th>
<th>2008</th>
<th>2009</th>
<th>Current (2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>Moderate/Severe*</td>
<td>Mild*</td>
<td>Mild/Moderate</td>
<td>Mild/Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>I</td>
<td>Moderate/Severe*</td>
<td>Mild*</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>II</td>
<td>Moderate/Severe*</td>
<td>Mild*</td>
<td>Mild/Moderate</td>
<td>Mild/Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>III</td>
<td>Moderate*</td>
<td>Mild/Moderate*</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>IV</td>
<td>Moderate*</td>
<td>Mild/Moderate*</td>
<td>Mild</td>
<td>Mild/Moderate</td>
<td>Mild/Moderate</td>
</tr>
</tbody>
</table>

* Impact rating for ACES
Table 22

*Categories and Themes for Rick.*

<table>
<thead>
<tr>
<th>Categories</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Effects</td>
<td>Duration and Nature of Program</td>
</tr>
<tr>
<td></td>
<td>Identification/Awareness of Stuttering</td>
</tr>
<tr>
<td></td>
<td>Behaviors</td>
</tr>
<tr>
<td></td>
<td>Speech Techniques Learned</td>
</tr>
<tr>
<td></td>
<td>Desensitization and Transfer of Skills</td>
</tr>
<tr>
<td>Indirect Effects</td>
<td>Motivation and Readiness</td>
</tr>
<tr>
<td></td>
<td>Clinician Attributes</td>
</tr>
</tbody>
</table>
Participant 7: “Yolanda”

Yolanda is a 39-year old female who attended the intensive clinic in 2006. She did not receive any follow-up services after the intensive clinic. She is currently a practicing speech-language pathologist. During the interview, she mentioned that she continues to work toward being more accepting of her stuttering and has sought counseling on multiple occasions after attending the intensive clinic. She also attended multiple workshops through the National Stuttering Association (NSA) to help gain a better understanding of stuttering and how to cope with stuttering better.

Clinical measures reported for Yolanda include speech related measures of % SS for a conversational sample, a monologue, a reading passage, and three phone calls; and stuttering severity as measured on the SSI-3. Attitudinal measures include scores on the S-24 Scale of Communication Attitudes, the LCB, and the OASES. These measures are reported for Yolanda at the time when she first attended the intensive clinic (pre-intensive); at the conclusion of the intensive clinic (post-intensive) in 2006; and at the time of the interview completed in 2010. Changes in clinical data over a period of four years are reported in Table 23. Impact ratings for the OASES are reported separately in Table 24.
Table 23

Clinical Data for Yolanda

<table>
<thead>
<tr>
<th>Clinical Measure</th>
<th>Pre-intensive</th>
<th>Post-intensive</th>
<th>Current (2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>S-24*</td>
<td>16</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>LCB*</td>
<td>26</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td>SSI-3</td>
<td>12</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>%SS Conversation</td>
<td>11.67</td>
<td>9</td>
<td>6.3</td>
</tr>
<tr>
<td>%SS Monologue</td>
<td>13.19</td>
<td>5.33</td>
<td>6.3</td>
</tr>
<tr>
<td>%SS Reading</td>
<td>4.33</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>%SS Phone Calls</td>
<td>11.82</td>
<td>13.33</td>
<td>4.1</td>
</tr>
</tbody>
</table>

*Lower scores indicate more positive attitudes*
Table 24

_OASES impact ratings for Yolanda_

<table>
<thead>
<tr>
<th>OASES Section</th>
<th>Pre-intensive</th>
<th>Post-intensive</th>
<th>Current (2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>Moderate</td>
<td>Mild/ Moderate</td>
<td>Mild/ Moderate</td>
</tr>
<tr>
<td>I</td>
<td>Moderate</td>
<td>Mild/Moderate</td>
<td>Mild/ Moderate</td>
</tr>
<tr>
<td>II</td>
<td>Severe</td>
<td>Moderate</td>
<td>Mild/ Moderate</td>
</tr>
<tr>
<td>III</td>
<td>Mild/ Moderate</td>
<td>Mild/ Moderate</td>
<td>Mild/ Moderate</td>
</tr>
<tr>
<td>IV</td>
<td>Severe</td>
<td>Mild/ Moderate</td>
<td>Mild/ Moderate</td>
</tr>
</tbody>
</table>
The clinical data for Yolanda indicates that she made measurable gains in speech related measures as a result of attending the intensive clinic. Further, Yolanda was able to maintain these gains in speech related measures four years after being discharged from therapy. A big part of this process, as Yolanda mentioned during the interview, was learning more about stuttering and being more comfortable as a person who stutters. The clinical data for attitude measures indicates that Yolanda made clinically measurable gains after attending the intensive clinic; however, current scores appear to be closer to her scores recorded before the start of the intensive clinic. This indicates that Yolanda could have possibly benefitted from follow-up services that focused on maintaining changes made in relation to attitude toward communication and stuttering. The primary theme from her interview was that of Attitude Change/Counseling and she also stated during the interview that she continues to struggle with maintaining a more positive attitude about stuttering and has sought counseling to help her with the process.

A detailed analysis of the transcript generated from the interview with Yolanda revealed six themes. The six themes generated from the interview with Yolanda fit in two of the three categories described in the previous interviews. All categories and themes have been outlined in Table 25. Only one additional theme was generated from the interview with Yolanda. This theme is discussed below.
### Table 25

**Categories and Themes for Yolanda.**

<table>
<thead>
<tr>
<th>Category</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Effects</td>
<td>Duration and Nature of Program</td>
</tr>
<tr>
<td></td>
<td>Speech Techniques Learned</td>
</tr>
<tr>
<td></td>
<td>Attitude Change and Counseling</td>
</tr>
<tr>
<td></td>
<td>Desensitization and Transfer of Skills</td>
</tr>
<tr>
<td></td>
<td>Education About Stuttering</td>
</tr>
<tr>
<td>Indirect Effects</td>
<td>Motivation and Readiness</td>
</tr>
</tbody>
</table>
Education About Stuttering. This theme was used to code statements that indicate the participant perceived a benefit from activities during therapy that helped educate and increase general knowledge about stuttering. Examples of such statements include:

Yolanda: Well definitely the iceberg analogy and after that so many people mentioned that theory and I was like Ooo I know that! Also surveys. Ok so I remember one of the handouts I think that was some statement about stuttering and I don’t remember exactly but like stuttering is not something that happens but something that I do; something like those taught me to be responsible and another thing is that whether I stutter or not the listener is not going to know or how did it go, something like a time thing avoiding to stutter because it is not about the listener but about the way I feel. Learning about the process of attitude and feeling.
CHAPTER 5
Discussion

The purpose of this chapter is to summarize the results of this study in context of the research questions. This chapter seeks to triangulate the qualitative themes obtained from participant interviews with objective clinical data to gain a better understanding of treatment effectiveness from both a client and clinician perspective. The evidence gathered in this study will then be discussed in relation with relevant literature, providing the reader with a summary of what components and aspects of therapy contribute to treatment effectiveness. This chapter will also discuss the relevance of various objective clinical measures to treatment effectiveness and how that corresponds with client values. Finally, this chapter will also discuss various limitations of this study and directions for future research in the area of treatment effectiveness.

Factors Contributing to Treatment Effectiveness

According to Denzin and Lincoln (1994), the purpose of qualitative research is to make sense of- or interpret phenomena in terms of the meaning participants bring to them. It involves the use of various methods, including in-depth interviews which help describe various moments and meaning in individuals’ lives. Thus the goal of qualitative research focuses on participants’ perspectives and the meaning of a particular experience for the individual (Creswell, 1998). The research questions guiding this study sought to gain a deeper understanding of participants’ experience with stuttering therapy provided at BGSU via the Intensive Clinic and follow-up therapy, when provided. Additionally, the study sought to understand how well objective clinical measures relate to participants’ perspective of treatment effectiveness. A qualitative approach thus formed the core method of this mixed-methods study and employed a phenomenological approach to describe the meaning of the participants’ experiences with the intensive clinic and
follow-up therapy received at BGSU. Toward this end, in-depth interviews were conducted with seven participants who had attended the Intensive Clinic at BGSU.

The purpose of this section of chapter five is to summarize participants’ experiences with the intensive clinic and their reports of what factors contributed to treatment effectiveness. Further, this section also triangulates relevant clinical data with the qualitative data. Thematic analysis of the transcripts generated from the qualitative interviews was completed and statements meaningful to participant’s experiences were coded using the concept of treatment effectiveness as a “lens” for analysis. Member checks were used to enhance credibility of these analyses. In addition to member checks, two external reviewers also coded all statements to ensure credibility of the codes assigned.

Results of this analysis revealed eight themes that were replicated across all participants. In the results section, these themes were further categorized as: (1) Direct Effects; (2) Indirect Effects; and (3) Other Relevant Themes. These analyses help address the first two research questions: (1) What factors do clients report as contributing to treatment effectiveness?; and (2) What therapeutic procedures do clients report as helpful in the long-term maintenance of treatment benefits?

Objective clinical data was triangulated with the qualitative data to provide a comparison between participants’ self-reports of treatment effectiveness and objective measures of treatment outcomes thereby addressing the fourth research question: What is the relationship between clients’ self-reports of treatment effectiveness and objective clinical measures of treatment outcomes. The objective data presented here also helps address the third research question in this study: What changes in objective measures of stuttering are noted after therapy?
Direct Effects

The first category, direct effects, includes themes where the participant talked about various aspects of the program at BGSU that they perceived as relevant to their perception of treatment effectiveness. This category includes the following themes: duration and nature of program; speech techniques learned; attitude change and counseling; and desensitization and transfer of skills.

A careful analysis of participant transcripts indicates that all participants feel that the residential nature of the intensive program was very beneficial. Most participants mentioned that they had not had the opportunity to live with other PWS and work on common goals before this experience. They all seemed to find it beneficial to get to know other PWS and this promoted a sense of comfort and acceptance that encouraged them to focus on and work on their speech. A number of studies have explored the role of support groups such as the National Stuttering Association (NSA) in coping responses for PWS (Hayhow, Cray, & Enderby, 2002; Yaruss, et al., 2002; Yaruss, Quesal, & Murphy, 2002). Studies indicate that most individuals appear to benefit from group interaction with other PWS; a theme that has been resonant with all participants in this study as well. In addition to the effect of living and working with other PWS on similar and related goals, participants also perceived a benefit from the intensive nature of the program. The 15-day residential program is one aspect of therapy that participants perceived a benefit from. Previous studies by St. Louis and Westbrook (1987) and Hayhow et al. (2002) indicate that intensive programs offer effective treatment and are highly effective in helping PWS achieve fluency early in the process. Participants in this study independently reported that they perceived the most benefit from the intensive program when they received hours of therapy focusing on fluency shaping and stuttering modification techniques. A few participants also
reported that it was beneficial to meet as a group during the program and realize that they were not in this alone. They felt a sense of comfort and motivation from hearing about other clients’ struggles and successes. This theme also strongly corroborates the objective clinical measures of stuttering severity measured using the SSI-3 (Riley, 1994). Table 26 provides an overview of changes in stuttering severity noted at the beginning and conclusion of the intensive clinic. SSI-3 scores obtained at the time of the interview are also included in Table 26 to provide the reader with a perspective of changes following the intensive clinic. This data will be discussed further and corroborated with the qualitative data and relevant literature on the topic in the following sections of this chapter. The data indicates that all participants experienced measurable clinical gains with respect to stuttering severity.
Table 26

*Pre- and Post-intensive and Current SS-3 Scores for Participants*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Pre-intensive</th>
<th>Post-intensive</th>
<th>Current (2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daniel</td>
<td>36</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>Cody</td>
<td>36</td>
<td>32</td>
<td>27</td>
</tr>
<tr>
<td>Teddy</td>
<td>40</td>
<td>26</td>
<td>23</td>
</tr>
<tr>
<td>Mike</td>
<td>26</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Nicole</td>
<td>27</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Rick</td>
<td>36</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>Yolanda</td>
<td>12</td>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>

*Scores are positively correlated with stuttering severity*
Thus the objective clinical data gathered appears to corroborate the participants’ perspective on the effectiveness of the intensive program. As can be seen for the data presented, all participants made the most progress and experienced the greatest reduction in stuttering severity at the conclusion of the intensive clinic. Current data indicates that most participants maintained gains made during the intensive clinic and some participants reported a slight increase in stuttering severity. Part of these changes can be attributed to the variability of stuttering. However, the role of the intensive nature of the program, the type of follow-up received, and the duration since discharge from therapy also appears to play a role in the results presented in Table 26.

A second strong theme generated across participants’ in this study within the category of speech techniques learned. All participants reported that they perceived a benefit from learning strategies to manage disfluencies better and modify their stuttering. Specific techniques participants’ reported as being helpful include a mix of fluency shaping and stuttering modification techniques including easy onsets, slow prolonged speech, continuous phonation, and pull-outs. This theme also corresponds with the fist theme of duration and nature of the program. All participants reported that practicing these techniques in a focused and intensive nature during the program helped them achieve higher levels of fluency during the program and maintain clinical gains made. One participant explicitly stated that it was helpful to practice talking the “right way.” This indicates that learning to- and using these techniques in an intensive nature is helpful for clients to make changes and maintain these changes. A number of previous studies have reported efficacy for fluency inducing techniques including slow prolonged speech, easy onsets, and continuous phonation (Andrews et al., 1980; Bothe et al., 2006; Cordes, 1998; Craig et al., 1996; Hancock et al., 1998; St. Louis & Westbrook, 1987; Yaruss, 1998.) In addition
to this literature supporting these methods, the clinical data gathered as part of this study and presented in Table 26 also corroborates with the qualitative theme. In general, objective data reported for individual participants appears to corroborate these qualitative themes and provides preliminary evidence of a possibly high correlation between client values and clinician measures of treatment effectiveness.

