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# A Qualitative Analysis of the Therapeutic Alliance From the Perspective of Adolescents Who Stutter

Kelli D. Rikkenbach

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UNIVERSITY OF NORTHERN COLORADO

Greeley, CO

The Graduate School

A QUALITATIVE ANALYSIS OF THE THERAPEUTIC  
ALLIANCE FROM THE PERSPECTIVE OF  
ADOLESCENTS WHO STUTTER

A Thesis Submitted in Partial Fulfillment of the  
Requirements for the Degree of Master of Arts

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College of Natural and Health Sciences  
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August, 2015

This Thesis by: Kelli D. Riggerbach

Entitled: *A Qualitative Analysis of the Therapeutic Alliance From the Perspective of Adolescents Who Stutter*

has been approved as meeting the requirement for the Degree of Master of Arts in College of Nature and Health Sciences in School of Human Sciences, Program of Speech-Language Pathology.

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## ABSTRACT

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There has been research outlining the importance of the client-clinician relationship in therapeutic outcomes; however, there is a relative lack of research as to the development of the therapeutic alliance in the area of fluency therapy, particularly with adolescents. The purpose of this investigation was to learn about the perceptions of adolescents who stutter regarding characteristics of effective and ineffective speech-language pathologists as well as how these adolescents perceive their own and their speech-language pathologist's role in the therapeutic alliance. This study addressed the following questions:

- Q1 How do adolescents with fluency disorders describe their role within the therapeutic alliance?
- Q2 How do adolescents with fluency disorders describe their speech-language pathologists' role within the therapeutic alliance?
- Q3 How do adolescents with fluency disorders perceive factors common across clinicians as they relate to an effective therapeutic experience?
- Q4 How do adolescents with fluency disorders perceive factors common across clinicians as they relate to an ineffective therapeutic experience?

The phenomenological method of qualitative research was employed as a framework to interview three participants who were adolescents who stuttered. Four themes emerged during data analysis as key factors that impacted the development of a

client-clinician relationship: adolescents' trust of the SLP, adolescents' investment in therapy, partnership and collaboration in therapy, and building a therapeutic alliance.

These themes were discussed and may be considered in the treatment of adolescents who stutter in order to develop strong therapeutic alliance.

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## **CHAPTER I**

### **INTRODUCTION**

Stuttering, often referred to as a fluency disorder, is a disruption in the forward flow of speech marked by repetitions, blocks, prolongations, interjections, and hesitations, that the speaker perceives as a loss of control (American Speech-Language-Hearing Association, 2014; Guitar, 2014; Ramig & Pollard, 2011). Fluency disorders occur in about six percent of children in the United States and the treatment of stuttering requires the skilled services of a speech-language pathologist (SLP) for an individual to achieve fluent speech (Doty, Gates, Tomblin, Boyle, & Cruickshanks, 2010; Guitar, 2014). Even with the help of an SLP, 17% of the children affected by fluency disorders will continue to stutter into adolescence and adulthood (Stuttering Foundation of America, 2014).

In addition to the physiological aspects of stuttering, fluency disorders that persist into adolescence are typically associated with emotional and cognitive reactions to the moments of stuttering (Yaruss & Quesal, 2006). Current best-practice standards for the treatment of stuttering incorporate the combination of fluency shaping techniques, stuttering modification strategies, and client counseling (Ginsberg & Wexler, 2000; Guitar, 2014). Fluency shaping techniques are those that allow an individual to be more fluent by easing into a word, sentence, or phrase, (Guitar, 2014; Yaruss, Coleman, & Quesal, 2012). Stuttering modification strategies are alterations of the physical aspect of

the stutter to reduce the speaker's reaction to the moment of stuttering (Saltuklaroglu, Kalinowski, Dayalu, Stuart, & Rastatter, 2004; Yaruss et al., 2012). Counseling in fluency therapy has also been shown to be a critical component because it can reduce the frequent feelings of shame, embarrassment, fear, and anxiety in order to promote positive self perceptions for those who stutter (Flasher & Fogle, 2012; Ginsberg & Wexler, 2000; Guitar, 2014; Yaruss et al., 2012). Guitar (2014) and Manning (2001) specify that all three components may or may not be necessary for each adolescent who stutters so it is essential to individualize fluency therapy on a case-by-case basis.

While fluency therapy is similar for each age group, there are distinct differences in the needs of school-age children, adolescents, and adults. Unfortunately, there is limited research as to the best treatment of stuttering for adolescents (Blood, 1995; Hearne Packman, Onslow, & Quine, 2008). It is common that adolescent fluency therapy is a piecing together of different components from school-age child and adult stuttering treatments found in the literature (Blood, 1995; Hearne et al., 2008). Hearne and colleagues suggest this leads to less than optimal success for adolescents, because they are unique and require their own unique methods of treatment to glean the maximal benefits from fluency therapy. Teens who stutter experience distinctive challenges, particularly related to emotion and perceptions associated with their speech. Considering these challenges, the limited research on emotions and self-perceptions has shown that counseling and stuttering modifications are particularly beneficial (Ramig & Bennett, 1995). In order for adolescents to be successful in fluency therapy, other factors need to be present, such as the therapeutic alliance (Katz, 1999; Plexico, Manning, & DiLollo, 2010).

The therapeutic alliance, which is defined as a “collaborative, healthy, and trusting relationship established between the client and clinician,” (Plexico et al., 2010, p. 334) is dependent upon the dyad and what each member (client and clinician) brings to the relationship (Cameron, 2014; Ciraky, 2013; Hearne et al., 2008; Katz, 1999). The client factors of the therapeutic alliance can be accounted for through the self-determination theory of motivation (Daly, Simon, & Burnett-Stolnack, 1995). This theory states that an individual’s well-being is dependent upon the core needs of competence, autonomy, and relatedness in order to have sustainable, autonomous intrinsic motivation (Ciraky, 2013). Ryan and Deci (2000) suggest that a client’s contributions to the therapeutic alliance and outcomes are dependent upon therapy meeting those three core needs. This suggests that so long as an adolescent feels competent, autonomous, and relatedness to the SLP, fluency therapy will be more effective.

The clinician’s contributions to therapy can also impact the effectiveness of fluency therapy and can be accounted for by the common factors model of therapeutic change (Lambert & Bergin, 1994; Messer and Wampold, 2002; Wampold, 2001). Common factors include clinician competence, skill level, personality traits, emotional state, and focus (Karson & Fox, 2010; Manning, 2006; Martin, Garske, & Davis, 2000; Martin, Romas, Medford, Leffert, & Hatcher, 2006). Wampold (2001) suggests that the factors common across clinicians determine how an intervention is implemented and is more predictive of successful therapeutic outcomes than is the treatment itself. The common factors model of therapeutic change accounts for the importance of the

therapeutic alliance in determining therapeutic outcomes, which plays a significant role in the success of therapy (Plexico et al., 2010; Wampold, 2001).

An important component of successful speech-language intervention is the interaction between the client and clinician. The therapeutic alliance, a bond between a client and an SLP developed by working toward the common goal of successful therapy, is one of many characteristics common across successful interventions (Hearne et al., 2008) but is not currently well represented in the literature in the field (Ebert & Kohnert, 2010).

While treatment itself is critical, the manner in which it is implemented can affect the outcome for the client and can vary based on the clinician's competence, mannerisms, mood, and belief systems, as well as a number of other factors (Cameron, 2014; Ebert & Kohnert, 2010). These variables can greatly impact the relationship between the client and clinician as well as influence the building of rapport (Hearne et al., 2008). Differences in implementation have not been studied extensively from the perspective of the speech-language pathology client, although there has been some research in the field of psychology (Ebert & Kohnert, 2010).

### **Overview and Purpose of Study**

Client and clinician factors have an impact on the therapeutic alliance formed during fluency therapy and impact the effectiveness of such therapy. This information combined with current research serves as the framework for the research questions. Research in the field of psychology has demonstrated the importance of the therapeutic alliance in therapeutic outcomes and that client and clinician factors affect the formation and maintenance of the therapeutic alliance. If this is the case, why are clinical outcomes

in speech-language pathology assumed to be wholly dependent upon a given treatment as is stated by the American Speech-Language-Hearing Association's (ASHA's) Joint Coordinating Committee on Evidence-Based Practice (2005) and not the manner of implementation of the treatment? According to Plexico and colleagues (2010), adults who have undergone fluency therapy found the therapeutic alliance, as determined by both client and clinician factors, with their SLP to be the most impactful on their perception of the effectiveness of fluency therapy. The purpose of this study was to uncover and understand the perceptions of adolescents who stutter regarding the therapeutic alliance they formed with their current and previous clinicians and the impact that client and clinician factors had on the forming and maintenance of that relationship.