A third qualitative theme relevant to this discussion is that of attitude change/counseling. Six out of seven participants in this study indicated that they perceived a benefit from counseling activities including cognitive behavioral therapy (CBT) completed in therapy. The use of counseling as part of stuttering therapy is a strongly recommended approach, but has limited evidence to support its use (Cordes, 1998). More recent research by Menzies, Onslow, Packman, and O’Brien (2009) indicates that the use of CBT can help decrease anxiety and social avoidance thereby increase engagement on everyday speaking situations for PWS. Participants in this study reported that desensitization activities and CBT was helpful in decreasing social avoidance and helped increase confidence in their communication abilities. This appears to have an overall effect of reducing stuttering severity and increasing engagement in a variety of speaking situations. The program at BGSU utilized multiple scales to measure changes in client’s attitude toward communication and stuttering, and the overall impact of stuttering on their lives objectively. These scales include the LCB, the Erickson S-24 scale of Communication Attitudes, and the OASES. These measures were obtained prior to the intensive program, at the conclusion of the intensive program, during follow-up therapy, and at the time of the qualitative interviews completed as part of this study. Table 27 presents scores reported for each measure prior to the start of intensive therapy, and at the conclusion of intensive therapy. For the LCB and Erickson S-24 scale of Communication Attitudes a higher score indicates negative attitudes and lower
scores indicate more positive attitude. For the OASES, the overall impact rating is provided in Table 27. It should be noted that the OASES comprises four sections. Scores for individual sections of the OASES have been reported in section 2 of the results section. The reader is referred to that section of this paper for more detailed information. The OASES was not administered for participants who attended the intensive clinic in 2004, hence this table will only report OASES impact ratings for five participants.

As seen from the objective data reported, attending the intensive clinic did result in a positive shift in attitudes and perceptions regarding stuttering and have a positive impact on the individuals overall experience as a PWS for most participants. These data when triangulated with the qualitative theme of attitude change/counseling, can be considered to lend preliminary support to the effectiveness of using CBT to address the affective and cognitive components of stuttering (Bennett, 2006). Additionally, the objective data reported for individual participants in section 2 of the results chapter indicates that the participants reported positive changes in their attitudes as a result of the intensive clinic. Follow-up data and current data indicate a negative trend in these measures.
Table 27

*Objective Measures of Attitude Change*

<table>
<thead>
<tr>
<th>Participant</th>
<th>LCB* Pre-intensive</th>
<th>LCB* Post-intensive</th>
<th>S-24* Pre-intensive</th>
<th>S-24* Post-intensive</th>
<th>OASES Pre-intensive</th>
<th>OASES Post-Intensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daniel</td>
<td>22</td>
<td>16</td>
<td>16</td>
<td>1</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Cody</td>
<td>30</td>
<td>15</td>
<td>20</td>
<td>13</td>
<td>Moderate/Severe</td>
<td>Mild/Moderate</td>
</tr>
<tr>
<td>Teddy</td>
<td>31</td>
<td>24</td>
<td>19</td>
<td>9</td>
<td>Moderate/Severe</td>
<td>Moderate</td>
</tr>
<tr>
<td>Mike</td>
<td>29</td>
<td>32</td>
<td>17</td>
<td>16</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Nicole</td>
<td>23</td>
<td>15</td>
<td>7</td>
<td>5</td>
<td>Moderate</td>
<td>Mild/Moderate</td>
</tr>
<tr>
<td>Rick</td>
<td>9</td>
<td>10</td>
<td>20</td>
<td>2</td>
<td>Moderate/Severe</td>
<td>Mild</td>
</tr>
<tr>
<td>Yolanda</td>
<td>26</td>
<td>18</td>
<td>16</td>
<td>5</td>
<td>Moderate</td>
<td>Mild/Moderate</td>
</tr>
</tbody>
</table>

*Lower scores indicate more positive attitudes*
This pattern in the objective data could also be indicative of the indirect effect of the residential nature of the intensive program on this process of positive shifts in attitudes. A few participants’ statements support this notion of an indirect effect of group work and the intensive clinic on positive shifts in attitudes. Selected quotes from participant transcripts supporting this argument include:

**Nicole:** Something that was new and different for me that stood out from any other experience was actually being with other people that stuttered and meeting with them and talking with them, I had, there was one guy in my high school who stuttered but we sort of ran in different friend groups so we really didn’t have any contact but I just knew of him and so it was just an awesome thing to see that I’m not the only one like this that other people have this issue. That is something that really stood out for me that was just different from what I have done before and then obviously the amount of therapy stood out as being different. It was an all day sort of thing as opposed to an hour one day per week.

**Daniel:** First, I was staying in the dorms with a few other people who stutter and I am still friends with two of those people who I went through the clinic with so it’s been positive in that respect and I think that going through an intensive clinic with other people who your rooming with I think you get a different aspect of therapy from the clinic just by being around those people all 24/7 and its sort of like a small family that you are sort of thrown in to, that is very helpful. So that was one aspect that was helpful.

Another important qualitative theme that supports the importance of the nature of this program and attitude change/counseling on the changes observed in objective measures of attitude change is that of desensitization and transfer. This theme was reported by six of seven participants in this study and summarizes the participants’ perceived benefits from completing activities geared toward desensitization to reduce fear of stuttering and transfer of skills learned in the therapy room to the real world. These activities included completing random surveys asking strangers questions about stuttering and making phone calls under supervision by the clinicians. This also includes homework activities completed outside of therapy. Most clients reported this to be beneficial. For some, it was the first time they had been pushed “outside their
comfort zone” and really learned a lot from activities of this nature. Participants’ reported that activities of this nature helped them overcome some of their fears of public speaking and helped them become more comfortable with stuttering. Although no direct cause-effect relationships can be determined, it appears this component of therapy was helpful in effecting positive changes in objective measures of both stuttering severity and attitudes.

**Indirect Effects**

In addition to the themes discussed above as direct effects, certain qualitative themes reported as contributing to treatment effectiveness are discussed under a broader category of indirect effects. The most common theme relevant across five of seven participants in this study was that of motivation/readiness. Careful analysis of each transcript indicated that a majority of the clients perceived significant benefits from the therapy experience because of their own personal motivation to attend the program and a general sense of readiness to change. Participants mentioned that their motivation came from sources such as entering a new phase in life or a perception of stuttering negatively impacting their careers/social life. Wingate (1964) indicated themes of change in attitude and speech practice as being significant to recovery, and both appeared to arise from a motivation or determination to change or overcome the problem. More recently Plexico, et al., (2005) completed a qualitative study using a phenomenological approach to understanding successful management of stuttering. Recurrent themes from this study include receiving support, having a successful therapy experience, self therapy and behavioral change, cognitive change, utilization of personal experience, and high levels of motivation/determination. The results of this current study support these findings with all participants in this study reporting a positive experience with therapy and specific techniques learned in therapy, a positive impact of attitude change, and also high levels of
motivation/determination to change. The participants in this study talked about motivation and an overall readiness to change. Most participants mentioned that they were ready to make changes when they came to the intensive program at BGSU.

Another relevant theme across participants is that of clinician attributes. Five of seven participants in this study stated that the general demeanor of the clinicians and the clinician’s responses in various situations during therapy had a positive impact on their motivation to make changes and their ability to benefit from the clinic as a whole. In general, participants’ reported that clinician knowledge about stuttering, willingness to help, non-judgmental nature, and their overall rapport with the clinicians were crucial factors in determining treatment effectiveness. For some participants’ this theme seems to integrate with the theme on motivation/readiness and they felt that the clinician attributes were possibly instrumental in maintaining motivation required to benefit from the program and effect change. Participants also discussed how the opposite is true and they did not feel as motivated in past therapy experiences in school when the clinicians did not seem knowledgeable and understanding. Another aspect discussed by a couple participants’ in this study is the clinician’s ability to adequately model all techniques taught. A few studies have explored clinicians’ attitudes toward stuttering (Cooper & Cooper, 1985; 1996; Horsley & FitzGibbon, 1987; Swartz, Gabel, & Irani, 2009; Yairi & Williams, 1970). Studies have found that SLPs hold largely negative stereotypes of PWS compared to People Who do not Stutter (PWDS). More recent studies (Cooper & Cooper, 1996; Swartz et al., 2009) indicate a positive shift in attitudes toward PWS; however, reports from the participants in this study indicate generally negative experiences with past therapy in their respective school systems. Specific reports from participants include:

Mike: when I was with speech therapist that didn’t give you a strange frown or what are you saying or anything like that I started speaking much better where you know, I started
to actually not stutter at all because there wasn’t anything in my mind where you know it was a blockage saying like “ah man what’s going on”. It wasn’t a strange look or it wasn’t like what are you saying again; I didn’t hear that – I didn’t understand that. So I actually, I think we spoke a lot better because they were there basically saying stutter – we want you to stutter and I started to not stutter that much anymore. I think that it gave me a comfort level that I was not used to.

Rick: It was nice that they didn’t tell me I stuttered so severely that they could never possibly help me, it’s just something I have heard several times.

Nicole: Ok, the ones when I was younger I don’t remember 100% but I know that I saw a school therapist in elementary school. It was the kind of thing where I would be pulled out of class to see the therapist during school hours but from what I remembered that therapist focused more on dealing with the average speech issues of young children like not saying their /r/ correctly or having a lisp and so my problem was new to her so she didn’t really know how to handle me and I don’t really remember that really well because I was so young but I don’t think that was very successful and I did see another woman outside of school and she focused mainly on, instead of focusing on me, it was more of focusing on what were my; like she was trying to figure out what in my atmosphere and what in my life was causing this so she was saying that my parents were putting too much stress on me or I had an older sister who acted like the normal older sister always teasing me and picking on me but it wasn’t anything out of the ordinary which she claimed its stress and this relationship with my sister was causing me to stutter so that really wasn’t too successful either.

Thus the clinician and the clinician-client relationship appear to be indirect factors that play an important role in determining treatment outcomes and client perceptions of treatment effectiveness.

*Other Relevant Themes*

The last category summarizes themes that are relevant to participant perception of effective treatment; however, were not replicated across participants. This category comprises two themes that are specific to certain participants who participated in different variations of the intensive program.

The first theme within this category, follow-up, summarizes the importance of regular non-intensive follow-up therapy after completion of the intensive program. A meta-analysis by
St. Louis and Westbrook (1987) indicated that intensive programs were reported to be effective in achieving fluency early on in the process but were faced with the problem of relapse. This meta-analysis recommended that a mix of an intensive and non-intensive model of therapy delivery was the most effective. Clients participating in the intensive program at BGSU had in the past been given various options for follow-up therapy at the conclusion of the intensive clinic. Some participants chose to attend intensive weekend workshops while others attended regular non-intensive therapy at the clinic. However, the intensive clinic often attracts participants from geographically distant locations and it is not always possible to provide follow-up services due to geographic limitations. Since 2008, the intensive clinic has offered regular structured follow-up sessions via video-telepractice for all participants for up to six months after the conclusion of the intensive clinic. Participants then have the option to continue receiving services if they are needed. Two participants, Daniel and Mike, specifically recommended that follow-up therapy be offered to help transfer skills learned during the intensive and maintain the progress made. Teddy, who participated in the intensive clinic in 2008 and received follow-up services via telepractice, stated during the interview that he found it beneficial to receive follow-up through this method.

Another relevant theme reported by two participants, Rick and Teddy, was that of the effect of the duration of the program. Both participants attended two separate offerings of the intensive clinic. Rick attended the clinic in 2006 and 2009 whereas Teddy attended the clinic in 2008 and 2009. Prior to 2009, the intensive clinic was offered as a three-week/15-day program; however, in 2009 it was offered as a nine-day program. Thus, the experience of attending both variations of the intensive clinic was unique to only Rick and Teddy. Both during the interview, independent of probing from the interviewer, reported that they perceived the longer three-
week/15-day clinic more beneficial than the nine-day offering of the clinic in 2009. They felt the longer duration allowed for more time to focus on and practice fluency shaping and stuttering modification techniques. Therefore, there may very well be a benefit to the longer version of the program.

*Objective Measures of Treatment Effectiveness*

The results from this study indicate that the intensive program has been effective for all participants interviewed in this study. The data presented in Table 17 indicates that all seven participants made clinically measurable gains measured on the SSI-3 as a result of attending the intensive clinic. Current data gathered at the time of the interview indicates that the participants have been able to maintain these gains over a period of time ranging from one- to seven years. Cody’s data indicates that he has continued to make progress as is evidenced by a reduction of his score on the SSI-3 at the time of the interview. In the interview Cody stated that he finds it helpful to practice techniques regularly, but also addressing his feelings and attitudes about various situations. He mentioned that he continues to make positive changes in his attitudes toward communication to this day and is more accepting of his stuttering as evidenced from his transcript, “previously I used to beat myself up on it, I think that’s the big change. I’m more accepting now.” Similar to Cody, Daniel and Teddy’s data also indicates a reduction in stuttering severity at the time of the interview. The remaining four participants’ data indicates that they have either maintained the gains made during the intensive clinic, or a mild increase in severity rations; however, all participants’ objective data at the time of the interview was lower than the pre-therapy data gathered before the start of the intensive clinic.

As described in Chapter 3, in addition to objective measures of stuttering severity, scales to measure attitudes toward stuttering and the impact stuttering has on the individual’s life were
also administered to objectively measure changes in attitudes as a result of attending the intensive clinic. Data from these scales is reported in Table 25. The data from the scales measuring changes in attitude indicate that five of seven participants reported a tendency toward a more internal locus of control as measured on the LCB. These indicate that the participant’s felt more responsible for their speech as a result of therapy and were less likely to experience a relapse following therapy. All seven participants reported more positive communication attitudes as a result of attending the intensive clinic, as measured on the Erickson S-24 scale of Communication Attitudes. Five of seven participants reported scores that were similar to the mean scores of PWDS at the conclusion of the intensive clinic. In addition to the LCB and S-24, five of the seven participants also completed the OASES to objectively measure the impact stuttering has on them. In addition to the OASES, Rick completed the ACES scale when he attended the intensive clinic in 2006 because he was 16 years old at the time. The impact ratings for the OASES indicate that all five participants reported a less negative impact of stuttering on their lives at the conclusion of the intensive clinic. Daniel and Mike attended the intensive clinic in 2004 and the OASES was not used as an outcome measure at the clinic that year.

Thus, the objective clinical data indicate that the intensive program has been effective in reducing stuttering severity and addressing the affective and cognitive aspects of stuttering as well. As discussed by St. Louis and Westbrook (1987), the intensive clinic helped gain success early on in the process. Following the intensive clinic, most clients were able to maintain gains made. Five of seven participants received follow-up services or returned for additional offerings of the intensive clinic. Four of the participants received regular non-intensive follow-up after attending the intensive clinic, and one participant, Daniel attended an intensive weekend workshop. Daniel also found a private speech therapist close to home to receive regular non-
intensive follow-up from. Thus, for a large majority of the client it is important to provide regular non-intensive follow-up after an intensive clinic. BGSU now offers regular follow-up services using telepractice to allow for face-to-face interactions with participants who were previously not able to receive follow-up services due to geographic limitations.

Limitations and Directions for Future Research

Yaruss (1998) discusses that a study using retrospective analysis of clinical data cannot demonstrate a cause-effect relationship between the treatment and outcome. He further adds that it is difficult to establish reliability of clinical data gathered by different clinicians over a number of years. One of the primary limitations of the current study is the use of retrospective data for analysis of objective gains in treatment outcomes. The use of retrospective clinical data limits the ability to establish a direct cause-effect relationship between the treatment and its outcome. Hence, the reliability of data related to stuttering severity and %SS could not be established. The intensive clinic at BGSU; however did collect data systematically each year which allows for a comparison of pre- and post-intensive outcomes for participants’ attending the program. Additionally, the clinic also administered objective measures of attitude change systematically to allow for pre- and post-intensive clinic comparison of outcomes. Future research studying this program should utilize a more prospective, outcomes approach.

A second limitation of this study is the inability to generalize the results obtained to the larger population of PWS. The study used a mixed-methods design, with a phenomenological approach as the core method. The primary concern with the use of qualitative methodology is the small number of participants that might not be representative of the sample. Additionally, maximum variation sampling was used to recruit participants. While the participant’s
demographic information does indicate that factors such as age and gender ratio are representative of the general population, one must interpret the results of this study with caution.

The method of recruitment of participants can also be considered a weakness of this study. Client’s who had attended the intensive program between 2003 and 2009 were emailed to request participation in the study. Thus, participants who responded to the email were recruited for the study and completed the semi-structured interview. One can then argue that the sample recruited for this study could have been biased and more likely to report positive outcomes. Future research can utilize a Repeated measures Analysis of Variance (R-ANOVA) design to compare objective clinical measures of stuttering severity and attitudes across all client’s who attended the intensive clinic between 2003 and 2009. This can allow examination of group effects or trends in data and determine whether the gains reported for the participants in this study are replicable across all or a majority of clients’ attending the intensive clinic. Future offerings of the intensive clinic can implement more systematic data collection procedures and reliability checks for data gathered at different stages of therapy. Additionally, the use of a randomized trial or multiple baseline design for the intensive clinic can help establish a cause-effect relationship of treatment and outcome.

An important theme discussed in this study was that of follow-up. Analyzing the effectiveness of using video telepractice as a means of regular structured follow-up was not within the scope of the current study. However, it is important to systematically gather data at regular intervals during follow-up therapy to examine the outcomes and effectiveness of follow-up via video telepractice. Again, future studies should utilize a prospective design studying the benefits of the intensive program coupled with a well designed follow-up program, most likely using telepractice.
Future studies can also utilize randomized controlled trials to compare treatment outcomes for non-intensive therapy delivered in person and delivered via video telepractice. This will allow one to establish feasibility and effectiveness of using video telepractice as a viable means of delivering therapy to PWS who might not have access to therapy due to geographic limitations.

Another important factor to evaluate in future studies is the effect of duration of the intensive clinic on treatment outcomes. This is an important consideration from a client’s perspective, considering both clients’ stated a preference for the 15-day program. In the future, studies can utilize a randomized control trial to evaluate treatment outcomes for a 15-day versus a nine-day intensive clinic. It will be important to utilize a mixed methods design initially to triangulate client values with objective data gathered to inform treatment outcomes.

Additionally, some participant’s indicated that they benefitted from getting spare time in the evening to complete home assignments and practice speech techniques independently. The effect of assigning homework to be completed independently or in groups with no clinician present must also be evaluated in future studies.

Conclusions

The participants in this study demonstrated clinically measurable gains on all objective clinical measures of stuttering severity and attitude change. These gains were maintained for all participants interviewed anywhere between one to seven years after their first experience at the intensive clinic. The participants reported that they found the intensive clinic effective and reported a number of factors that contributed to their perception of effectiveness of the program. In addition, participants’ also reported their views about what aspects of the intensive program
were not beneficial to them, could be structured differently, or added to make the program stronger and more effective.

Triangulation of clinical data with qualitative themes indicates general agreement with the clinician views expressed in the objective data and client perceptions stated in the semi-structured interviews. Thus, the clinical data gathered at the time of therapy agrees with, and reflects participant values. Future studies should explore various aspects of the intensive program in a controlled fashion and determine feasibility of providing follow-up therapy via video telepractice.
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APPENDIX A

Interview Protocol

1. Could you tell me about your experience as a Person Who Stutters?

2. Could you tell me about your past therapy experiences?
   a. How would you describe their impact on your stuttering?
      i. What parts of therapy would you describe as helpful?
      ii. What parts of therapy would you describe as not helpful?

3. Could you talk about your experiences with BGSU’s Intensive Clinic for Adolescents and Adults who Stutter and/or the Multifaceted Stuttering Therapy for Adolescents and Adults?
   a. How satisfied were you with this experience?
   b. What were some things you did in therapy?
   c. What parts of therapy do you feel were the most meaningful/helpful to you?
      i. And what parts continue to be meaningful to this date?
   d. What parts of therapy do you feel were not meaningful/helpful for you?
   e. What part of your therapy experience do you cherish the most?

4. What are some things, related to your therapy experience, that you feel have helped you in the long-term?

5. Could you rank order what parts of therapy/specific activities were most helpful for you?

6. Could you rank order what parts of therapy/specific activities were not helpful for you?
APPENDIX B

Webex Tutorial

WEBEX: Quick Reference

Step 1: You will receive an email invitation in your email inbox.

Step 2: Click on the link to the meeting room (in the email invite).

Step 3: Clicking on this link should take you to the Cisco Webex page shown below. Enter your name (can be a pseudonym), email address, and password (in the invitation email) on this page to log in.

Step 4: After entering the required details, click on the “Join Now” tab. This should get you to the chat room (see below).
Step 5: Click on the option to join audio conference via your computer by clicking the join tab above. At this point, you will be able to communicate verbally with me. The next step involves sharing video. To share video, you will need to click the “Send Video” tab.

Congratulations, we are now setup and ready start a videoconference!!!!!!!!!!
Basic Troubleshooting

1. No sound? – leave meeting by clicking “File” and “end meeting.” Then join the meeting again following steps 2, 3, & 4 above.

Now slide the bandwidth bar down from “high” to medium bandwidth. This should improve audio quality. The quality of the video might be compromised (appear pixilated) but this generally does reduce “freezing” and improves audio quality.
Overall, I feel stuttering is a difficult disorder to cope with as it impacts verbal communication, an integral part of social interaction. A lot of people have very limited knowledge about stuttering and often tend to associate it with nervousness. I feel listener responses can have either a positive or negative effect on the speaker’s ability to manage stuttering and apply various fluency shaping and stuttering modification strategies taught in therapy. I strongly believe in the ABC model of stuttering and feel it is important to address all three components: Affective, Cognitive, and Behavioral aspects of stuttering in therapy.

I feel I am more biased toward using an eclectic approach that teaches client’s to use stuttering modification and fluency shaping techniques as a package and allow them time to practice these techniques in a “safe” clinical setting. I think it is important for clinicians to be empathetic and understanding and help the client’s “transfer” skills learned in the therapy room to the outside environment. Counseling and desensitization are big components of a therapy program for me and I feel that allows the client’s to gain more confidence in their abilities as effective communicator, and more importantly in their ability to use techniques effectively in all speaking situations.

I definitely feel an intensive program is an excellent way to help the client gain the skills required to manage their stuttering effectively in a short duration; however, it is important to provide continued support after the completion of the intensive program. I think follow-up is important to help the client’s maintain gains made in the intensive clinic. I think it also provides the client with a time specifically dedicated to practicing techniques in a safe, non-judgmental atmosphere thereby promoting better motor learning. Thus, I have a preference for a mixed-model approach to delivering therapy for People Who Stutter (PWS). I think telepractice is an
effective means of providing follow-up therapy but have certain reservations about its implementation. I feel the physical contact is lacking and the ability to complete outdoor transfer type activities is missing. I think this is an important component of therapy and hence, do not feel we can move to a “telepractice only” model of delivering therapy. I am open to exploring outcomes of a telepractice only clinic, provided the necessary back-up to provide therapy in person is available.

With respect to stages in therapy, I feel it is important to first establish rapport and get to know the client as a person first. I feel the client-clinician relationship has a big role to play in treatment effectiveness and a clinician needs to establish rapport with the client from the first day. Once rapport is established I think education and awareness of stuttering behaviors is very important. This can be followed by activities to help the client achieve some fluency in the therapy room and learn about the importance of attitudes toward communication and stuttering to the effectiveness of the program. In addition to teaching “skills” to move through stuttering moments more efficiently and being fluent, I think it is of utmost importance to be honest with our clients and not misguide them in any way to believe that these skills will transfer to their daily life immediately. Let then client’s know that this is a process and we are taking the necessary steps required to complete the process. I feel it is also very important to encourage clients’ to be open and honest about how stuttering makes them feel and how they react to their stuttering. Bring about an awareness of self and help the client’s learn to be more “honest” to themselves about stuttering and their perceptions of self; also the role stuttering plays in identity construction and perceptions of self.

In conclusion, I feel the client’s motivation to attend therapy, the clinician-client relationship, the nature of the program (a mix of intensive and non-intensive), clinician and client
honesty, teaching clients’ a variety of techniques to manage stuttering, and helping the client be more honest and open about their stuttering contributes to treatment effectiveness.
Hi [Name],

I am emailing to request your participation in a treatment effectiveness study for the Intensive Stuttering Clinic for Adolescents and Adults who Stutter offered by the Speech and Hearing Clinic here at Bowling Green State University. I am currently in the final year of my program and this is my dissertation project.

The purpose of this study is to gain a better understanding of the services offered at the clinic and use this information to improvise on services offered in the future. This study will also help us determine what treatment approaches have been helpful in the short- and long-term for those who have received services here in the past. Hence, this study will provide us with insights about our program and help us improve our services in the future. You will not be eligible to participate in this study if you are under 18 years of age.

Procedures: I estimate that your participation in this study will take approximately 4 hours. Your participation in this study will involve:

- A 30- to 60-minute interview that will be conducted online using a web conferencing software called Webex®. All interviews will be conducted by the primary investigator, Farzan Irani, at a time convenient to you. You will require a reliable internet connection to participate in this study. I will mail Webcam’s and headsets required for conducting the online interview to you. Following the interview, I will review your responses to the interview questions to interpret them. You will be provided with my interpretation of your responses and can make changes/modifications/suggestions as required.
- 4 speech samples. The samples will include: (1) A regular conversation with the primary investigator (me); (2) A 3 minute monologue where you will be required to talk for 3 minutes on a topic of your choosing; (3) A short reading passage; and (4) 3 brief phone calls made to local businesses.

*Note: The interview and speech samples will be audio- and video-taped for review later by the primary investigator.

- And 3 short online questionnaires/surveys and 1 survey via mail. Completion of the surveys should take no more than 1 hour.

Risks and Benefits: There are no known risks beyond those that you would normally encounter in your daily life. You may benefit by learning more about the program and gaining insights about stuttering and what you have previously learned here in the program.
Payment / Costs: Participation in this study is voluntary. If required, you will be mailed a webcam and compatible headset to allow participation in this study. These materials will be provided at no charge and will be yours to keep following participation in the study.

Confidentiality: All records related to this research (including recordings of the interviews) will be maintained in a locked laboratory and will be available only to those assisting with the project. You will be assigned a participant number and this will be used in place of your name. The investigator will not reveal any identities if they publish or present the results of this study. Please note that e-mail is not 100% secure, so it is possible that someone intercepting your e-mail will gain knowledge of your interest in the study. Please remember to clear your browser’s cache and page history in order to protect your privacy if you are using a public computer (e.g. office, university).

Questions: If you have any more questions you can contact Farzan Irani, M.S., CFY-SLP (firani@bgsu.edu; 419-372-4320; 419-206-6392) or Rodney Gabel, Ph.D, CCC-SLP, BRS-FD (rgabel@bgsu.edu; 419-). If you have questions about the conduct of this study or your rights as a research participant, you may contact the Chair of Bowling Green State University's Human Subjects Review Board at (419) 372-7716 (hsrb@bgsu.edu).

*PLEASE READ THE ATTACHED INFORMED CONSENT FORM BEFORE RESPONDING TO THIS EMAIL. THANK YOU!

Consent: I have been told what will be done in this study. I have also been told how it would be done, what I will have to do, and how long participation will likely take. I am aware that participation in this study is voluntary. I may quit and/or refuse participation at any time without repercussions. If I am a student, the decision to participate or not participate will have no impact on grades, class standing, or relationship to the institution in any way. If I am receiving speech-language-hearing services at BGSU, my decision to participate or not participate will have no effect on my relationship with the institution / clinic or the treatment I receive. If I am a member of the National Stuttering Association (NSA), the decision to participate or not participate will have no effect on my membership to the NSA. If I want it, the investigator will give me a copy of this form to keep for my records.

If you agree to participate in this study, please respond to this email with the words “AGREEMENT CONFIRMED” in the subject line. If you do not wish to participate in this study, you do not need to respond to this email.

Thank you for your time and consideration.

Sincerely,

Farzan
APPENDIX E

Interview Transcripts

The transcripts below use the pseudonyms given to the participants to maintain confidentiality. Any statement or word in the transcripts that might compromise participant confidentiality has been replaced by “XXXX.” Any statement that was not clearly recorded and/or could not be understood at the time of transcribing the interview has been marked by “XX.”
Participant 1: Daniel

INTERVIEWER: Overall, your experiences as a person who Stutters. Any relevant experiences that you would like to share about being a person who Stutters?