## **CHAPTER II**

### **REVIEW OF LITERATURE**

#### **Overview of Fluency Disorders and Treatment**

Stuttering is one of the many disorders that require treatment by a speech-language pathologist in order to elevate communication skills to a level desired by the client (Ramig & Pollard, 2011). An individual is diagnosed with a fluency disorder when disruptions such as repetitions, prolongations, and/or blocks are present in that person's speech (Ramig & Pollard, 2011). These disruptions are also commonly accompanied by conditioned behaviors and negative attitudes and emotions associated with the moments of stuttering (Guitar, 2014; Ramig & Pollard, 2011). These are secondary behaviors, which may impact communication as significantly as the physiological dysfluencies (Guitar, 2014; Ramig & Pollard, 2011, Yaruss et al., 2012). While about six percent of children will stutter for a short period of time and recover either naturally or through speech therapy, lifelong stuttering affects more than three million people in the United States alone—about one percent of the population (Stuttering Foundation of America, 2014).

Stuttering, a highly complex disorder affected by physiological, environmental, emotional, behavioral, and cognitive factors in addition to the individual's participation in the surrounding environment, has been found to impact many facets of an individual's life, as shown in Figure I (Yaruss & Quesal, 2006). According to Ramig and Pollard



(2011), many speaking situations in which an individual has previously stuttered can and often are associated with feelings of embarrassment, fear, and trepidation. This increased emotional stress will likely be accompanied by heightened physical tension, leading to more, and often more severe, stuttering, precipitating a vicious cycle (Ramig & Pollard, 2011). Typically, stuttering becomes classically conditioned with particular speaking situations due to the negative emotions associated with those situations (Ramig & Pollard, 2011).

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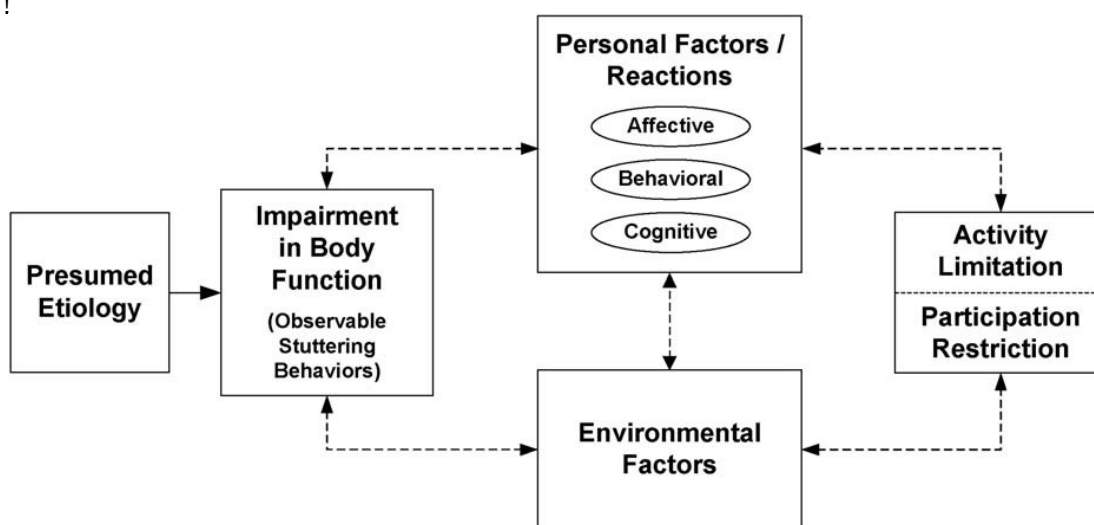


Figure 1. Schematic version of the World Health Organization's International Classification of Functioning, Disability, and Health (ICF, WHO, 2001) as adapted from "Overall Assessment of the Speaker's Experience of Stuttering (OASES): Documenting multiple outcomes in stuttering treatment" by J. S. Yaruss and R. W. Quesal, 2006, *Journal of Fluency Disorders*, 31. Copyright [2006] by Elsevier. Reprinted with permissions that can be found in Appendix C.

Many "cures" for stuttering have been sought over time, including placing stones in the mouths of individuals who stuttered in Ancient Greece, bloodletting in the Middle Ages, and more recently even electroshock therapy (Justice, 2006). Historically, the elusive etiology of stuttering has led experts in the field to believe it was psychological in

nature and treat them from a primarily psychological perspective, and this inaccuracy led to ineffective treatment of fluency disorders (Klingbeil, 1939; Ramig & Pollard, 2011).

Current best practices for treatment of stuttering typically provide intervention in a three-pronged approach—through fluency shaping, stuttering modification, and counseling (Guitar, 2014; Saltuklaroglu et al., 2004; Yaruss et al., 2012). Additional best practices indicate that the success of fluency therapy should not be measured simply by the number of stuttering instances, but also take the communicative success of an individual as a result of the intervention into consideration (Yaruss et al., 2012). Fluency shaping and stuttering modification are implemented into fluency therapy through direct treatment in concert with indirect treatment (e.g. operant training and environmental modification) (Corcoran & Stewart, 1995; Justice, 2006; Yaruss et al., 2012).

Stuttering modification is a group of techniques, the names of which vary depending on the clinician and researcher (e.g. bouncing, purposeful stuttering, voluntary stuttering, silly stuttering, Tigger Talk) (Grossman, 2008; Guitar, 2014; Manning, 2001; Walton, 2013; Walton & Wallace, 1998; Weigel, 2013; Yaruss et al., 2012). These techniques have been shown to reduce stuttering in subsequent speech, thereby increasing overall fluency and reducing an individual's dysfluencies to a less complex state (Guitar, 2014; Saltuklaroglu et al., 2004). Fluency shaping is also recommended because it incorporates normal prosody and rhythm of speech with a slight stretch into the first transition of the initial word of a phrase to create fluency that sounds more natural in conversation (Grossman, 2008; Guitar, 2014; Kroll & Scott-Sulsky, 2010; O'Brian, Packman, & Onslow, 2010). Moreover, stuttering moments frequently occur in the utterance-initial position; fluency shaping and stuttering modification techniques may be

beneficial due, in part, to their placement at the beginning of an utterance (Richels, Buhr, Conture, & Ntourou, 2010). Research has shown that successful adolescent fluency therapy overlays fluency shaping and stuttering modification techniques on structured and unstructured linguistic tasks (Bothe, Davidow, Bramlett, & Ingham, 2006; Guitar, 2014; Manning, 2001). Individual's dysfluencies tend to increase with increasing utterance length and complexity; therefore, the length and complexity of treatment targets should be selected based on the level at which each client is the most successful with clinician assistance and gradually increased over therapy (Guitar, 2014; Manning, 2001; Richels et al., 2010; Ryan & Ryan, 1983).

As is the case with all speech-language interventions, clinicians must provide their clients with the emotional support regarding acceptance, adaptation, and decision-making (Flasher & Fogle, 2012). In order to address issues and concerns that may impede the success of fluency therapy, SLPs should have conversations with their clients about their attitudes and emotions regarding stuttering (Flasher & Fogle, 2012; Ginsberg & Wexler, 2000; Guitar, 2014; Manning 2001). Due to the nature of typical adolescent behaviors, Zebrowski (2006) posits that counseling adolescents who stutter is paramount to positive therapeutic outcomes. Cognitive therapy techniques can be employed by SLPs by listening and valuing the feelings of adolescents who stutter and following up with questions to better understand their perspectives (Zebrowski, 2006). Specific to adolescents, it is important to include the clients' parents in the conversation to whatever extent is tolerable or appropriate as determined by the adolescents (Flasher & Fogle, 2012).

### **Fluency Therapy Specific to Adolescents**

While this complex struggle with speech can affect individuals of all age groups, it is particularly impactful during the already complicated adolescent developmental period (Hearne et al., 2008). An adolescent's self-esteem may be reduced, potentially leading to decreased social interactions and participation in class or avoidance of speaking altogether (Blood, Blood, Tellis, & Gabel, 2003). Because adolescents are developing and utilizing Piaget's 'formal operational thought', therapy for this age group can capitalize on their new-found abilities in abstract, hypothetical, and logical thought processes (Hearne et al., 2008).

Few interventions for stuttering are designed specifically for adolescents. Fluency therapy for adolescents is a patchwork of established school-age child and adult therapy programs, but the uniqueness of the adolescent mind necessitates its own brand of treatment (Blood, 1995; Hearne et al., 2008). Because adolescents are unique in their wants and needs for an effective therapeutic experience, it is paramount that researchers investigate therapy techniques specifically developed for this population rather than adapted from school-age or adult therapy programs.