Daniel: Yeah, I mean I have had tons of different experiences. I’m just trying to figure out the most relevant experiences. I guess I will start when I was younger. One of the first experiences that I remember when I was 5 years old. I was riding in the car with my elder sister somewhere, I forget where we were going but she was driving and I was telling her something and I remember that we were crossing the railroad tracks in the car and I was stuttering on something. I was having a whole word repetition of something so my sister looks at me and she is like Daniel you are stuttering, you need to stop stuttering. So I just felt really bad about that because I felt like I had a problem with my speech, which I did and so I just remember that being real negative for me.

INTERVIEWER: How about therapy experiences? What kind of experience have you had before you came here to bowling green?

Daniel: I had a lot of therapy experiences. I had a little bit of therapy in grade school but I don’t remember that being very helpful. But then again I don’t think I was ready for therapy in grade school either so it was probably partially my fault on that. I had some therapy in high school and that was more helpful but I still wasn’t ready for it and in fact I was still looking for a cure back then. So I would do the therapy in the therapy room and I’d be mostly fluent and I’d be fluent when my therapist was with me and then once she left, I would rapidly go back to my old stuttering behaviors. So it never really transferred at all for me in high school. And then I went to college at the university of Nebraska at Kearney and I had off and on probably at least 4 years of therapy there. I had several different speech clinicians. We worked on a combination of fluency
shaping, stuttering modification and different types of therapy to work on my attitudes with my stuttering. I think those experiences were all helpful in the sense that they all forced me to talk a lot more and before I came to college I wasn’t really talking that much. So I didn’t really have experience with how do you maintain a conversation, how do you start one. I just didn’t have much experience with the talking in general. So for me therapy was really helpful in just helping me to learn how to maintain a conversation.

INTERVIEWER: Are there any specifics you remember about the therapy that you had previously that was helpful. Also specific things you did in therapy?

Daniel: yeah, well I remember that the DAF machine was really helpful for me in therapy. It was so helpful that I got my own machine. And then it worked really well for a few weeks then I got used to the feedback and it stopped working. That was really helpful in therapy, I achieved fluency there. I would say that other things that were helpful were just trying to get me to adjust my attitude toward my stuttering and they tried all these different activities to help me start to try and think differently about my stuttering but I was so set on trying o learn to be fluent that I didn’t really take those activities too heart unfortunately. Like they would do activities like list everything positive about yourself so that would be a pretty long list and then the other side was negatives about yourself. Offcourse that was a shorter list, but the stuttering was there and for me the stuttering was more significant than the long positive list. And so I can never really see that Im a lot more than my stuttering from activities like that. I would just focus on the stuttering. So I had good clinicians who had all these good activities but I was way too focused on trying to learn how to be fluent instead of learning how to communicate more effectively and still stutter. INTERVIEWER: Were there things in therapy that you feel were not as helpful? Like you mentioned the DAF was helpful initially in the short term and the therapy room but in the ling-
term it was not that effective, you started getting used to the feedback. Similarly were there things that were not as helpful that you did in therapy previously that maybe helped in the short-term but not in the long-term or was not helpful right from the start?

Daniel: yeah, we spent a lot of time trying to slow down my rate of speech and I think maybe it has slowed down a little bit in the past decade but I’ve always been a fast talker and for me it took more mental effort that it was worth for me to really alter my rate of speech. So I always had a hard time with that one. And the second thing I feel like we spent too much time in therapy working on speech strategies instead of going outside and trying to incorporate some of those strategies in real life situations. And third my clinicians didn’t really do a very good job of modeling the strategies being used. So if we did go outside somewhere Id be using the strategies and they wouldn’t really model them for me and it was just sort of weird.

INTERVIEWER: So you feel like it would have been more helpful if you were doing more activities outside and clinicians were actively modeling different techniques?

Daniel: Yeah, true because I felt you know more as somebody who had a problem since I was the only person working on my speech in the outside situations. So it was me the solo stutterer and nobody else which just felt pretty strange and sounded pretty strange too.

INTERVIEWER: Have you had any group experiences before, were there any other clients who stutter in therapy with you that you would interact with or?

Daniel: Unfortunately at XXXX I don’t really remember any group situations. There were a couple I think. Well, my brother he was in therapy there for a semester too so he and I did maybe one group therapy session. I don’t really remember any group therapy sessions besides that. So I think that group therapy would have really helped me because I could have seen what some other people who stutter, what they were working on and how they were handling their stuttering. So
that was a missing piece for me back then but to XXXX’s defense their fluency case load was pretty low so it was probably difficult for them to put me in a group with another person too.

INTERVIEWER: Could you tell me a little bit about your experiences at Bowling Green’s intensive clinic you attended?

Daniel: Well, leading up to the bowling green intensive clinic I was, I would call myself a pretty severe stutterer back then. And so my stuttering really affected me at my job as a speech-language pathologist. I mean I was able to carry out my job pretty well but there were times where it was really difficult to talk. So that gave me the motivation to go through the intensive clinic and to get as much from that clinic as I possibly could. I would say I was a 10 of 10 as far as being motivated for that clinic so that was helpful. Then, the clinic itself was helpful for me for several reasons so I will just list those different reasons why it was helpful for me:

First, I was staying in the dorms with a few other people who stutter and I am still friends with two of those people who I went through the clinic with so it’s been positive in that respect and I think that going through an intensive clinic with other people who your rooming with I think you get a different aspect of therapy from the clinic just by being around those people all 24/7 and its sort of like a small family that you are sort of thrown in to, that is very helpful. So that was one aspect that was helpful

Two, we did some group therapy and we had several large group sessions, I liked those to because that was so much similar to group therapy I feel. And we got a few smaller group sessions too where there were two people who stutter and one or two clinicians and those session were helpful too.

The other thing that was helpful was just pushing me to do things outside of my comfort zone and really, I mean there was some hand holding that was involved but some pushing too
like you just need to do this no matter what. I guess one example that stands out the most is that I have always been very fearful of approaching strangers and just talking to them. That’s something that I used to hate doing, I mean I’m still not fond of doing that but it was a lot scarier for me back then and before the clinic I would always have severe blocks in doing a situation like that or it was just real though so doing that situation, I think it was the first few days of clinic. We were outside by the library and my clinician she’s like I want you to approach these people and ask them a few questions. So I did one or two of those and it just went really hard for me and it I was not able to maintain eye-contact that was one of our goals and it was just really difficult so I think by the third one I was starting to shut down and so my clinician she is like Ok by don’t you approach another person and I’m like I don’t think I want to because its just so tough and so one of the supervisors was there too and so she pulled me to the side and she was like ok so what’s wrong. So I told her what I was experiencing inside and so she listened to me which was helpful and then she showed a techniques that she thought might help me in this situation. So she suggested just doing some voluntary stuttering to get me going for a conversation and just try to maintain the eye-contact. So I did that and it was the first time that I can remember that I approached a stranger using voluntary stuttering and at the same time maintaining eye contact. So that was a big success for me and something that I had to be pushed to do because I would never do that by myself. Something else I wanted to mention that for me it was pretty helpful doing large group and even class like presentations in the stuttering clinic so I think I did probably two or three of these and towards the last one I started to realize that I enjoy public speaking even though it was fearful for me so that was pretty positive too.

INTERVIEWER: So getting the practice of doing that in a safer or more controlled environment?
Daniel: Yeah the environment was more controlled and safer because my clinicians were sitting in front of me, XXXX was there and the other clients were there too so I felt it was a pretty safe place to stutter in public and a safe place to practice a few of my speech strategies also.

INTERVIEWER: Are there any specific activities or tasks that you can remember doing either outside other than this or in the therapy room are there something that you remember doing that were either helpful or not very helpful? So, from your perspective what were some things you can remember that were helpful or were not as helpful?

Daniel: I’m trying to remember specific things that were did that were or were not helpful. Well, one thing that was not helpful and I’m sure XXXX knows this because he could see me that I wasn’t enjoying it but when I went through the 2004 clinic we spent about I think it was close to a whole day using the DAF machine so yeah we just spent the whole day talking very slow either reading or having a conversation with our clinician but just going very slow and I remember just hating that and I don’t feel like at the end of the day I really got anything from that. So I wasn’t too happy about that. I’m trying to think of other examples. Ok yeah back when I went through and I still stress this, XXXX really stressed doing journaling about your speech and how you feel about your speech so I really took that to heart and after the day was over I would sit down and just write my thoughts about my speech and how I felt about it any ideas I would have I would just write down and so for some of the sessions I would have like a page or a few pages to talk to my clinician about and I just remember getting into these real good discussions with my clinicians about my journal writings so I feel that was pretty helpful. For I felt like I had a lot of I would say both rational and irrational thoughts about my stuttering and how I feel about myself when I stutter and just a lot of thoughts about it so it involved me to put everything out there on the table and then talk with my clinicians about it.
INTERVIEWER: Are there any other things that you have felt were really meaningful or helpful or not helpful/negative?

Daniel: Yeah, looking back before going to the 2004 intensive clinic I had never done the identification stage before where you identify what you are doing with your speech what your thinking and then tallying I had never done that before so that was really helpful for me that was a big positive so I would say what I have said so far have been the biggest positives for me from the intensive clinic so I mean besides doing the DAF all day I cant really think of any negatives that stand out.

INTERVIEWER: So if you had to list some things or activities that were really meaningful like a hierarchy of meaningful activities how/what would you put I that list as being the most meaningful at the time of therapy and in the long-term?

Daniel: I would say probably on top of that list would be talking to strangers while using a speech strategy that I am most comfortable with that would be on top of the list. Other things on top of the list, I guess the next thing would be all the journaling and just talking to the clinician about my thoughts and having the clinician do some counseling about my thoughts so helping put things in perspective. So I would say those are probably the top two and then I would say after that comes the identification phase for me is number three I would say.

INTERVIEWER: And what are some things that you took away from the clinic and have incorporated in your life that you use even today?

Daniel: Good question let me think about that for a little bit. Well, I think one of the things that I took away from the clinic is this sense that I can control my stuttering I mean I cant stop stuttering but I can control how I stutter you know and I can control how I think about my speech and myself. I would say that I took those points away from the intensive clinic. The other thing
that I took away is that I realized that when I have some control of my speech I am pretty outgoing, I like talking to a lot of people especially when I have a few strategies I can sort of get me moving forward.

INTERVIEWER: So what are some of the strategies that you use to “get moving forward”? Daniel: I would say that the biggest ones are voluntary stuttering and I would say the best one by far for me has been the biggest one and then I use a few pull-outs every now and then but for myself its easier using the voluntary stuttering than the pull-outs once I am in trouble unless I am in a speech block.

INTERVIEWER: Is there anything more that you would like to add about the overall therapy experience and how you have integrated that in your life? Daniel: Yeah, well once I completed the intensive clinic I came back here for a few follow-up intensives so that was helpful but I still felt like I needed more therapy more help with my speech and how I felt about myself so I found a private therapist who I worked with for about a year just to do more work on how I felt about my stuttering and we tinkered around with different strategies too but towards the end of that therapy I found that I needed to use some basic strategies and yet not try to over control my speech either like if I try to you know really concentrate and use easy onsets on every sentence and you know almost try to have myself stutter minimally I found that I found myself getting all tensed and not very happy in general so for me it was sort of like finding my individual plan as far as what works for me and what doesn’t for best managing my stuttering. Sort of reflecting on my different therapy experiences and then just seeing what’s helping me and what is not helping sticking to what’s working.

INTERVIEWER: In conclusion, can you describe your journey from when you started the intensive clinic to date, can you describe how you feel your speech has changed over time as in
gotten better or worse from your perspective? So how it has changed and it’s effect on you over this entire period?

Daniel: Yeah, let me back track to 2004. From that time I was, I sort of relearned some of the speech strategies and you know got even better at those. I had learned those many years about but I just you know learned them better this time. That was helpful, I still had quite a bit of trouble with the carryover part though, incorporating those strategies or different ways of thinking in my everyday life that was still missing but I did start to have more confidence in my stuttering and I began to start thinking differently about it very slowly over time and started to very gradually alter my belief system about my stuttering.

INTERVIEWER: So, this is all after completion of the intensive clinic you felt the carryover was not happening?

Daniel: Correct, the carryover was still lacking. So then I saw this private clinician and I would say that was really intense therapy even though it wasn’t intensive it was once or twice of week but we put a lot of thought into each session and my therapist would ask me really hard questions during the session and put me on the spot that would really get me thinking about how I feel about my stuttering and what I believe to be true and not true about my stuttering he would really get me to analyze it. So by having him ask me those hard questions that helped me t start thinking differently about my speech too a little bit so that sort of was a catalyst for more change with how I think about my stuttering even though I was still really severe back then I was starting to change my thoughts about it. And then going through school here at BG was helpful or helping me continue to alter how I thought about my stuttering and I think what helped was supervising in the intensive clinic and just going over everything that I went through as a client and seeing it from a different perspective as a clinician that was helpful and then having
successes in doctoral school was helpful for my confidence piece for example teaching a college class for the first time was the scariest thing I had ever done but probably the most rewarding too for me from a confidence standpoint with my fear.

INTERVIEWER: Also, to add to that how do you feel your speech was all that time? Stuttering severity was going up, down, stable?

Daniel: Great question, I would say from 2004 until I XXXX I would say I had a lot of fluctuations in my speech. I was pretty severe most of the time through that time frame and then once I got here in 2006 still had a lot of fluctuation in my speech but I think on average its gradually been getting better over time each semester from 2006 until now which is 2010 and I think a lot of that is due to achieving various goals like supervising graduate clinicians, doing a lot of direct therapy with clients, teaching a lot of college classes. I think each of those successes helps somebody who stutters, I mean gradually over time it helps.

INTERVIEWER: So would you say something that has helped is seeing your dreams or goals come true, actually going in and achieving them has helped propel or push this change in attitude and control with speech?

Daniel: Yeah true, achieving goals has been very helpful for me in developing a more positive or helpful attitude toward my stuttering and also something that i forgot to mention is just not being afraid to take risks whether its stuttering or something else. Something that you really want to do just go ahead and do that even though it might seem very dangerous from a stutterers perspective still do it and still try anyway and that’s been very helpful too. Because back when I was a more severe stutterer I would not try I would not take risks and so I think too well for me anyway too for me progress with my stuttering I just sort of put myself out there and take more risks with my speech and learn how to not feel so negative about my stuttering when I risk like XX just
learning helpful adult talk like that really crashed and burned but tomorrow I will be better and stuff like that.
Participant 2: Cody

INTERVIEWER: The first thing I would like to ask you is broad; in general can you describe your experiences with stuttering as a person who stutters?

Cody: I guess it’s difficult because it something that not everyone does and so it maybe frowned upon or people tend to have a judgment for it but it is also sets me back in communicating with other people and make me feel self-conscious at times but it has been getting a lot better since probably grade school when I started, I have been feeling better about it. It’s just speaking even though I’m stuttering and not getting down on myself. I tend to have or the sounds that I have trouble on tend to change all the time. I think right now it’s the sounds that we sort of blow air through like the ‘s’ sounds and the ‘f’ sounds. Well and the XX sounds also tend to be trouble like a lot of times I hit the sound too hard and tighten up. I try to think about having easier contacts and stuttering rather than blocking on it.

INTERVIEWER: So controlling the stuttering in a way?

Cody: Yeah. Some speaking situations are harder than others like speaking in front of a group of people. Just recently, I have a class in which the class is sometimes telecast to a XXXX student classroom, it’s like a joined class with them and they have this system in which the camera can be moved to anyone in each class and both classes could see you and we all had to introduce ourselves so the XXXX students went first one-by-one and we went after that and I came in late so we sat at the back but because the class was going on everyone was introducing ourselves. It was pretty nerve-racking but I think I did alright.

INTERVIEWER: Those would be typically scary situations for most people.

Cody: Yeah. I remember I have a tough speaking situations now I’m always like proud of myself no matter of the outcome or how much I stutter so it is like how I handled it and it was probably
difficult for everyone there and I don’t think that like previously I used to beat myself up on it, I think that’s the big change I’m more accepting now.

INTERVIEWER: That’s wonderful. So, just kind of summarizing everything I think you are saying you’re at a stage right now where you’re just more comfortable with dealing with/managing stuttering moments as they come and not looking or ruminating about things that happened moments that you maybe have not managed as well before?
Cody: Yeah.

INTERVIEWER: That’s really important to stay in the moment and not ruminating or even when moving forward not worrying about the past.
Also, Can you tell me a little bit about your therapy experiences previously before you first came to bowling green?
Cody: I think speech therapy in the school, I don’t think I was very much into it. The only thing we would do was to look at the characters of Winnie the Pooh and all of them had a different way of handling stuttering something or like rather than handling it, like I think it was Tigger that spoke slowly or and then some other character spoke fast and some other ones spoke in the XX voice but the owl spoke in the preferred way, he would breathe in and then breathe out a little bit and start speaking on your exhale. There was some name for it forgot that. Then we would just do sounds, or have to repeat words that started with sounds that I was having trouble on and then I would just mainly talk a lot at the therapy. There was no real focus on the mental aspect of it and how to handle situations or controlling most, it was just the outer aspects.
INTERVIEWER: So like being more fluent in a way?
Cody: Yeah.
INTERVIEWER: From what you’re saying I am getting the sense that there was not much practice outside of the therapy room?
Cody: Yeah there wasn’t much of it.

INTERVIEWER: So, what do you feel in your past experiences was helpful and not as helpful? If you were to list things that were helpful and not helpful?
Cody: Things that were not helpful were people telling me to either slow down or hurry up or people telling me to just say it, it’s like yeah I am trying to say it. People not giving eye-contact, but is more understandable though be people, it was embarrassing for them to look at me while I was stuttering and I guess mainly when I was younger it was easier but now it feels like, maybe I want to communicate more easily I feel, I don’t know but I really vale eye-contact right now. Things that helped were mainly things that I would do like controlling emotions you know like I think we we did this in speech therapy but not to try to block emotions like nervousness you know but like to use like extra energy to maybe focus more on a technique or yeah like to have more control over the situation will help. Also the techniques we did in speech therapy like the pull-outs but those only work when you seem to control your emotions and you can handle the situation better but like you can’t be like the same like for all of them, it gets harder.

INTERVIEWER: At this point, I would like to ask you about, if you can summarize your experiences with the intensive clinic and any type of follow-up you received at BG. If possible, since you have attended more than one intensive if you can walk me through your experiences from then till now?
Cody: The first time I went I think I made the most progress, I think also because I had no real speech therapy before that but yeah just focusing on my speech that intensively and thinking everything out like that and then using all the techniques to sort of learn how to speak again kind
of I think that helped me out a lot. I liked how it didn’t kind of bit of just working on harder sounds but it was going over the emotional aspects of it. I felt that like in the later clinics I would have like more of the focusing on harder sounds and like the techniques for that. I feel that we did more of the controlling emotions and events of it but I feel that just depends on the person, I feel I’m better at handling the emotions part than using the techniques like at different times but that’s probably not for everyone.

INTERVIEWER: So you feel for you particularly it was more beneficial to rationalize thoughts and attitudes toward communication and getting more comfortable with stuttering?

Cody: Like I thought it was more helpful like to go through the techniques and the fluency shaping and all that but like only after the emotions and feelings part was taken care of I guess because I feel like the techniques and stuff helped me the most.

INTERVIEWER: Are there specific techniques that you feel were extremely or that helped a lot more and you use to date?

Cody: Yeah, I try to remember the easy onsets and the pull-outs if I’m blocking. One thing that I need to work on is to not stop and like I know in my mind that I might stutter on a certain word. I feel like I need to move through it like the words I think I will be fluent on. I tend to block more when I pay too much attention to the word that I think I will stutter on.

INTERVIEWER: Can you think of specific activities that you might have done during the intensive clinic or follow-up that strike out as being either helpful or not helpful at all?

Cody: Yeah the random survey was helpful, probably the most helpful. After just knowing all the techniques and trying to use them in a situation like that I think was really good practice like some of them weren’t too demanding because you can always come back to the therapist and talk
about it and it was interesting to see how the people would respond to everything like me stuttering and how they responded.

INTERVIEWER: So kind of getting to know about people’s take on it?

Cody: Yeah, it’s really like, no one has a strong opinion about it it’s just, I think stutterers have the strongest opinion about it, makes sense but it’s not a great way to think about it but it’s just like they have objective take on it it’s just not big deal you know, it’s not effective, I don’t know.

INTERVIEWER: And, are there things that you feel were like not helpful?

Cody: Well, I didn’t feel like the cancellations were that helpful because you can’t really do that. It’s like kind of weird if you do that in feel like you know just speaking with someone it’s not that practical but I also think that it was a little counterproductive because it may be rewarding fluency that just speaking you know because or I guess it’s how you take it because if I would say it again I would try to be more fluent but I guess you may have been supposed to say it as easy as possible but I would still try to be fluent because I wouldn’t want to say it again you know.

INTERVIEWER: So with the cancellations you felt like you needed to be more fluent to avoid having to repeat the word?

Cody: Yeah, but I think yeah I wasn’t too into that.

INTERVIEWER: Ok, and if you had to kind of rank order things as being meaningful or useful to you, like everything that you’ve got out of therapy that was feel was really meaningful or useful and it’s kind of helped in the long-term like even today it’s something that’s stayed with you and you’ve used regularly. How would you rank-order things?

Cody: I think number one would be to just talk and not avoid situations or not or talk whatever you wanted you know. Then I think just talking a lot like the clinic we did a lot of practicing of
just with the techniques and the surveys and I think that correct repetitions helps a lot. More than
just talking a lot it’s like talking the correct way a lot.

INTERVIEWER: So you mean practicing the movements associated with

Cody: Yeah, yeah and like the repetitions is just helps a lot. Then you have to keep it up
afterward not even as much repetition like enough to retain everything.

INTERVIEWER: So afterward you mean like after the intensive clinic?

Cody: Yeah, it is more to keep up with it. Then I think the emotional part of it was also
important. Maybe that should be number two. First is just talking then two is the emotional
aspects of it and like just not worrying about the other person maybe thinking or you know
whether he or she is judging you and controlling the emotions stuff like I then I then number
three will be the repetition and practice.

INTERVIEWER: And if I asked you to rank-order stuff that was not helpful?

Cody: Just like the clinic stuff only?

INTERVIEWER: Yes.

Cody: Number one I think it would maybe the DAF cause it, I understand like why we didn’t use
that afterward because it sort of just gives expectation or it was just, you can’t/don’t want to talk
like that either. Yeah, then I think the cancellations stuff. It feels like pretty much everything else
helped me out in some way. Yeah.
Participant 3: Teddy

INTERVIEWER: If you can tell me in general experience with stuttering as a PWS?

Teddy: I have been stuttering close to about two decades now. I have had a lot of experiences with stuttering. What I noticed is that my stuttering is variable so it can change from being fluent to disfluent depending on the situation I am in, who I am talking to, and it can change just in minutes. If I am speaking to my class that I teach I am usually more fluent but if a student asks me a question, I become more disfluent. From my experience I have learned that my stuttering is very variable, it can change drastically over the course of the day and stuff. The main thing that helps me be more fluent is to be rested so get plenty of sleep and also with people who I am more comfortable with I am more fluent.

INTERVIEWER: Could you briefly explain your therapy experiences before you came for the intensive clinic at BG in 2008? So just a quick summary of different therapy experiences you have had prior to BG?

Teddy: Well, I began going to therapy when I was 5 years old and I stayed with the same clinician for 6 years. I am not sure the approach that they took in therapy, I don’t really remember, but it was – one of the main things was my SLP went to my school and talked to my teachers and said that just because I stutter they should not avoid to call on me, so I guess she was asking to treat me the same. I became very fluent when I was with her. Then my family moved to the US when I was 11 and since I didn’t know how to speak English I couldn’t really go to speech therapy so I didn’t have therapy for 3 years till eighth or ninth grade and that combined with the changes of being a teenager I became a lot more disfluent. So I had therapy from when I was 15 till now and I was in different things. A few years back as a freshman in college I worked on breathing techniques using the diaphragm to breath.
INTERVIEWER: What parts of your previous therapy would you describe as helpful? Even specific activities that you may remember?
Teddy: I would say I did a lot of stuttering modification techniques such as the easy onset and pull-outs and prolongations and all that. For me, techniques are usually really helpful for a while and then they don’t become that helpful. Then I also tried the speecheasy like 3 or 2 years ago. It was helpful in certain situations, made me more fluent but it was very hard to use it if I was talking to more than one person in a private setting because of the noise. So I stopped using it, but it was more helpful in phone calls and stuff like that.

INTERVIEWER: Were there things you feel were no helpful?
Teddy: Let me think about this for a second. I am not sure really. It is hard to say because things were helpful for sometime and then they didn’t work anymore such as the easy onsets and some, I guess the breathing techniques became a secondary behavior for a short time also. So, basically most of the techniques that I have tried have been good and bad really.

INTERVIEWER: Can you describe your experiences at the intensive clinic the first time you attended it at BG?
Teddy: Ok, we had therapy for 3 weeks and the weekends off so 15 days total. I had one clinician and 1 supervisor and they did therapy for most of the day (approximately 6 hrs/day) and then we had homework to do at night. I thought that it was really helpful for me especially doing the videos and watching myself stutter so I could see the type of disfluencies I have. That was really helpful, just knowing my stuttering helped me know how I could go about and reduce it. Doing phone calls and listening back to them was also really helpful for me to recognize what I was feeling and I also like going around campus and talking to random people. That helped me
to desensitize and also my fear of stuttering in public. Yeah, so I thought that the camp was the most helpful type of therapy that I did especially the 15-week one.

INTERVIEWER: Could you describe specific parts of therapy that you feel were meaningful or helpful for you?

Teddy: Yeah, the playback of the video recordings was a crucial thing. Then tallying my disfluencies was also really helpful. Also listening back to recording of the phone calls that I made and a very important thing was the take home assignments we had to call businesses because that really helped, I guess to generalize more of what we learned. The whole clinic comfort thing, doing things on your own was good to know that you could be doing something after clinic too by yourself and it was something simple yet helpful.

INTERVIEWER: If you had to rank things that were helpful like X being the most helpful? How would you rank activities from being most to least helpful?

Teddy: It all came in stages really but the main thing for me was looking back at the video of me speaking and tallying, so because a lot of my disfluencies were interjections so once I became aware of that and also aware of my secondary behaviors I was able to work on them and get down to the core behaviors. Yeah so I would say that the most important thing was eliminating secondary behaviors and just having core behaviors. That really laid the foundation for everything else that I did.

INTERVIEWER: Also, one part of what we want to know is things that were not helpful? Like activities that you feel were not as helpful to you at the clinic?

Teddy: Things that were not helpful. I think that, what I can think of as the least helpful would be having the group therapy so having 3 more people and working on fluency. We were all very
different level and were on a different level and working on different techniques. So I thought that more time could have been devoted for me than watching someone else doing therapy.

INTERVIEWER: So, when you say groups you mean sitting with another clinician client pairs and working together?

Teddy: Yeah, yes like not the discussions that we had at the end of the day with XXXX. I thought that those were helpful. There were sometimes during the day that we would like. I remember playing a board game during a group setting and working on a technique so that is what I am talking about.

INTERVIEWER: Ok, I just wanted to clarify. Are there any other things you can think of that were not as helpful to you?

Teddy: Not helpful to me. No. I guess that the day that we go downtown, could have been done in a more efficient way. There was a lot of time wasted in that so I felt that we talked to relatively few people for the amount of time that we were down there.

INTERVIEWER: What were some things you learned or did in therapy that you feel have been helpful to you in the long-term or a longer duration?

Teddy: The importance of recording yourself and analyzing what you are doing. Slowing down your rate is really helpful. And also do different techniques at the start of a sentence has been helpful for me. So those techniques were helpful for outside of the intensive clinic. And also it really helps to analyze a situation and being more positive like not being so hard on myself and be more accepting of being a person who stutters.