Brisk, Healey, and Hux (1997) reported that clinicians who treat fluency disorders showed lower numbers of successful therapeutic outcomes with adolescents than they did with any other age group, potentially due to social, academic, physical, and psychological factors (Daly et al., 1995; Justice, 2006). Adolescents contend with very specific challenges—time commitments, peer pressure, academic demands, drive for individuality and autonomy, self-esteem, and self-doubt (Justice, 2006). Brisk et al.'s findings provide evidence for clinician difficulties and, likely, adolescent clients' frustration with

stuttering therapy (1997), indicating a general need for further investigation into the treatment of adolescents who stutter. Lack of appropriate treatment methods may also lead to adolescents' reluctance to participate in speech therapy (Hearne et al., 2008).

Speech-language pathologists must implement treatment specific to improvement of speech patterns (Justice, 2006). Ramig and Bennett (1995) and Manning (2001) suggest targeting this aspect of fluency therapy through the use of fluency shaping and stuttering modification approaches, which is rooted in Van Riper's (1975) approach for treating stuttering. The stuttering modification techniques that an adolescent can use to work through moments of stuttering include cancellations (pausing after a word containing a dysfluency, waiting for control, and continuing on with a gentle stutter) and pull-outs (stopping during a dysfluency, waiting for control, and gently continuing the rest of the word) (Justice, 2006). Bothe and colleagues (2006) conducted a systematic review of fluency treatment research from 1970 through 2005 and showed that the stuttering modification techniques were, in fact, effective for adolescents. In addition to these therapy techniques, Manning (2001) suggests that SLPs encourage their clients to identify moments of stuttering, and reduce sensitivity to those moments through variation and modification of stuttering behaviors. Manning's (2001) suggestions are supported by Ryan and Ryan's (1983) study in which 16 adolescents experienced increases in fluency (<5% syllables stuttered) through stuttering modification. This variation and modification of stuttering behaviors will weaken the conditioning that is so powerful in preserving exaggerated stuttering behaviors (Guitar, 2014). This traditional stuttering modification treatment has the potential to desensitize the individual to their stuttering, thereby reducing and managing fear and avoidance of stuttering (Manning, 2001). This

was shown by both Blomgren, Roy, Callister, and Merrill (2005) and Eichstadt, Watt, & Girson, (1998) in studies of intensive stuttering modification on the frequency of dysfluencies for adults.

### **Counseling in Fluency Therapy**

There is a need to both modify stuttering behaviors and shape fluency when treating individuals with fluency disorders, all the while providing counseling regarding the individual's attitudes and emotions surrounding stuttering (Ginsberg & Wexler, 2000; Guitar, 2014; Manning, 2001; Yaruss & Quesal, 2006). It is common for individuals who stutter, including adolescents, to experience a variety of negative emotions related to speech and stuttering (Ramig & Pollard, 2011). As found by Mulcahy, Hennessey, Beilby, and Byrnes (2008) adolescents who stutter often suffer from anxiety correlated with difficulty speaking, although the anxiety is related to the psychosocial conflict of speaking difficulty rather than the surface features of stuttering.

In an expert report, Yaruss and Quesal (2006) emphasize the importance of the emotional component on the daily life and overall well-being of an individual who stutters. In order for fluency therapy to truly have a positive impact on the person's communication, it is critical that a clinician counsel that individual about their feelings of shame and guilt, which are regularly seen across this population (Yaruss & Quesal, 2006). Based on a multiple-baseline study of three adolescents and clinical evidence, Blood (1995) established a treatment program with a strong counseling component for adolescents who stutter that reduced and maintained an overall reduction in dysfluencies in all participants. In an expert report Daly et al. (1995), also outlined a suggested treatment program that focused on counseling to best serve adolescents who stutter. In

their respective therapy programs, Blood (1995) and Daly et al. (1995) suggest several specific considerations in the treatment of stuttering with the adolescent population.

These include the following:

1. Address knowledge of stuttering, including etiologies and treatment
2. Introduce self-instructional and cognitive strategies to promote awareness of and responsibility for therapy outcomes
3. Teach relaxation strategies to increase awareness and implementation of relaxation techniques
4. Practice mental imagery to visualize fluent speech in different speaking situations
5. Model positive self-talk and positive language in self-describing
6. Instruct as to the use of positive coping strategies (i.e. expressing emotions and recovery after moments of stuttering)
7. Implement assertiveness training and encourage alternative methods of expression (i.e. art, exercise, writing, etc.)
8. Identify available social support systems, including friends, family, educators, and community members

Counseling in stuttering intervention involves helping the person who stutters, regardless of age, maintain or develop appropriate and healthy beliefs about stuttering and themselves as a person who stutters (Ginsberg & Wexler, 2000; Guitar, 2014; Yaruss et al., 2012). As stated by Flasher and Fogle (2012), the counseling that occurs between the SLP and client in fluency therapy allows for emotional closeness and contributes to the development of a strong relationship. In order to provide adequate counseling to a

client, a clinician must be in the process of establishing or have in place a strong client-clinician relationship (i.e. therapeutic alliance) (Flasher & Fogle, 2012). This will require the clinician to understand what each client brings to the therapeutic alliance (Katz, 1999).

### **Self-Determination Theory**

Adolescents who stutter may be some of the most difficult clients to engage in the therapy process due to their lack of motivation, emotional state, and likely extended time already spent in fluency therapy (Daly, Simon, & Burnett-Stolnack, 1995; Manning, 2001). That being the case, Ryan and Deci (2000) grounded client contributions to therapeutic outcomes in Bandura's (1986) self-determination theory (also known as self-efficacy theory). Self-determination theory is defined as "people's inherent growth tendencies and innate psychological needs that are the basis for the self-motivation and personality integration, as well as the conditions that foster positive processes" (Ryan & Deci, 2000, p. 68). The psychological needs associated with self-determination theory are competence, autonomy and relatedness (Cameron, 2014; Ciraky, 2013; Scheel, 2011).

Competence, relatedness, and autonomy are more than just signs of well-being, they are the components vital to well-being (Ryan & Deci, 2000). They are the three intrinsic values (i.e. core needs) necessary to a person's well-being, growth, and productive social improvements as would be seen in outcomes of fluency therapy (Ciraky, 2013). These three motivational components convey two different concepts—how an individual orients to the environment and regulates behavior, and how self-determined that individual is in various life situations (Bandura, 1986; Deci & Ryan, 2008). Ciraky (2013) and Deci and Ryan (2008) provide a comprehensive description of



these three intrinsic values. *Autonomy* is the intrinsic value of power of free choice toward a desired goal and implies the ability for self-governance (Ryan & Deci, 2008).

So long as clients' intrinsic need for autonomy is met, they can feel a sense of control and maintain motivation because an independently selected activity is more likely to be motivating. *Competence*, the belief that one can accomplish desired outcomes, is the second intrinsic component (Deci & Moller, 2005). The client must feel capable of success within the therapy session to be motivated, because a person who feels competent is more likely to pursue activities to enhance that competency (Bandura, 1986).

*Relatedness* is another intrinsic value that allows for a sense of attachment to others (Markland, Ryan, Tobin, & Rollnick, 2005). It is motivating in a therapeutic context for the client to feel the need to relate to the clinician due to the fulfillment of connection with others through purposeful engagement. While self-determination theory neatly divides these three qualities, they will likely overlap significantly in real situations.

In the case that one of the three core needs is not met in fluency therapy, the client may lose motivation for improvement because well-being is not fully intact (Bandura, 1986; Ryan & Deci, 2000). Ciraky (2013) suggests that a clinician can facilitate a close bond with a client by facilitating the client's perception of each of the three needs. Sheldon and Niemiec (2006) along with Stone, Deci, and Ryan (2009) hypothesize that the more competence, relatedness, and autonomy are present in a person, the more intrinsically motivated that person is, leading to sustainable and autonomous motivation. Although self-determination theory research is primarily focused on psychotherapy, the client motivation information may still be applied to fluency therapy, particularly as it relates to the client-clinician relationship. Self-determination theory is useful in

describing a client-clinician interaction because it accounts for multiple factors that impact a successful therapeutic alliance (Bandura, 1986; Ciraky, 2013). The client factors are not the only ones that need consideration as the clinician factors also play a significant role in the development of a therapeutic alliance (Cameron, 2014). Wampold (2001) stressed the importance of the clinician characteristics in the therapeutic process and relationship in the understanding of client outcomes, as suggested by the common factors model.

### **Common Factors Model**

The common factors model is defined as the model under which components or dimensions of treatment that are not particular to any specific treatment are integral in successful therapeutic outcomes (Lambert & Bergin, 1994). Common factors in therapy are typically practical and generic actions performed by clinicians in various therapeutic settings based on procedural knowledge (Cameron, 2014). Messer and Wampold (2002) posit that factors common across clinicians are more powerful in determining the effectiveness of comparable therapeutic techniques.

There are several clinician skills that underlie common factors (Karson & Fox, 2010). The first of these skills requires the clinician to set and maintain boundaries of the therapeutic relationship. Next, a clinician must bring the client's attention to the relationship by attending to it and regularly commenting on their interpersonal interaction. Third, a clinician's personal distractions should be minimized so as not to exhibit them to the client. Lastly, it is important that the clinician maintain the interaction as professional, rather than a friendship. While these skills are important for a clinician to possess, a successful clinician must balance these along with many other

qualities, such as the ability to provide clear, educational information and express thoughts about treatment to include the client in the analysis and planning (Manning, 2006).

Manning (2006) outlined several additional factors that can contribute to a clinician's effectiveness, including the perceptions a clinician has about stuttering and those who stutter, the manner in which clinicians interpret stuttering, clinical decision-making skills, and the ability to make clinical adjustments. In addition to the above factors, several researchers in the area of stuttering argue that certain clinician personality traits (empathy, genuineness, charisma, creativity, and honesty) can enhance the effectiveness of fluency therapy (Cooper & Cooper, 1985; Manning, 2006; Van Riper, 1975; Zinker, 1977). Manning (2006) also emphasizes a clinician's inclusion of humor into therapy sessions not only as a way to strengthen the relationship between a clinician and client who stutters, but also to improve the mood of fluency therapy sessions and cope with difficult communication problems in a healthy manner. While there are many clinician characteristics preferred by adolescents who stutter, Martin et al. (2006) found that they prefer specific "helping" qualities from adults such as openness, recognition, guidance, trust, freedom, identification, time shared, and familiarity. In a focus group study of adolescents in a non-clinical setting, Martin et al. (2006) made the assumption that these findings would generalize to the clinical setting. In addition to clinicians' "helping" qualities, the correlation between clinician competence and satisfaction with fluency therapy shows that SLPs treating adolescents who stutter should demonstrate competence in the area (Yaruss et al., 2002).

Under the common factors model of therapeutic change, the outcome of any therapy is dependent, in part, upon the therapeutic alliance (Plexico et al., 2010; Wampold, 2001). Ryan, Lynch, Vanteenskiste, and Deci (2011) have argued that client factors such as client motivation and autonomy in the common factors model are equally important to therapeutic outcomes as the therapeutic alliance.

### **Therapeutic Alliance**

Due to the complex nature of adolescent speech therapy, the present study will focus on one aspect: the therapeutic alliance between adolescents and their clinicians. Plexico and colleagues (2010) defined the therapeutic alliance as a “collaborative, healthy, and trusting relationship established between the client and clinician,” (p. 334) which suggests that the client and clinician have agreed on the goals of therapy and have a shared understanding of the therapeutic process.

While there are many challenges for both the client and clinician in building a positive therapeutic alliance, Katz (1999) emphasizes the importance of this relationship. A strong therapeutic alliance creates the atmosphere in which adolescents who stutter can improve their capacity for fluent speech (Katz, 1999). The therapeutic alliance can be influential on the effectiveness of therapy due to the highly interactive nature specific to fluency therapy (Manning, 2001; Zebrowski & Wolf, 2011). It should be understood by clinicians that the therapeutic alliance is not constant, but is a dynamic interaction and will be stronger at times and weaker at others, as is the case with any human relationship (Katz, 1999).

When analyzing the building of therapeutic alliances, a factor to be considered is the preconceived notions of both clients and clinicians (Katz, 1999). Clinicians will

develop their ideas based on a case history, parent interview, or file created by a third party; adolescents will develop their own opinions based on knowledge about previous SLPs, parents, and any research they do on their own. As is human nature, both parties will initially assess one another and develop opinions before, during and after meeting (Katz, 1999). Clinicians must be aware of and minimize any of their own preconceptions because an adolescent client cannot be expected to manage his/her preconceptions (Katz, 1999). After the initial meeting, Katz (1999) suggests that if an adolescent client perceives the SLP to be detached, disinterested, insensitive, or displaying signs of hostility or anxiety, the therapeutic alliance will be much more difficult to form. After the first meetings, Katz (1999) provides suggestions for clinicians in establishing the therapeutic alliance, particularly if the adolescent is proving not to desire a working relationship with the SLP:

- Clinician acknowledges being a stranger
- Clinician provides evidence of trying to understand the adolescent's situation
- Clinician seeks adolescent's assistance in analyzing and problem-solving situations
- Clinician demonstrates interest in helping adolescent by capitalizing on opportunities to help

Clinicians may have an advantage over other adults in developing positive alliances with adolescents who stutter, because adolescents typically seek positive relationships with adults in their lives (Katz, 1999). Clinicians typically have the luxury of entering an adolescent's life at this opportune time with a clean slate, allowing them the opportunity to develop a positive alliance more easily (Katz, 1999). This may be due

to their need for autonomy, as well as their desire to be accepted and approved of by adults who are nonjudgmental in a setting in which they can learn about themselves and their speech (Katz, 1999). This need may be particularly true for those adolescents with more sensitive temperaments (Katz, 1999).

Individuals who stutter commonly have more sensitive temperaments, thereby making them more reactive to the moments of stuttering and more likely to develop a true fluency disorder (Bleek, Reuter, Yaruss, Cook, Faber, & Montag, 2012; Guitar, 2014). Temperament is the reference to biologically based, relatively stable individual differences that appear early in development, although these traits may develop over time as a result of environmental influences (Eggers, De Nil, & Van den Bergh, 2010). A multitude of personal characteristics can contribute to this sensitive temperament including anxiety, shyness, agreeableness, conscientiousness, anger/frustration and decreased emotional stability (Bleek et al., 2012; Bleek, Montag, Faber, Reuter, 2011; Eggers et al., 2010). Per Katz's (1999) suggestions, SLPs may need to adjust therapy techniques for adolescents with these traits as they are often correlated with more sensitive temperaments.

Over the course of two questionnaire-based studies, Ebert and Kohnert (2010) found, in a group of speech-language pathologists, that the most highly valued characteristic in effective clinicians was not really a clinician characteristic at all, but rather the clinician-client relationship. In a randomized investigation of the establishment of trust between children and adults, Gurland and Grolnick (2008) confirm that the quality of the clinician-client relationship is dependent upon both. Cooper, Eggerston, and Galbraith (1972) reported a relationship between clinician affection and a successful

therapeutic dyad in which the client made measurable progress based on their analysis of the research at that time. According to Cameron (2014), this dyad can be described as a relationship based on trust and support as demonstrated by the clinician's empathy, genuineness, and understanding, as well as the ability to encourage and inspire the client to believe in the therapy. Cameron (2014) also emphasizes the client's willingness and ability to engage in the meaningful therapy.

The therapeutic alliance has been investigated to some degree in adult populations with fluency disorders, but there has been a relative lack of research into this phenomenon for children and adolescents (Gurland & Grolnick, 2008; Hearne et al., 2008). Specifically, the perceptions of adolescents with fluency disorders regarding the therapeutic alliance with an SLP have not been evaluated. Interview-based qualitative research by Plexico and colleagues (2010) evaluated adult fluency clients' perceptions of the therapeutic alliance with an SLP during stuttering treatment and the therapeutic alliance was found to be critical to the success of therapy. The impact of the therapeutic alliance may be even greater for individuals with fluency disorders in that stuttering therapy very much involves in-depth discussions of attitudes and emotions of the clients regarding stuttering (Cooper, 1966; Guitar, 2014; Hearne et al., 2008; Manning, 2001; Plexico et al., 2010). With more research in the area of therapeutic alliance in the treatment of fluency disorders, particularly for adolescents, clinicians were better able to learn what is important from the perspective of the client, which may positively impact therapeutic outcomes.

### **Research Questions**

The purpose of this study was to investigate the perceptions of adolescents who stutter regarding characteristics of effective and ineffective speech-language pathologists as well as how these adolescents perceive their own and their speech-language pathologist's role in the therapeutic alliance. The following questions were addressed through a qualitative research project investigating the phenomenon of the therapeutic alliance formed during fluency therapy that occurs between speech-language pathologists and adolescents who stutter:

- Q1      How do adolescents with fluency disorders describe their role within the therapeutic alliance?
- Q2      How do adolescents with fluency disorders describe their speech-language pathologists' role within the therapeutic alliance?
- Q3      How do adolescents with fluency disorders perceive factors common across clinicians as they relate to an effective therapeutic experience?
- Q4      How do adolescents with fluency disorders perceive factors common across clinicians as they relate to an ineffective therapeutic experience?



## **CHAPTER III**

### **RESEARCH METHODS**

#### **Introduction**

Qualitative research methodology is an approach to research that focuses on the “discovery, insight, and understanding from the perspectives of those being studied” (p. 1) that Merriam (2009) argues has the most promise to make a difference in people’s lives. Ary, Jacobs, Razavieh and Sorenson (2006) suggest that the strength of qualitative research is that it has the capacity to delve deeply into many forms of human behaviors and can do so in multiple contexts. Qualitative research is dynamic and multidimensional in nature. It provides researchers with a framework to understand the meanings individuals have constructed to make sense of their world and experiences in it (Merriam, 2009).