INTERVIEWER: So also working on how you perceive yourself and how you perceive stuttering and emotions?
Teddy: Yeah, that was probably the most, the thing that carried over the most because after the clinic there were times that I was really disfluent. The comfort level of being someone who stutters was something that kept at a good level like it was in therapy.

INTERVIEWER: Any activities or techniques that did not carry over or were not helpful?

Teddy: Something that was not helpful I guess was that even though the clinicians were warning us that speech during the intensive clinic was the best that your speech will be since you were devoting 100% of your time to your stuttering. So a lot of the techniques that would work perfectly during the clinic would not work so perfectly out in the real world. So my bounces in clinic were smaller but then outside after clinic since there were pressures like in a job – so just the techniques didn’t work as they well as during the clinic.

INTERVIEWER: Is there anything else you would like to add that you feel was either helpful or not helpful from the experience you have had?

Teddy: Yeah, I participated in the 15 day and then the 9 day clinic. I personally thought the 15 day was a lot more helpful for me. There was a lot more time to work on the techniques and I really liked that we had take home activities to do too. I think that that was an important part for me - the take home activities of calling businesses and recording all the experience of doing that to the clinician the following day.

INTERVIEWER: Thanks, is there anything else you would like to add?

Teddy: Yeah I think it is a really good program and the best speech program that I have done because it really worked on my speech and my feelings and emotions about someone who stutters so I think that those were really 2 of the main aspects of being someone who stutters. I really like how we still have contact with the clinicians after therapy is over because as everyone says the hard part is once you leave the clinic and go to the real life. So it was extremely
important to have that support system of the telepractice and having someone to talk to and share. So that was really a big part of what I gained from that therapy.
Participant 4: Mike

INTERVIEWER: Could you describe your experiences with stuttering to me just in general?
Mike: When I was a kid, I didn’t take a lot of instruction. I didn’t go to a speech clinic until I was in sixth grade. They had a clinic that was actually part of the educational system so I started to take speech therapy in sixth or seventh grade and it wasn’t a lot; it was maybe about once a week. So I didn’t get a whole lot of speech therapy when I was a kid so you know I was in my teens when I first got any speech therapy. Growing up as a teen it was a problem, it was an issue that it caused me some embarrassment throughout the years when I’m talking to people or when I was talking to groups or stuff like that and there were certain words or sounds that were hard for me to make like a lot of s sounds were very hard for me to make so you know I had some difficulties and there were certain situations that I wasn’t very comfortable in being a teen. You know like speaking in front of class was one, speaking to a stranger sometimes, ordering food sometimes when you’re at a drive-through or in front of a line in restaurants. So you know, I had much heavier bouts of stuttering when I was younger so you know it wasn’t good for me, it hurt my self-esteem somewhat because honestly I everyone else was speaking right perfectly and you know that you just feel jealous sometimes. So it wasn’t terrible but it wasn’t great and then sometimes kids would actually make fun of me because they couldn’t understand that or they are just kids like how kids are!

INTERVIEWER: Can you tell me a little bit about your therapy experiences before you came to the intensive clinic – so in a nutshell what was helpful and not helpful in previous therapy experiences?
Mike: You know the funniest thing is the last year before I went to high school I was taking therapy in school and I probably actually spoke better because I was getting therapy then; and
then it kind of stopped and it was summer time and I was starting high school. I didn’t have any speech therapy at all in high school and if I did then – like I said it was years ago. I had speech therapy twice before I visited the clinic. I was in individual speech therapy in which I actually went to her house and I went there for about 6 months and then she actually quit doing therapy because she got pregnant and then a few years later my mom she said let us find another speech therapist for you so I actually went to another lady and I went to her for about 6 months and then she quit or something like that and then for years after that I had no speech therapy at all so I just kind of had to relate to – I kind of had to just accept the stutter. I never really did tell a lot of people they would sometimes think it’s kind of funny or cute or just spit the word out, something like that and until I went to the speech clinic at BG and what happened with that was that a couple years ago I was seeing a XX brother in Australia and he did a special on speaking and stuttering because he stuttered and he went to a specific, I believe it is in I think Maryland where he actually got treated and I remembered that and then a couple years later I was looking for that clinic so I was just going online just looking for different speech clinics because I didn’t know about anything around here and I found this clinic and then I found the clinic in BG and I got information from all of them and then I contacted a couple of them and you know to be honest with you, BG was kind of the cheapest clinic out of all of them. My mom, she helped me a little bit and I put the rest of the money and it was like 7-800 and then I decided to go with that clinic. That was my experiences with speech clinics and going to different clinics. So I never went like 4-5 years; I didn’t start till I was 4-5 years old. You never know, I might have been a better speaker by now!

INTERVIEWER: Past therapy experience what were some things that helped you? Like techniques or things that therapists did that helped you – before BG?
Mike: They worked a lot on actually getting through like speech blocks and harder words and from what I remember some of them were kind of similar; it’s been years but some of them were kind of similar where they actually want you to slow down the words when you start talking so instead of – I know there is a word that is hard for me. They worked on similar things- I can’t remember a lot to be honest with you. But a lot of them were either trying to ease my way into words or to slow down my speaking; there wasn’t a lot of like psychological things – they would just basically ask me how I felt when I actually stutter you know stuff like that – but it’s been so long I don’t remember the individual techniques to be honest with you. They tried to see what words that I actually had problems with when I stutter and then they tried to find ways for me to get through the words. They didn’t really make me go out and use speech techniques. I think one that they did make me go through once or twice – and this is when I was going individually in school – was to actually go to a fast food restaurant and order something but that’s you know; speaking in front of the public like that is considered a fearful thing. So it was beneficial in the short time that I was using it. It’s just that I didn’t consistently continue on speech therapy because the high school that I went to, they didn’t offer it. It wasn’t an option. They had like special instruction/therapy for people that had learning problems and learning disabilities but they didn’t have a speech clinic. That was a public school thing. So that was pretty much my experience from there that I can actually remember.

INTERVIEWER: Ok, and how about the intensive clinic – what were your general experiences at the clinic here?

Mike: My experiences were funny because I didn’t know what to expect. I drove up to BG; it was my first time actually living on a campus seeing this big campus – little town, big campus. My first day there you actually pull up and I don’t know if this is your experience but you
actually pull up and there was like 15 very attractive women XXXX And the first thing that
actually happened was they took to a room and then did an individual interview and it was two
ladies and I was nervous so I was stuttering probably more than I usually do. The whole situation
was new to me I didn’t know what I was getting in to I didn’t know the stuff they were going to
ask me. So they asked me quite a bit on general stuttering questions and they taped everything.
They recorded everything in these little booths that you had on campus. So from my XX
experiences from it, I might a lot of really interesting people. I met XXXX which was a shock
because he is a speech therapist but he also stutters, I didn’t think that that happened. So, the big
thing that happened there is that when I was with people that stuttered and when I was with
speech therapist that didn’t give you a strange frown or what are you saying or anything like that
I started speaking much better where you know, I started to actually not stutter at all because
there wasn’t anything in my mind where you know it was a blockage saying like “ah man what’s
going on”. It wasn’t a strange look or it wasn’t like what are you saying again; I didn’t hear that
– I didn’t understand that. So I actually, I think we spoke a lot better because they were there
basically saying stutter – we want you to stutter and I started to not stutter that much any more. I
think that it gave me a comfort level that I was not used to. I was there with some people that
stuttered a lot worse than I did, some barely stuttered at all; where you kind of like think, “why
are you here?” in my mind and then you know I was like XXXX, and he stutters. So it was weird
mix and XXXX and me we were the oldest people there. I think XXXX was 26-27 something.
We were the oldest people there so we just kind of befriended each other and befriended all the
other clients and it was interesting because we were asked to go into different situations and
actually tell people that we stutter. I’m a stutterer and I’m doing this for my research for my
school and everything and I had never really admitted to people that I am a stutterer. You know,
I still don’t do it like, “Hey how are you doing? I’m a stutterer!” I never did do that but if somebody asks me now I think that I am more prouder of actually opening because I see that there is nothing wrong with being a stutterer and from getting evidence and seeing a lot other people that stutter I didn’t know that James Earl Jones stutters but I discovered JEJ and there is other people that are really famous and stutter too. This I didn’t know until I went there and it gave me an opportunity to just truly realize the fact that there is nothing wrong with stuttering. I actually work in sales and every once in a while you will meet somebody like that who stutters so it was weird to see somebody else stutter because you don’t see it that much. But the one thing that I did notice is that everybody kind of stutters from time to time – but they can recover quicker than a stutterer can so it just made me real – very cognizant to who I was and it actually made me feel better because we had to do some speeches and stuff like that and I actually did really well in some of the speeches. I did a speech on fear and it wasn’t just like general fear; it was the fear that a lot of us have in different situations – it doesn’t matter if your rich or poor, pretty or you have a PhD. Seems like in certain situations everybody has some fears and the thing that kind of shocked me about the speech was in the end I had all this speech therapy and had all these students who had these masters degrees and all this – said that the speech actually touched them because it doesn’t matter how you look – there is always a time you felt a little uncomfortable – maybe joining a new group or coming to a new place. I was actually shocked that so many people got that out of the speech – XXXX actually told me that you have talent, you could have a career in this type of speech – trying to motivate and in the end when it was about over with, we had one last lunch. And then everybody have to tell you how much they got from each other and it was the first time that I teared up to know that a lot of people were very happy because I was encouraging all the other students and you know to not get down on
themselves; not do this; I have never heard so many people give me kind of deep felt thank you or appreciation and I teared up and it was shocking to me. So, overall it was a good experience. It really was.

INTERVIEWER: Another question I have is – can you tell me about certain activities, specific things that helped you in the short-term and long-term – so helped you cope with stuttering and manage your stuttering better that you might be using even today?

Mike: I would say that the big thing that helped me was that I actually worked in a retail business. I actually worked in about 4 or 5 jobs in retail and different types of retail and that made me talk. You had to talk to customers. You couldn’t just stand there and watch customers because they would ask you for help you had to explain, so it was a lot fo one-on-one interaction. I remember there was one job which I worked in retail that I didn’t like it just because you had to go on loudspeaker a lot. You had to call for this manager. I didn’t like it for that part because I was so scared that I would stutter over the open mic in front of a whole store so that helped me I think just actually gain confidence. There was a lot of customer service jobs that I never did apply for because there was so much speaking to it and that was one thing that helped me. Another thing that helped me was in school – the speaking class. Actually my major was communication so you had to do all these interpersonal and small group communication. You had to take effective speaking and basically that is the speeches. One thing is that I was really nervous thinking about talking in front of the class. I was the only one basically that did speeches with no notes, no guidelines, It was just all stuff that I remembered in my head and I was shocked to see that I got an A in the class and I actually got through it. But probably one of the most embarrassing times was I took a creative writing course –and it was a creative writing fiction course where we had to write short stories. Probably one of my most embarrassing times was you had to read your stories
to the class and there was one particular story that I read where I just stuttered my way through the whole thing and I felt so embarrassed, just felt down and mad at myself and I got through it but it was hard. I took a psychology class where we had to do a group presentation so we talked about crime and I said let me do this and I’m going to XX being a street character where I was showing emotions and a lot of XX and that’s not me but I put myself in the character and show a 3-dimensional element of that character and the people in the class say that you may have talent as an actor. From a stutterers point of view you may think that I can’t be an actor. From there I did a college – because I wrote for the school paper- and I met this group that did visits XX for the class so I actually ended up joining that and doing XX in different subjects and the last one we did we went to a wine farm or a vinery and we did this for children in Africa that we put on a play. I think all these things helped me gain more confidence.

INTERVIEWER: So you feel the general line of work and education you have chosen has been pretty helpful with managing?

Mike: You know the thing, it was because I made an effort to XX to myself and to get out of my thoughts because when you stutter sometimes you can be a loner, because you are not open to being in groups and you know. Whereas now, If I’m in a group right now some people are great at stories, I still don’t do that because I don’t have all these great experiences and I don’t take all these great experience but when you challenge yourself sometimes. I didn’t start working in retail to do that it was just kind of just part of it, where one XX to other.

INTERVIEWER: What are some things you picked up in therapy that you feel might have been helpful say at your job – just in general managing stuttering?

Mike: They taught me how to actually get through blocks where you slow down your words. So if there is a word like a w word and I’m having a problem with you can kind of slow it down to
get in to words. They actually taught me how to think a little bit slower you know to prepare yourself when you are speaking so if you are about to start a conversation, start it slower and then slow in to the word a little bit more and I use some of that stuff now but because I didn’t continue therapy. I came home and I was very tired and very confident from it. But the thing about it is the last week we were there we were eating junk food and we were going out drink, probably stuff we shouldn’t be doing; but we were going out drinking and having a good time and I actually got sick from that. I actually got a bad cold and sore throat from it. I mean we were eating at that pizza place that makes these thick pizzas and my throat was sore for like 2 weeks where I didn’t talk much and it was like I kind of forget some of the stuff to use it as much as I would have used it. But the thing was that I was speaking so much better that you kind of just fall into a you know I’m all right so since then I have had some stuttering episodes. They have not been real bad and the thing that happens a lot of the times are I like should have used this – that so I kind of feel bad about it. I still have my book from clinic with all the different techniques and stuff like that I was actually supposed to write a follow-up, I got to write a letter.

INTERVIEWER: So you think there some things you did in therapy that was not as helpful?

Kevin: let me think about that. No, no we did a lot of individual therapy. We actually got a closer relationship than you would with a regular speech therapist because they lived kind of in the same dorms or they lived upstairs from us. So we got a closer relationship than you normally would. XXXX he was there all steps of the way looking over what the students were doing. He didn’t really do a lot of individual therapy but it was more of a XXXXX. No, I wouldn’t really say that there was any one piece that didn’t work for me. I don’t know about the other clients though.
INTERVIEWER: If you had to rank order – like X was the most helpful – so rank order most to least helpful?

Mike: Oh as far as what? Being therapy, individual therapy?

INTERVIEWER: Whatever in the clinic you found was the most helpful for yourself?

Mike: Ok, from speaking in front of the class I would probably give it a 5/10. From individual therapy I would probably give that a 7 or 8/10 because we got a lot above individual therapy. We actually did therapy with a lot of people.