Quantitative methods rely on concrete instruments and numerical data collection, whereas qualitative research allows for rich descriptions of complex phenomena and enhances the knowledge of events or experiences as well as the context in which they take place (Ary et al., 2006; Sofaer, 1999). Both methods overlap in that they require set guidelines and planning; however, qualitative research allows for a more open-ended, inquisitive clarification of values, meanings and language attributed to those who play different roles (Soafer, 1999). The natural context in which qualitative research takes place allows participants to “speak in their own voice” (Merriam, 2009; Sofaer, 1999, p.

1105). Although the quantitative approach may be preferable when more objective data collection is possible, the qualitative approach is apt when gathering less concrete data (Creswell, 2013). Qualitative research is well suited when it is not possible to define the research outcome in a limited number of quantifiable metrics (Merriam, 2009).

A major component of qualitative research involves the use of the researcher as the instrument of measurement for all data collection rather than the quantitative use of concrete instruments or assessments (Creswell, 2013). Because the researcher is the primary measurement instrument in qualitative research, it is crucial that the researcher outline her personal perspective relating to the research. The benefits of a human as a data collector (i.e. ability to analyze complex and rich information, while remaining flexible enough to interact with the environment) often outweigh the detrimental potential of the researcher to influence data with his or her own personal bias (Ary et al., 2006; Sofaer, 1999). Within the rigorous qualitative research design are specific methods to recognize and abate researcher bias and its effects (Creswell, 2013; Merriam, 2009). This also involves defining the theoretical framework from which the researcher operated during the study and the methodology most fitting to understand the experiences of adolescents who stutter within the therapeutic alliance. In addition, information is provided as to the methods with which participants were selected as well as how data were collected and analyzed.

### **Research Design**

The study followed a qualitative research approach. Qualitative research encompasses several methodologies intended to provide rich descriptions while imposing minimal disruptions on the natural environment of participants (Merriam, 2009). One

such form of inquiry is phenomenology, which was the methodological perspective of this study (Merriam, 2009). Creswell (2013) defines phenomenology to be a study of commonalities shared amongst individuals as they experience a phenomenon. Research that is best suited for the phenomenological approach is that which investigates the lived experiences of several individuals' common experiences in the phenomenon of interest so as to develop a deeper understanding of the features of that phenomenon (Creswell, 2013; Moustakas, 1994). Plexico and colleagues (2010) examined the phenomenon of clinician characteristics that contributed to effective (or ineffective) therapeutic experiences for adults who stuttered. The phenomenon examined in this study was the therapeutic alliance formed between SLPs and their adolescent clients with fluency disorders and the characteristics common across the SLPs and adolescents involved in forming that alliance. In order to examine this phenomenon, the researcher investigated the perceptions of adolescents who stutter regarding the therapeutic alliance and characteristics of their SLPs.

### **Theoretical Framework**

The theoretical framework used to guide this research was constructivism. According to Crotty (1998), constructivism is the belief that meaning is not created, but rather constructed by humans' experiences in, interactions with, and interpretations of the world. Put simply, each individual constructs their own categories of knowledge, thereby constructing their own reality (Crotty, 1998). Social constructivism is an extension of this in that it emphasizes that meanings are conveyed socially and not in isolation. Social constructivism is built on three principles—knowledge, reality, and learning. Knowledge is constructed through individuals' interactions with one another and their environment

(Crotty, 1998), whereas reality only exists after its social interaction (Kim, 2001; Kukla, 2000). When individuals engage in social activity, they experience the learning and interaction on which constructivism is based, which is shaped by external forces alongside internal ones (McMahon, 1997). Constructivism, particularly social constructionism, emphasizes the value of interactions with the world and one another. Because therapeutic alliances are developed through social interactions, this theory provides a unique perspective in examining the interaction between clinicians and their adolescent clients with fluency disorders.

### **Researcher's Role & Biases**

According to Merriam, the researcher is the main instrument used in collecting and analyzing data for qualitative research methodologies, so it is essential to outline a description of the researcher, biases, and the role played in the research (2009). Differences in age, gender, class, and ethnicity between the participants and researcher can play a role in how much and what kind of information comes to light during the interview process (Merriam, 2009). So as to minimize misinterpretation of data, it is important to acknowledge and reflect on these differences.

At the time of the study, the researcher was a master's student in speech-language pathology. As a speech-language pathology graduate student and clinician, the researcher was studying the methods used to make speech-language intervention as effective as possible for every client. In each therapeutic interaction, the researcher attempted to provide clients with a highly productive and engaging therapy session in order to build a therapeutic alliance. This proved difficult due to the lack of information provided by research as to how to develop this alliance, particularly due to the high

degree of variability between clients and their different ages and needs. Anecdotally, the researcher observed inconsistency among different age groups' needs for building an effective therapeutic alliance. For example, young children required more nurturing qualities, while older adults required less of such qualities and school-age children seemed to vary in their preferences.

As a graduate clinician, the researcher had developed many different therapeutic alliances with clients. Some were more successful than others and it was unclear what factors affected the quality of those relationships.

In addition to the above listed clinical and education perspectives that the researcher carries, the researcher had some preconceived notions because her significant other was a person who stutters. The researcher had learned about and witnessed moments of frustration with his speech and developed the opinion that stuttering is simply a physiological manifestation of unknown etiology affecting a person's speech. The researcher had also been privy to his conveyance of therapeutic experiences, with some acknowledgement on his part of the therapeutic alliance and the role it played in his fluency therapy. It was the researcher's belief that a negative, weak, or moderate therapeutic alliance would likely form in the face of less than optimally effective therapy and a strong, positive therapeutic alliance was likely to form preceding or due to effective fluency therapy.

The researcher presented herself to the participants as a graduate student and future speech-language pathologist who wanted to learn what had been the most effective in developing a therapeutic alliance between the clinician and adolescent client with a speech disorder as well as the characteristics common across clinicians for effective or

ineffective therapy outcomes. The researcher presented the therapeutic alliance as being the relationship between the participant and their current and previous SLPs. The client and clinician factors were presented to the participants as how each party behaved to allow them to get along better or help the fluency therapy to be more effective. The researcher was her mid-twenties and wore professional clothing appropriate for the clinic environment. The researcher attempted to have the adolescents view her as just another clinician.

### **Research Participants**

Qualitative research sampling differs greatly from quantitative research sampling in that the researcher does not attempt to find the widest reaching relevant sample possible, but rather attempts to recruit participants with relevant and representative experiences as related to the research questions. While about six percent of children will stutter for a short period of time and recover either naturally or through speech therapy, lifelong stuttering affects more than three million people in the United States alone—about one percent of our population (Stuttering Foundation of America, 2014). Given that recovery from stuttering generally occurs early on in a child's life (Guitar, 2014; Manning, 2001), participants with persistent developmental stuttering were selected for this research. Persistent stuttering was considered that which had been present for longer than two years post onset (Guitar, 2014).

To ensure the sample did not represent the extremes of the phenomenon, emblematic participants were selected for this research as is done in typical sampling (Merriam, 2009). Participants were selected who did not hesitate to speak in order to maximize the amount of data that were provided in the interviews. In order to recruit

adolescent participants, the researcher collaborated with SLPS who treated adolescents who stutter in Northern Colorado to identify appropriate participants. Each SLP contacted for this study was asked to provide the researcher's contact information to clients eligible for this study along with their parents so that all client/participant information was provided to the researcher on a voluntary basis. The researcher then asked the adolescent clients to participate in one or more interviews. To maintain anonymity, all participants were assigned pseudonyms that were used in data collection, analysis, and reports.

Those individuals most suitable for this research were adolescents (ages 13-17) who had been diagnosed with developmental stuttering for a period of two or more years and were engaged in fluency therapy with an SLP (Hearne et al., 2008). Additionally, it was important to the nature of the research that each participant had fluency therapy with at least two SLPs so as to provide more information regarding differences across clinicians. All reasonable attempts were made to recruit participants from different clinics to maximize the diversity of current and previous clinicians across participants; however this proved difficult. Because stuttering varies so much across individuals, stuttering severity was not used as either inclusion or exclusion criteria, but was reported by each individual. In order to limit the number of extraneous variables, individuals with other known speech and language disorders, cognitive impairments, or disabilities did not participate in this study. Participants were selected through a purposeful convenience sample.

Three participants were selected, per recommendations of Creswell (2013) for a phenomenological study, and interviewed until saturation was reached with each

individual participant. Saturation is the point at which enough information has been gathered from the participants that no new data arise from new interactions and a model can be fully developed (Creswell, 2013). Saturation may also be defined as the point at which information begins to be repeated and no new information arises (Seidman, 2006). The redundancy of information will be the ultimate factor to determine the final number of participants (Merriam, 2009).

Additional variables that may have been present, but were not anticipated to be factors for inclusion in the research study were stuttering severity, gender, religion, socioeconomic status, educational level, or racial and ethnic identity. The data for these variables were collected only if offered by the participants in order to better understand the participant demographics. This additional data provided some clarity to unexplained themes that arose from the interviews.

### **Data Collection**

In order to achieve data triangulation and provide validity to findings, data were collected through three methods (Creswell, 2013). These methods were individual semi-structured interviews, journaling, and field notes. The main source of data were the individual interviews, although the other methods provided supplemental information as context for the research study.

Six in-person interviews and one phone interview were recorded on a password-protected iPad and transcribed within 72 hours on a password-protected computer. Upon completion of the transcription, each interview recording and transcript file was transferred to a password-protected flash drive and deleted from the iPad and computer. The password-protected flash drive was stored in a locked file cabinet in a secure room in



Gunter Hall located on the University of Northern Colorado campus. All field notes were scanned into a password-protected computer and transferred to the password-protected flash drive. After being saved on the flash drive, documents were destroyed within 24 hours. The researcher's journal, containing only pseudonyms, was stored on a password-protected computer and transferred to the password-protected flash drive when saturation has been reached for each participant. A master list containing a list of participant names and corresponding pseudonyms was also be stored on said flash drive. Only the research advisor and the researcher will have access to the locked file cabinet and password to the flash drive.

### **Field notes**

In order to supplement the interview transcript and research journal, the researcher took field notes. Field notes were intended to shift the perspective of the researcher from a "wide angle lens" to a "narrow angle lens" in order to look at a specific person, activity, or interaction (Merriam, 2009). While interviewing each participant, the researcher took notes as to the interview setting (i.e. lighting, temperature, participant and researcher placement, interruptions, mood of participant). If an interview took place via phone, notes were taken as to the participants' tone and rate of speech in addition to any audible disturbances. Field notes were taken before and during the interview process in order to capture the most accurate setting possible. The field notes included drawings of the setting and movements as well as pieces of data that were remembered at a later time.

### **Interviews**

Two to three semi-structured interviews as needed to reach saturation, lasting up to 60 minutes each were conducted with each of the adolescents who stutter. Semi-

structured interviews are those guided loosely by a set of suggested interview questions; however, the actual format of the interview follows the lead of the participants as long as the topic remained pertinent to the research question (Glesne, 2006; Merriam, 2009). These interviews typically allow the researcher more freedom to explore different areas and allow the participants more freedom in their answers, as well. The list of questions in Appendix A are categorized into two groups, those that the researcher asked every participant and those that are optional follow-up questions. The participants were asked to describe successful speech-language therapy, the “ingredients” in an effective therapeutic alliance, and thoughts and feelings about speech-language therapy sessions and interactions. Additionally, participants or their parents were asked to provide details about their stuttering severity along with the length of time spent in therapy and the number of therapists they have worked with. This information provided the researcher with a better context of their experiences with fluency therapy. Interview questions can be found in Appendix A.

All interviews took place in northern Colorado and interactions between the participants and the researcher took place by phone or in person. All interviews were recorded with a digital audio recorder and then transcribed by the researcher. Any interviews in person took place in a quiet room with a closed door with a sign requesting privacy and no disturbances. Per the research protocol outlined by Merriam (2009) and Patton (1990), the researcher utilized respondent validation in which each participant was provided with an opportunity to review his or her interview transcripts for accuracy. Respondent validation took place after each participant’s interviews were completed to allow the researcher and participants to reflect on the interview (Patton, 1990). All initial

and subsequent interviews were scheduled for a time and place convenient for each participant.

### **Journal**

The researcher kept a journal throughout the study in order to record observations, preliminary analyses, reflections, questions, and thoughts about the data collection and analysis (Janesick, 1999; Merriam, 2009). Due to the intent to focus on the dialogue of the interview, the researcher wrote reflections of the interview within 12 hours of the interview having taken place per the interview protocol recommended by Patton (1990). In the journal, potential future interview questions as well as the interpretations of the experiences and any other relevant thoughts were included.

### **Validity**

Validity (often referred to as credibility) is integral in conducting all research. For qualitative research it is the level of believability of the observations, interpretations, and conclusions of the researcher (Ary et al., 2006). Confirmability is the objectivity of a qualitative researcher and focuses on his or her ability to remove any and all bias from data collection and analysis processes (Merriam, 2009). Seeing as how the complete removal of bias is not likely to be possible, it is the goal of a qualitative researcher that other researchers investigating the same condition confirm data collected and conclusions drawn (Ary et al., 2006).

The primary source of validity and confirmability for this research study was data triangulation—the use of multiple data sources (Merriam, 2009). Creswell (2013) explains that when a code or theme is found in different data sources, a researcher is triangulating data and providing validity to the findings. In addition to data triangulation,

respondent validations were implemented in order to provide participants with the opportunity to approve of or adjust the representation of themselves in the interview transcripts. As recommended by Patton (1990), respondent validation was accomplished by providing each participant with a copy of the interview transcript and an explanation of the respondent validation process within 72 hours of the participant's final interview having taken place. Upon receiving the interview transcripts, the participants were given one week to review them and submit any changes they deemed necessary.

### **Transferability**

Ary et al. (2006) define transferability as being the degree to which the findings of a qualitative research study can be generalized outside the specific context of the study to other contexts or groups. So as to ensure maximal transferability, the researcher provided detailed and rich descriptions of herself as well as the findings. With these details, readers would be able to make judgments and comparisons as to the potential for transfer of results across service delivery models and client-clinician interactions involving other speech and language disorders.

### **Data Analysis**

The digitally recorded interviews were transcribed in their entirety, providing the main source of data for analysis. The analyzed data were comprised of information obtained from the interviews in addition to the researcher's journal and field notes. Data were analyzed based on Merriam's (2009) constant comparative method of data analysis. As such, after interviews are transcribed, data were coded into meaning units, or meaningful pieces of information. The repeating codes, or ideas, were found and labeled

for each participant. Each repeating code was analyzed across all participants and reorganized into main themes or categories.

In order to allow independent readers the ability to authenticate the results of this study, the researcher also maintained an audit trail (Merriam, 2009). An audit trail is an explicit description of the method the researcher followed to arrive at the results so that a reader may confirm the study's findings (Merriam, 2009). A detailed outline of the study and data collection process is located in the research journal. Additionally, all digital audio recordings were maintained during the study so as to ensure that a copy of the original sources of data were readily accessible through the completion of the research.

## CHAPTER IV

### RESULTS

Interviews were designed to better understand how the students perceived the factors that impacted the therapeutic alliance and its formation. Data triangulation was completed using two additional points of data collection: field notes and a researcher's journal. Inter coder reliability was accomplished by having two coders code units or themes individually then discuss codes in person. The first coder was the researcher and the second coder was the research advisor, a speech-language pathology professor. Reliability was completed based on Creswell's (2007) suggestions regarding the second coder procedures used in his research:

We felt that it was more important to have agreement on the text segments we were assigning to codes than to have the same, exact passages coded. Second coder agreement to us meant that we agreed that when we assigned a code word to a passage, that we all assigned this same code word to the passage. It did not mean that we all coded the same passages – an ideal that I believe would be hard to achieve because some people code short passages and others long passages...we looked at the passages that we all four coded and asked ourselves whether we had all assigned the same code word to the passage...the decision would be either a “yes” or “no” decision, and we could calculate the percentage of agreement (pp. 210-211).

After in-person discussion of code units and themes, the two coders reached 100% consensus. The sample coded by the second coder was selected per Lombard, Snyder-Dutch, and Campanella Bracken (2002) who stated that the representative sample must be at least 50 text segments or ten percent of all interview data.

In order to code more than one participant interview, the second coder coded 25% of the full sample. In order for the second coder to select a random 25% of the full sample, all interview transcripts were placed in temporal order within one document. The total number of words in the full sample was calculated and divided into four sections. The second coder entered the numbers one through four into a random number generator, which selected the number two; therefore the second coder coded the second 25% of the full sample (What's this fuss about true randomness, 2015). The goal was for the coder and second coder to agree after discussion on at least 80% of the codes. After in-person discussion of codes and themes, the researcher and second coder reached 100% consensus, or a coefficient of 1.0. Neuendorf (2002) reported that "coefficients of .9 or greater would be acceptable to all, .80 or greater would be acceptable in most situations, and below that, there exists great disagreement" (p. 145). This chapter presents the results of this qualitative study.

### **Demographic Data of Participants**

The participants were asked to provide basic demographic information including descriptions and ratings of dysfluencies, which can be found in Table 1 and are described in more detail below. The majority of this information was collected at the start of the first interview with each participant, but collection was continued throughout the course of all interviews. All information represented below was self-reported and was not verified with any outside resources. Additionally, as stated in the methods section, the real names of participants were replaced by pseudonyms and no real participant names are used below. Three participants were interviewed in person and by phone ( $n = 3$ ), two

of whom were male and the other female. Participants ranged in age from 13 years to 15 years old.