INTERVIEWER: Was the individual more helpful than group?

Mike: You know it can be. I think it depends on the relationship you have with that person and if you are really comfortable or not because some people had a better rapport than the others did. So I would say that is probably about 7-8/10. That all depends on you and them. And as far as book stuff, we did not do a lot of that, we were provided all the information so I would say probably 5-6 on that. We did not get a lot of extra books on stuttering, we didn’t see a lot of stuttering videos. So I would probably give that a 4-5 so average. I would probably say that probably would could be improved about the program is probably to do more individual follow-up where it was more closely aligned to you. But it is hard because a lot of people were graduating and going into their own careers. I would probably say that with the addition of video and webcams you could probably do that. You can actually do an individual therapy session as a follow-up for a few months if you could set it up where each person has a webcam. Do follow-up to check and see progress. I think that can be added to the program pretty easily. Maybe possibly have it where it is possible where the person went straight from the clinic back into therapy just to make sure that they are actually doing the techniques and to brush up on the techniques if one
gets a little lapse on it. I would say that those would be some of the individual improvements that I would suggest.

INTERVIEWER: Is there anything else you feel you can add to this about your experience at BG?

Mike: I would probably say probably put more pressure situation – not like go ask for a date or something – but more situations where it could be completely blind where say they took a micro-recorder in their pocket and went into situations where there is no body looking at them. Where all you basically hear is their vocals. But then you can’t read their body language unless you are looking at them from the far. Sometimes you can get more comfortable with the person next to you because you know they are there to help – not to not stutter but you know that they are a safety net for you. This way you can hear them alone because eventually you are going to be alone when you leave the clinic as you become an adult because that is where the real world comes in. I would suggest those things, especially a lot more follow-up if possible and see if you can get a direct connection with a therapist in the area or maybe a couple sessions or once a month for 6 months just to make sure that they are taking what they learn. You can actually get lazy with this stuff. I’m a lot older so I have come to adjust and just realize that I stutter and I probably will never be this super-fluent person. They did suggest I go to toast-masters where you actually go in and do speaking. I actually went to one class because I had a friend who was doing it. But I never followed up with it and I probably should that thought even at my own age. I would like personally to actually do some public speaking on motivation.
Participant 5: Nicole

INTERVIEWER: Could you describe your experiences in general as a person who stutters: a general overview on stuttering and how it has affected you?

Nicole: Sure, I stuttered for as long as I can remember, I’m pretty sure that my parents said that I have been stuttering since I started to speak. In elementary school I was stuttering and it was never really a big deal kids just sort of accepted it. It was in junior high when kids started to notice or make fun of it and when all of my secondary behaviors started to kick in so then tension in the mouth and face, doing crazy things with my hands, avoiding words, avoiding situations. That all started and then I went to some therapy here and there throughout high school but no one was really an expert in stuttering so they didn’t really know what to do with me and then I went to the intensive clinic before I started college and that was what got me into accepting it and moving forward from it and then I did therapy on and off with XXXX throughout college and now I am not in therapy at all and I am in a job where I speak in front of a group of people all day for the entire day so it hasn’t really been an issue or problem for a really long time.

INTERVIEWER: So you handle it pretty well I guess. Next, can you tell me a little bit about your therapy experiences before the intensive clinic? So all therapy experiences you have had before the intensive clinic in a little more detail?

Nicole: Ok, the ones when I was younger I don’t remember 100% but I know that I saw a school therapist in elementary school. It was the kind of thing where I would be pulled out of class to see the therapist during school hours but from what I remembered that therapist focused more on dealing with the average speech issues of young children like not saying their /r/ correctly or having a lisp and so my problem was new to her so she didn’t really know how to handle me and
I don’t really remember that really well because I was so young but I don’t think that was very successful and I did see another woman outside of school and she focused mainly on, instead of focusing on me, it was more of focusing on what were my; like she was trying to figure out what in my atmosphere and what in my life was causing this so she was saying that my parents were putting too much stress on me or I had an older sister who acted like the normal older sister always teasing me and picking on me but it wasn’t anything out of the ordinary which she claimed its stress and this relationship with my sister was causing me to stutter so that really wasn’t too successful either. The one slight bit of success was in high school when I saw a man at Kent State and he actually was a stuttering specialist but he had some health problems and sort of on his way into retirement so he really wasn’t able to give me 100% of what he had and then I think my issue was I was still in denial and I was not either at the age or maturity level to talk about it in a open way and be honest with him and to really accept that this was an issue that I had and now I needed to work on how to fix it. He was definitely the first sign of hope but I didn’t think that myself at that age where I was at, I was not prepared for that. So, that was before the intensive clinic.

INTERVIEWER: And if you had to kind of summarize that as things that were helpful like specific things that you remember as helping you or not helping you?

Nicole: Definitely the things that didn’t help were the people that weren’t really familiar with stuttering just telling me to slow down, take a deep breath, don’t be so nervous. It just seems like it didn’t know anything more that the average person. That was things the average person off the street would say like slow down, calm down, just take a deep breath and start over. Like I felt like if that’s what you’re saying you obviously have no idea what stuttering actually is and then I guess what did work was the guy at Kent State actually giving me specific techniques to try and
like I said that sort of fell through because of his illness and my own attitude but he had like a CD that I would put in the computer and it was basically, I don’t remember the exact names of the therapy techniques but basically teaching you how to sort of like blend the words together and only saying a few in one breath that way you have adequate breath support. So just sort of like sitting at the computer and the words would come up and they would like scroll by and I had to practice saying them in the same pace that it was scrolling by and that as I said was like a glimmer of home but I just sort of blew it.

INTERVIEWER: So you feel like phrasing as you said saying a certain number of breaths per word and just using a slow prolonged speech pattern was something you found helpful?

Nicole: Yes

INTERVIEWER: Is there anything more you would like to add to that?

Nicole: I guess just an overall comment is I think what really blocked me from being successful; I think there were a lot of therapist who didn’t know what they were doing but even with the one that did what blocked me from being successful was my own personal attitude and opinion on the whole thing.

INTERVIEWER: So you feel there is a big component of how; so kind of like your own personal views also have an effect on how successful therapy can be?

Nicole: At least it was for me.

INTERVIEWER: We will move on to the Intensive clinic at this point. Can you, in general, describe your experiences at the intensive clinic and your overall thoughts about things you learned from there?

Nicole: Ok, I attended the clinic the summer before I started college and it worked out that I was planning to start college XXXX. So for me it was exciting because I felt like I was just getting a
kick start on my college career because XXXX. What was nerve racking was I was still pretty young to be away from home and be living on my own like I was only 18 at the time and never lived on my own so that was sort of an added component of just the nerves of like being far from my parents. Something that was new and different for me that stood out from any other experience was actually being with other people that stuttered and meeting with them and talking with them, I had, there was one guy in my high school who stuttered but we sort of ran in different friend groups so we really didn’t have any contact but I just knew of him and so it was just an awesome thing to see that I’m not the only one like this that other people have this issue. That is something that really stood out for me that was just different from what I have done before and then obviously the amount of therapy stood out as being different. It was an all day sort of thing as opposed to an hour one day per week and then another thing that really stood out for me was just the acceptance of people that stutter like if you stutter that’s Ok but we’ll help you out if you want the help; whereas before the attitude that was always presented to me was this is a problem and it needs to be fixed and then another thing that I always remember is having to call businesses and like the therapist is watching me call the businesses and I absolutely hated that and I was begging them I didn’t have to do it and they always made me and I guess so then those are the things that stood out in my mind that being scared that I was away from home actually meeting people that also stuttered a long amount of time, the attitude of its ok the help is here, and then those phone calls. But overall I mean it really did change my attitude and perception and willingness to work on it I guess that’s my general feeling about it.

INTERVIEWER: That’s some really good information. I had one question: I think you brought up a really good point about how/the perspective being presented about the clinicians of acceptance versus this is a problem that needs to be fixed; how much role do you think that
might have played in your motivation to work towards goals related to managing stuttering and you feel that had an effect on how you benefitted from the program or how much you took out of that program?

Nicole: Oh yeah, like I think that changed a lot. A big thing for me is I’m a perfectionist and I have a really big fear of failure and especially in high school with my parents I was always fear of not being perfect for them or letting them down and I think I knew in the back of my mind that my stuttering would never just go away and I think that my mom was thinking; and I have no idea if this is how she thought or not or just is just how I perceived that she was thinking. I just had this idea that she thought that I’m gonna send her to therapy and then this problem will fix itself but I think I knew that it was never going to be completely fixed so I was too scared to even try because what if I actually tried and put effort and then it didn’t get fixed like my mom was expecting it to. So it was easier to just not to try because I knew that the outcome would not be this perfect fix whereas I was saying at the clinic having that attitude of like we are not here to fix you we are here to make your life as enjoyable and successful as you want so there was just sort of this attitude of we’re just going to make you as fluent and under control of it as you want and so that was just like a much more, so much more safe to want to try because I knew that the end result that was being expected of me was just that I was happy with the result. So with that in mind all I need to do is improve to the point where I am happy and satisfied as opposed to I have to continue to fix it until my speech is completely fluent like it was just so much easier to actually go into it because I wasn’t scared of the failure.

INTERVIEWER: Thanks Nicole, that was some really good information there, really important for what I am doing thanks! Another question I had was, if there were any specific activities that
you remember to date or any specific techniques that you picked up that you use even today?

Specifics from the clinic that have stayed with you to this date?

Nicole: Sure, probably the one that I use the most often without even thinking about it. It comes sort of natural is, I think it’s called easy onset where if I’m just having a block or a hard time getting through a word I’ll just sort of stop; think about easy onset (not the name) but that I have to ease into it and now when I start back up just easing into what I am trying to say so that for me when I start o just have my words fly all over the place and I realize that I am having a lot of disfluencies that’s when I’m like all right hold it! Time for an easy onset and I’ll like ease into it to get myself in a more consistent pattern. And then another one that I, like I said these have become sort of natural so I don’t remember their names; but maybe deliberate something, the way that we learned it was we put on a headset and then by some technology that I don’t know if we were talking at the pace that the headset was set on we would hear that echo so we had to use our pace correctly and so we couldn’t get the echo; but the thing that I remember from whatever that technique is called is that the hardest part of speaking is the stopping and starting so just the idea of if I know I am having a bad speaking day I really concentrate on only saying a few things with each breath. When my air supply is at its end is when more disfluencies pop up so really just making sure to put it in a phrase instead of trying to finish every sentence in one breath.

Really making sure that I am taking more pauses and breaks to breath and also I don’t know the work for this either but flowing from one word to the next; so like within that one phrase instead of saying each word and having to start and stop each time which can cause me to have a disfluency; make sure I am flowing all of my words together in one so that right there is a good way for me to make sure I’m fluent. It’s not always 100% fluent but it’s enough for me to get done what I need to get done and I use that a lot when I am speaking to someone like a customer
service representative on the phone or calling some business or I have to get specific information that’s when I use that or when I’m meeting someone for the first time; that’s the kind of thing where I’ll often use that.

INTERVIEWER: What were some things that were not as helpful to you so like certain parts of therapy which you did not really use anymore or did not find as helpful?

Nicole: This one was sort of a pro and con but I think if this activity got redone then it would be helpful and that was like making these pretend phone call because I think a positive was like because I was someone who was scared of using the phone and so I’m not sure if the therapist were consistently putting me on the phone as compared to other people because they knew that I was scared of it or the amount that I was on the phone was just something that all of the participants had to do but I felt like they were always putting me on the phone and so it helped because toward the end I had no fear, I was like hand me the phone let’s just get this out of the way but something that I absolutely hated was to be able to like give me these opportunities to talk on the phone I had to create these situations of why I would need to call and like that whole idea like I’m trying to think of some situations that were created I think one was maybe like calling a car repair place and trying to get some information about how much a car repair would be or calling the library and seeing if they had a certain book in stock; you know just like creating these situations where I didn’t actually need to make that phone call and I just hated like bothering these people with this phone call that I didn’t really need that information and I hated being like put on the spot to create these questions and create this situation of why I would need to call someone and so I’m trying to think like something that I did after the clinic when I was seeing someone on a onetime per week kind of basis was I told her that I’m not going to make a phone call unless I have a purpose, an actual purpose calling someone. Since I was only seeing
her one time per week, if I had to make a phone call to get some information and it was something that could wait; I would write that down and not make that phone call until I had therapy so that way it was something that I needed to make that phone call for. So I think it’s I don’t really have a good answer to this but I think those repeated phone calls did really help me not be scared of the phone but I would hate to take that opportunity from someone but I literally despise having to create this situation of why I would have to call.

And another thing that I specifically remember and it’s kind of the same thing that there was some good out of it so I don’t wanna say don’t do it but I would say it needs to be rethought of how it’s played through and that was we just went up to like strangers on the street and would ask them like do you know someone who stutters? Do you think that it’s a problem? Do you think, are there any jobs that PWS cannot have? I don’t know if that still goes on or not but like I think I really gained some valuable information as far as what people really thought so like that to me was helpful getting this information of how these complete strangers would answer these questions but sometimes when the complete strangers didn’t have the nicest things to say about PWS like that was heart breaking and this was at the beginning of the therapy so I was still very new in my acceptance process kind of thing if that makes sense and I remember standing there trying to hold back the tears and be like I can’t believe that they made me go into this situation. So I don’t know something like you people who don’t stutter could go out and ask strangers and record it on a video camera and then show it to the people so that way they are like still getting the information and how/what these people are saying but your are not put in that uncomfortable situation where you are standing there in front of them in the middle of a crowd, in the middle of a street and they’re saying well stuttering people should for sure just go to therapy because it can be fixed – you know like just when they don’t have positive or nice things to say – ohm, that was
an awful experience. But not all of them were bad; like when people had positive things to say like I’m glad that I got that opportunity to hear this people that were complete strangers and didn’t know anyone that stuttered still had some positive things to say but I don’t think that that positive outweighed the devastation and scars that has been put on me from standing there and hearing someone say something like that to my face.