Table 1

*Basic Demographic Data of Participants*

	Adam	Ella	Max
Age (in years)	15	13	13
Grade	10 <sup>th</sup>	7 <sup>th</sup>	7 <sup>th</sup>
Number of SLPs Seen for Stuttering	8 or more	4	4
Total Time in Fluency Therapy	5 years	11-17 months	6 years
Age of Onset of Stuttering	5-6 years old	8-9 years old	7-8 years old
Main Characteristics of Dysfluencies	Blocks, jaw tremors, and previous tongue protrusions	Phoneme specific prolongations and blocks	Prolongations
Stuttering Severity Rating	Moderate	Mild	Mild

*Note.* SLP = speech-language pathologist

Adam was a fifteen-year-old male who was a sophomore in high school at the time of the interview. He believed that he had stuttered since the age of five or six years, but was unsure as to the exact age of onset. At the onset of his stuttering, Adam's parents sought out private fluency therapy that lasted for one year and was discontinued due to his family's relocation out of state. Since the age of 11, when Adam's parents again sought out fluency therapy for him, Adam had consistently attended therapy at the same clinic. He attended therapy at this clinic with one primary clinician who moved away and transferred him to his current primary clinician at the time of the interview, although he also saw two different SLPs when his primary clinician was not available. Adam has also received fluency therapy through his individualized education program (IEP) in his local middle and high school. He was unsure as to how many school SLPs he has seen through his IEP and was unclear as to exactly how long he has received these services. Based on



this information, it was determined that Adam had received five years of fluency therapy both private and school-based. At the time of the interview, Adam described his stuttering to be characterized by blocks with jaw tremoring as a secondary characteristic; however, he mentioned that tongue protrusion was a previously remediated secondary characteristic. Adam's self-rating of his stuttering was moderate. He was a talkative participant and provided detailed answers to questions with minimal prompting and independently elaborated on topics related to questions.

Ella was a thirteen-year-old female who was attending seventh grade at the time of the interview. She estimated that she began stuttering in second or third grade, but was not certain of the exact age. At that point, Ella reported seeing two graduate clinicians simultaneously at a university clinic for one or two semesters; she was discharged from this clinic due to her significant progress. After she noticed some regression in her speech, Ella sought out a private clinician. She had attended that fluency therapy for five consecutive months with two different clinicians, although only one SLP was her primary clinician. Ella attended private fluency therapy for a total of 11-17 months and had never received any school-based fluency therapy. At the time of the interview, Ella reported herself to stutter mildly characterized by prolongations specific to the phonemes /l/, /m/, and /s/ as well as blocks on /d/. She was not talkative and the researcher had to ask questions in several different ways to get detailed answers to most interview questions.

Max was a thirteen-year-old, seventh grade male who had begun stuttering sometime prior to the age of 8 when he began private fluency therapy. Max had consistently attended this fluency therapy for six years and had therapy with four clinicians. He spent the majority of his therapy with two SLPs, although one remained

his primary clinician throughout his time in therapy. Max had received no school-based fluency therapy at the time of the interview. He characterized his stuttering to be mild prolongations but noted that two years prior he would have considered his stuttering to be moderate-severe. Max was quite talkative and provided details and examples in his answers with minimal prompting.

### **Participant-Identified Themes**

The interviews conducted were aimed at understanding each adolescent's unique perceptions of the therapeutic alliance and the common factors that contribute to that alliance. The following research questions were addressed through interviews investigating the phenomenon of the therapeutic alliance formed during fluency therapy that occurs between speech-language pathologists and adolescents who stutter:

- Q1      How do adolescents with fluency disorders describe their role within the therapeutic alliance?
- Q2      How do adolescents with fluency disorders describe their speech-language pathologists' role within the therapeutic alliance?
- Q3      How do adolescents with fluency disorders perceive factors common across clinicians as they relate to an effective therapeutic experience?
- Q4      How do adolescents with fluency disorders perceive factors common across clinicians as they relate to an ineffective therapeutic experience?

Two participants provided a rich and detailed narrative filled with thought provoking detail, while the third participant provided a narrative that was slightly less detailed. Per the data analysis techniques outlined in Chapter III, the main themes identified from the participant data were teens' investment in therapy, trust of the SLP, partnership and collaboration, and building a relationship. The first theme addresses the first research question, while the second theme addresses the second research question, the third theme

addressed the third research question, and the fourth theme addressed both the third and fourth research questions. Each theme is further described with subthemes, which are specific categories within each theme. Subthemes are categorized by the frequency with which they appeared within the transcripts using frequency classification of consensus themes (themes shared by three participants), supported themes (themes shared by two participants), and individual themes (themes individual to one participant) (Lincoln & Guba, 1985). While a few themes (e.g. partnership and collaboration, no perfect SLP, and fluency therapy in the school setting) were defined explicitly by the participants, due to the developmental language abilities and general circumlocution of the participants the researcher developed definitions based on the overall content and goal of each meaning unit. Themes were then developed based on the compiling of meaning units. The goal of including themes and direct statements from participants is to help provide a true understanding of the diverse experiences illustrated through the participants in their interviews.

### **Theme I: Adolescents' Investment in Therapy**

The participants' ability to invest in fluency therapy emerged as a second theme. This theme addressed research question one in that it focused on the client factors that impact the development of a therapeutic alliance and the intrinsic motivation necessary for that client-clinician relationship as outlined by self-determination theory (Ryan & Deci, 2000). Adolescents' overall ability to invest in therapy was stated to influence and be influenced by a number of different factors. Specific ideas emerged within each of these subthemes. When discussing what he thought he did to affect therapy Adam simply said, "the only way to improve is to like invest yourself in it."

**Motivation.** The subtheme of motivation arose from the participants' belief that their level of motivation impacted the effectiveness of therapy and their investment in the therapeutic process. It should be noted that all three participants stated their motivation in fluency therapy came from the desire to achieve more fluent or completely fluent speech. Adam explained his thoughts on how his motivation impacted his therapy: "I think if you're not really motivated then you're just doing it and you're not taking it home." Ella also described how her motivation level impacted therapy:

I think it helps me improve a lot because I'm more motivated to practice like use the strategies I have so like if I wasn't that motivated to come and like practice and all that stuff I don't think I would be getting better.

Max noted that his own personal level of motivation was important because it kept him engaged and allowed him to glean more from his participation in fluency therapy:

I feel like if you're, or if you like something.... Well I like this... If it, if you're happy about something that it easier to do more with it. Like I hate science class so I don't do anything in science class really.

All three participants were in agreement that their personal level of motivation to achieve fluent speech allowed them to engage better, learn more, and more successfully generalize skills learned in therapy than had they not been motivated.

**Practice.** Practice emerged as a strong theme with all participants contributing with multiple statements each about practice. It was important to the participants to contribute to the therapeutic process by practicing what they learned in therapy. This was evident when participants were asked how they could impact therapy in both a positive or negative manner. When probed to explain what she could do that would negatively impact therapy, Ella stated, "I wouldn't be willing to try my strategies and you know practice my strategies in the real world kind of like I probably would just forget to do it

because it wouldn't be that important to me.” Additionally, Adam commented that different therapy session structure types affected how motivated he was to practice, thereby affecting how much he practiced:

Adam: I don't think it affects the outcome of, I mean overall, but from week to week when you come in I think if it's more structured like you feel like you have to practice more home too.

Researcher: Oh, if it's more structured?

Adam: Yeah, because then you're thinking that this I'm working on while I'm reading I'm bouncing or whatever then you go home and do that, it'll work just as well. Then if therapy is more, if it's more conversational then you feel like you can kind of work with it a lot more easily.

Adam also mentioned his preference for varied methods of practice using his speech strategies with the SLP in therapy, and how his comfort level with his SLP impacted the efficacy of practicing his speech strategies:

Adam: Yeah I think the good mix between like going hard and trying to work really hard for a long time like in trying to improve my speech, like a good mix between that and just talking. And I mean trying, trying to work things in there and help make that work but just a good mix between like casual and strict practice. I'm not sure that made sense.

Researcher: Yeah, okay. No, that makes sense. Why do you think that is the best?

Adam: Because you get kind of a taste of, um, you get kind of both like an interaction between you and someone that you don't know, between that and also practicing on your own. Like its easier to practice in conversation with the therapist than it is someone else but it's harder to like read and do different things like that with a therapist. Like if I'm just alone reading it's not hard I can do it it's not hard because I don't really care if I stutter.

Researcher: So there's less pressure?

Adam: Yeah, I mean not, like it compared to like the real world. It is very similar to being alone but it isn't quite to that level.