INTERVIEWER: If you had to rank order things that are helpful – so most to least helpful of everything you gained from the therapy experience? How would you rank activities/techniques you did in therapy?

Nicole: Kind of hard to rank. I would think the one that would definitely be towards the top are the group therapy; for me it was just awesome to hear like other people’s opinions to see other people really struggle to know that I was not the only one struggling but then also see people being successful to know that I could be successful. So I think like just being with that group was very helpful because I felt like I just never really had contact with anyone else who stuttered and I don’t think that many people at the clinic had that many opportunities to spend time with PWS so I think that would definitely be near the top. And then this is probably gonna conflict with what I said before but sort of making me face my fears and go in to the situations that I did not like but sort of remembering what I said that make sure those situations that are being forced on me are carefully planned out I guess so there is no emotional scaring! Yeah so just just being forced to stand up and talk in front of a crowd or being forced to talk to someone new or being forced to talk about how stuttering has affected me and how it made me feel so that whole component of how does it make you feel as a person and while your stuttering what kind of things are going on in your mind and how do you think that other people feel and etc. like those kind of topics had never been opened up to me before at all so being forced to really open up was
something good to me so I think definitely being forced into the things I was really scared of. Then I guess next would be one on one sessions so that way you can really focus on what your issue is and what you need to work on because obviously you hear people that stutter, we all sound completely different so off course we are going to be specific for us to really concentrate on, work on and what I’m going to be working on is not the same as someone else, for example I remember this one kid was so shy that they in his therapy session were practicing how to turn to a classmate and ask to borrow a pencil so like that was the point that he was at – so shy that he needed to work on asking someone to borrow a pencil whereas I was sort of past that and had other things that I had to work on so I think that being able to be by myself and focus on what I needed. I guess the things that rank bottom would be the ones I already said of being forced to like give that survey to people and then standing there when they gave me some possibly bad news or comment that were not positive and then being having to create these situations of calling on the phone.

INTERVIEWER: And lastly, what are some things that you feel have helped you in the long term with managing your stuttering?

Nicole: Well for sure just managing just how I am speaking would be the 3 things that I mentioned of; if I’m having a hard time getting something out to just stop and ease my way into it; second would be making sure that I am only talking in short phrases and taking a breath in between to make sure that my air supply is still good; and third making sure that my words are all connected so that way there is no chance of or there is less chance of having to stop and then start again because of stopping and starting where a lot of my disfluencies pop up and then that is what those three were the three things that have been in my mind. Now I don’t use the 24/7; I really only use them while speaking here and there and when I am speaking to friends or even
when I am in front of my class teaching there is just too many other things going on to really be able to focus on that so I just sort of bring those out when I need them it’s not something that I constantly have to focus on and then definitely just; and this to me is more important I think than being able to speak fluently is how I just feel about myself – I remember in high school just being so down on myself and afraid to talk I had all these dreams I would think would never ever happen. I didn’t think I was ever going to get a job or get a boyfriend or be happy or all these things I didn’t think were possible just because I couldn’t speak fluently. So that was a horrible and untrue mindset but that’s the mindset that I had I felt like I had all of these capabilities and potentials but my speech impediment was going to stop me from doing any of those. So I think really just that idea of yes you do stutter but that’s Ok and we are going to give you the tools that you need and so just that idea of hope and like just making the acceptance like the way I talk is just one small part of me and so how can it affect my life in such a way that I was thinking that it could. And then, also something else that and this sort of goes along with that acceptance and hope and just that realization that the fact that I stutter is not such a big deal was when XXXX had said and I think he had heard this from someone else but he said that he was obsessing over that if I stutter all these people are going to notice and be talking about me and saying all these things and a person told XXXX like how selfish are you that you think all eyes are on you and everyone cares about you and like no they have their own problems, their own things, and it’s no big deal and that is the phrase that has stuck to me so much that whenever I meet someone new and I’m like oh no! are they going to be weirded out by the fact that I stutter or when I’m talking in front of my class are all of my kids focusing on the fact that I stutter; I think about that phrase of how selfish am I that all eyes are on me and everyone’s going to spend their time talking and thinking about the fact that I stutter. Like no, that is not how it is, they may think about it for a
second but they are not going to spend their whole day obsessing over the fact that they have met someone who couldn’t speak fluently. So that sort of, like I said goes with that idea of hope and acceptance and that attitude that it’s not a big deal and who cares?

INTERVIEWER: Is there anything else that you would like to add?

Nicole: No I guess not I think I’m done!
Participant 6: Rick

INTERVIEWER: First question I would like to ask is if you could tell me in general about your experiences with stuttering as a person who stutters?

Rick: I think, I noticed that most people are very unfamiliar with stuttering and that they just don’t know how to respond to someone who stutters. Like one of the things they just try to help and they probably shouldn’t because sometimes they are inappropriate like I when I was in grade school I would have teachers say just spit it out while I was reading in class or answering and a lot of people will try to finish my sentences and I’m not sure if its them trying to help or just impatience.

INTERVIEWER: Could you tell me a little bit about your experiences with therapy before you first came to the clinic here at BG, so before 2006?

Rick: The vast majority of therapists I have had were very unfamiliar with stuttering and they told me that they were not sure they could help me since I stuttered so severely and they really didn’t push me outside of my comfort zone like I never had any assignments where I had to make any phone calls or go out and talk to anyone and I got a lot of really strange suggestions which seemed to include a lot of unusual things about stuttering like that part of the reason I was stuttering was that I don’t know what I want to say. That the talking actually causes pain for someone who stutters. I am sure there were probably a lot of such things.

INTERVIEWER: This information came from teachers or SLPs you worked with?

Rick: Mostly SLPs.

INTERVIEWER: If you had to describe activities that you did in therapy that were helpful what would that be (before BG)?
Rick: Helpful. Actually just having someone to talk to for an extended period of time where I could just practice talking and one of the therapist I had we did something she calls slow and easy speech. It’s just like talking at a very reduced rate of speech with a prolongation to start off every word. That was actually something I found helpful. It was a very blurry time I really wasn’t that serious about therapy, actually the last time I had therapy before BG was when I was 10 or 12 years old.

INTERVIEWER: So almost 5-6 years. If you could tell me a little bit about your experiences at the BG clinic right from the first time you came here in 2006 till now?

Rick: Well, during the initial assessment in 2006 they wanted me to make phone calls I thought they were crazy and I got a lot out of just pushing threw them and it really helped to make phone calls on my own. It was nice that they didn’t tell me I stuttered so severely that they could never possibly help me; it’s just something I have heard several times. It was actually really nice to just go outside of my comfort zone like during the stuttering surveys or going to administrative offices on campus to ask questions, that’s something, I have never done for any therapy.

INTERVIEWER: What were some things you did and learned during the initial intensive clinic and any follow up you received?

Rick: Yeah, I used to have a lot of secondary behaviors and I pretty much completely eliminated them during the first clinic. I got a lot more aware of how I am stuttering so it makes it a lot easier to manage my speech. I still found voluntary stuttering, pullouts and cancellations useful but seems like when I do that stuff it makes my stuttering seem more severe and I don’t get as good of a response from the listener as I do just by trying to talk smoothly and getting through the stuttering moments as soon as possible but they really make talking a lot easier in situations when I am able to use them. Actually, before therapy at BG I generally found talking absolutely
miserable and even when I didn’t have that much stuttering but when I am really able to manage my speech I actually enjoy talking.

INTERVIEWER: In general to summarize what you said, you feel like a smooth slow prolonged type of speech seems to give better listener reactions and using the modification techniques like voluntary stuttering and pullouts helps make speaking a lot easier when stuttering severity goes up?

Rick: Yeah. And it really doesn’t seem to have an effect on the response of a person I talk to quite often.

INTERVIEWER: So in a few situations you feel some people might have a different response when you are using a modification technique?

Rick: Yeah. It’s like only if it’s someone new or someone I don’t talk to that often.

INTERVIEWER: Next, what are some things that were not helpful that you did in therapy at BG?

Rick: I actually thought the longer clinic in 2006 was better just from having more time and spending more time on just working on techniques.

INTERVIEWER: If you have to rank, 1 being most helpful: how would you rank activities in therapy as most helpful being number 1 and least helpful further down the list?

Rick: OK. Yeah. I sort of like that the therapists was having me call some of their friends like to make phone calls and I thought it was odd that she wanted me to call some of my friends. I mean I would have preferred just making cold calls. It would have been nice if there was sort of a list of questions to ask when I was making cold calls. That’s what sort of stands out the most.

INTERVIEWER: Are there things you learned in therapy that you don’t really use or didn’t feel really benefitted you?
Rick: I’m not sure if I ever used voluntary stuttering. Oh, something else about the summer clinic that I didn’t like, my clinicians seemed to really want me to go through a drive-through and I thought it was a pretty bad idea not because I’m afraid of going through a drive-thru but I noticed that most people don’t have that much experience with stuttering and can get confused then and you really never know how someone is going to respond. I, in my, it didn’t seem like either of my clinicians was paying attention to what I was saying about not wanting to go through the drive-thru and they were just assuming I was afraid to because of stuttering.

INTERVIEWER: So you feel like you would like more of a chance to explain yourself? Are there other things, possibly other things that were helpful and not helpful like techniques or activities that you can think of?

Rick: Well, I got a lot out of using the tape recorder to having my speech played back to me and stuff like a lot of the pausing I was doing. Like I would just pause in random places in a sentence to avoid stuttering and it seemed like it made my speech sound real unnatural so that is something I changed.

INTERVIEWER: So getting that feedback was useful?

Rick: Yeah.

INTERVIEWER: Is there more you would like to add?

Rick: Not really.
Participant 7: Yolanda

INTERVIEWER: I'll start with a broad question, if you could describe your experiences as a person who stutters? How stuttering has affected your life in general, your overall experiences as a person who stutters?

Yolanda: Well, I believe that I started stuttering between age 3 and 5. My mom says I started stuttering when I started to combine words and I actually received therapy for my stuttering for the first time when I was 30 years old, or 32 at XXXX. Then my second therapy experience was the Intensive clinic at BGSU and then after that I attended various workshops, NSA meetings and another program and I think the more I learn about stuttering and met with people. I think I just needed to go over the same ideas or the attitudes to really understand.

INTERVIEWER: So just having that experience over and over again?

Yolanda: Yes, to fully understand what it means to accept that it’s OK to stutter and all those theoretical viewpoints and all that and many of those I learned in the intensive clinic but I think it took me a couple years to actually understand what your trying to teach me. I feel pretty good about myself even though I still stutter, I’ll unconsciously try not to stutter when I speak with people but overall my speech and communication skills I feel good about it but/instead I decided working on my psychological impact that I got over the years and I have been working with my psychiatrist to talk about why I think that way and sort of things and I always come back to the core of stuttering.

INTERVIEWER: That is really important I think. It takes a few years to get a better understanding and that acceptance is something and getting comfortable with stuttering is something that takes a long time for everyone. Briefly, can you describe your previous therapy
experience before you came to the intensive clinic? Can you discuss how you were managing/coping with your stuttering before you came to BGSU?

Yolanda: Well, I learned about self-disclosure at temple and it was really an eye-opening after that I went back to XXXX and worked there for 2 years before coming back to the US for my master’s program. Well, I don’t think that I was using any so called techniques so I decided to pursue SLP as my career and it took me a while to make that decision. By the time I went to Ohio I did and I was still uncomfortable with the fact that I stutter and I was hiding, I was trying to hide it. I decided to be a little more open because before I did not let other people know. I had found many different ways to hide and avoid that topic. But I don’t think that I was using any techniques and I did not really understand the impact of stuttering and how important it is to work on your attitude. So, yeah I did not know that until I attended that intensive program.

INTERVIEWER: Can you describe your experiences during the intensive program?

Yolanda: I was, I really enjoyed a lot but I think I was committed, I remember I would just stay out. I was staying in the student housing and I would just go out by myself to do some assignments, wrote lots of journal but what I enjoyed the most was I think XXXX’s lectures like iceberg analogy and all those handouts on the files. I think it was unfortunate that there wasn’t any other participant who was close to my age but besides that I think I got, you gave me materials that they may not seem immediately useful at a deeper level at that time.

INTERVIEWER: Can you describe any specific things that you did during the clinic that you feel were particularly helpful?

Yolanda: I think voluntary stuttering was helpful, the surveys that stuff was hard but I think that really helped. I broke into tears when I was interviewing a person and he started crying too! I
think that was the great part that helped me a lot. I also enjoyed doing those assignments. I sometimes did that with another participant.

INTERVIEWER: So just having the group you feel was in some ways beneficial?

Yolanda: yes, yes that was. I think to add that even though I said I didn’t have/ there wasn’t anybody around my age it was in turn interesting experience to work with for example a younger participant who had similar issue and we were working toward the same goals and doing the same assignment.

INTERVIEWER: So everyone had a very similar program but still different. What were some things that you feel were not helpful or not really very useful to you?

Yolanda: Not helpful, it’s kind of hard; I don’t think there was anything that was not helpful. I can’t think of things. No I can’t think of anything.

INTERVIEWER: That’s ok. Are there any things you learned during the clinic that you took away and use even today that you find helpful in the long-term?

Yolanda: Well definitely the iceberg analogy and after that so many people mentioned that theory and I was like Ooo I know that! Also surveys. Ok so I remember one of the handouts I think that was some statement about stuttering and I don’t remember exactly but like stuttering is not something that happens but something that I do; something like those taught me to be responsible and another thing is that whether I stutter or not the listener is not going to know or how did it go, something like a time thing avoiding to stutter because it is not about the listener but about the way I feel. Learning about the process of attitude and feeling.

INTERVIEWER: If you had to rank order things like this was most helpful; number 2; number 3; how would you rank activities as helpful to you personally?
Yolanda: I think surveys would be the top and the second would be those materials and handouts explaining about how to change just different viewpoints and third would be I think the amount of time and length I had in individual therapy that was really incredible I think.

INTERVIEWER: So would it be just having time to individually practice techniques over and over again?

Yolanda: One on one yeah was the best.

INTERVIEWER: Is there anything more you would like to add?

Yolanda: I think those homework assignments, Oh and the presentations that would go actually I would put it on the second yeah that was very helpful I think.