Max also noted that practicing his speech strategies was the best way to contribute to therapy and improve his fluency. When he was asked what he did to get the most out of

therapy he provided the following response:

The practice and the repetition. I just like coming here it's like you have to do the stretches so when you're coming out you're just still kind of like doing them which is kind of like automatically kind of. So it's just kind of the intensity, not the intensity but the intensive use of strategies.

The three adolescents all noted that their biggest contribution to fluency therapy was consistent practice in a variety of settings, which allowed them to gain the most benefits from therapy.

**Functionality.** Both Adam and Max indicated both their personal investment and overall progress in therapy depended upon its functionality. Adam commented, “I think it’s more effective when you are doing something that you would normally do.” When discussing the importance of practice, Max explained in multiple ways why he felt that practice was important and functionality was essential to practicing. He felt that the functionality of what he learned in therapy helped him to invest in the therapeutic process:

Max: ...It’s kind of like whoa I can use this.

Researcher: How did that come to be? How did you have that little mini epiphany?

Max: Actually I remember that it was in class. It was second grade and I was, I raised my hand to answer a question and I kind of got stuck at first and I was like, hey, stretches. And it was kind of like boom. It was just a great moment.

Additionally, he explained that the functionality of the strategies he learned in therapy allowed him to practice more and increase his competence with these tools:

Max: ...I was kind of joking around, we were talking in algebra class, we were like when are we ever going to use a quadratic equation in a grocery store or like when we’re just walking around.

Researcher: You’re not.

Max: Exactly, so how is it life applicable? So I feel like this really is and that's really great and I want to learn more because it is.

Researcher: So it keeps you invested in it?

Max: Yeah.

Researcher: Okay, what do you think you would get out of it if it wasn't applicable?

Max: I would probably learn a pretty cool skill but would never want to use it.

Researcher: Okay, how do you think that would impact your speech?

Max: I feel like it would not improve.

Researcher: Okay, if you did have something that was applicable and you could transfer it to your actual conversations that you have?

Max: Yeah, because if you were doing quadratic equations in the grocery store every single time you're there, you'll probably get pretty good at them and know how to do them pretty well but you don't so yeah, I feel like having that application makes it really nice.

In summary, the functionality of skills learned in therapy is critical in that it facilitated a transfer of said skills to communication settings outside the therapy setting and provided a source of motivation to work hard to achieve fluency.

**Speech-language pathologist trusts adolescent.** As trust was said to be an important part of developing a therapeutic alliance, two participants noted that their SLPs also needed to be able to trust them to demonstrate their personal investment in therapy. Adam emphasized the importance of the SLP trusting the adolescent in therapy when he stated, "I think you have to let them know that like you really want to work on it too, that you're not just there because someone told you to be, like you're there because you want to be." Max also expressed a similar sentiment regarding his SLPs' trust in him related to fluency therapy, "I guess she trusts that I will work on my speech and um exercise my

speech as much as I can and the best I can.” Both participants demonstrated a feeling of personal responsibility to show their SLPs their level of commitment to fluency therapy.

**Attitude and perception.** Each participant expressed their thoughts on the attitudes and perceptions that surround therapy and occur through effective therapy.

When discussing how his perception of the SLP and his therapy sessions with her impacted his investment in therapy, Adam explained his thought process:

Adam: I think you have to walk into it thinking okay I’m going to do this. Like you’re not walking into it thinking I’m not sure about this. You can’t or else it, I don’t think it will be as successful or as fast.

Researcher: Okay, um, what makes it hard to get to that place where you walk in and you think okay I’m gonna do this?

Adam: Just like your self-motivation level because I think that with anybody they want to help you, right? So I think at that point it’s just you because they’re probably just thinking they do this all day. They see different kids all day because it isn’t a big deal to them. I mean I wouldn’t know but that’s what I would think. But for the person who’s actually doing it, they only work with one person.

Researcher: Yeah, that’s like your only person that you work with.

Adam: So, just figuring out that like they do it too is a little hard but that kind of eases it a little bit I don’t know.

Max, when asked what he does that helps make therapy to be more effective, made a connection between her attitude and progress in therapy: “like positive attitude equals moving forward and moving forward equals positive attitude.” Ella also commented on what she did to enhance fluency therapy’s effectiveness, “Just have a positive attitude and it is...if I come in I don’t like want to try anything new or practice it I probably wouldn’t do it like I wouldn’t try my best.” Ella also noted that her SLP’s attitude influences her own and affects how she engages in the therapeutic process:

Ella: I think having a positive attitude definitely helps because it makes me have a positive attitude on stuttering and trying all these new things out and yeah



practicing my speech.

Researcher: Okay, why do you think it has an impact on all of that?

Ella: Because I mean if she's kind of like down about it I don't think I would be like, I would probably be down about it too like oh here we go again and practicing my speech.

She went on to further explain what an individual with a negative attitude should do and why:

I guess because you could say I mean I'm pretty positive about it but if there is somebody who had a negative attitude they should probably talk about it with their therapist and try to figure out some way to like make therapy fun and like practicing like fun.

Overall, the participants expressed the importance of their and their SLPs' positive perception in regards to their ability to invest themselves in therapy.

**Enjoyment.** The two younger participants expressed strong opinions that fluency therapy needed to be enjoyable in order for them to feel invested. Max explained how he felt that a therapeutic alliance allowed him to enjoy therapy more and invest himself in the therapeutic process:

Max: I guess sometimes we kind of just like goof around browsing the web for like something stupid or goofy still like using strategies and having small talk along the way but just without that relationship it would be hard to have that level of goofiness and funness.

Researcher: Okay, and that's important to you?

Max: Yeah.

Researcher: Okay so what do you think therapy would be like if it was more serious because you brought up a fun and goofy thing a lot and I'm just curious?

Max: Yeah. I feel like it would be another class in school. It's just a teacher who's teaching the stuff, here is your homework, see you tomorrow. Like I feel like it's still a learning place but it's not like of school class where you don't like going to it.

Researcher: Right. How do you think that would impact what you got out of it if it was more serious?

Max: I feel like it would get as much out of it because I wouldn't be as open to it.

Researcher: So, having that goofiness and level of fun kind of I don't know gets you to buy in a little bit.

Max: Yeah.

At another point in the interview, Max reiterated the importance of enjoying therapy:

Max: I guess it's usually pretty fun so I guess it's probably pretty important. Um, because it kind of makes it like an open, a more open learning environment I guess. I suppose if it's more fun it's easier to learn in some ways.

Researcher: Okay, if it's more fun it's easier to learn?

Max: Yeah, just an easier environment to learn in.

Researcher: Okay, why do you think that is?

Max: Um, it's not as pressured and then like its, you're not... what am I trying to say? It's, you're wanting to learn I guess and so it's fun and you're, it's you want to learn more, it's easier to want to learn more. If that makes any sense.

Researcher: No that makes total sense.

Max: Um, as opposed to like a, more like a strict environment where it's a little more here is what you do, do it now kind of thing.

Ella similarly stated her opinion as to how important having fun in therapy is to her level of motivation, "Yeah I think so. I think since I am, since I like coming here helps me because I think it's like fun and stuff because we just like play games and talk and it's like pretty fun so." Along the same vein, Ella noted:

I feel like, like when you're doing like games and like talking and stuff you don't notice that you're like practicing or like, like yeah but you are and it makes it like fun so you're not like ugh I have to do this so that you like improve in a fun way.

Ella's statements in both her interviews focused on the importance of her enjoyment of therapy and it should be noted that she reiterated this point in several separate statements.

Overall enjoyment of therapy was main priority for the two younger participants, particularly as it facilitated their investment and learning in therapy.

**Therapy leads to feeling productive and not alone in stuttering.** Although Max was the only participant to make statements from which this theme emerged, his strong feelings on the matter were present across his interviews. In one such statement when Max was asked why it was helpful to learn about stuttering he said, “It's um I mean just knowing why something happened it just makes it easier. You stutter but no one knows why like, but just kind of like knowing that there is a reason is just nice to know.” Later Max commented that therapy had been effective for him “because it's taught me how to help my speech and like the applications for that but also like yeah I guess that's probably the biggest part but it's also like somewhere to go to.” He also explained to that fluency therapy has been “a pretty positive thing. I mean yeah in some ways it's kind of a confidence thing, like just something to direct it towards I guess. Or like have...what are the right words...um...yeah it's just good to know that there's always hope out there I guess. I don't know something to do for it.” Max emphasized that the act of engaging in therapy as well as learning and commiserating with the SLP was beneficial in and of itself.

**Summary of theme I: Adolescents' investment in therapy.** All participants stated that their motivation to increase fluency allowed them to better engage, learn more, and more successfully generalize skills learned in therapy. The three adolescents felt that they contributed to fluency therapy through consistent practice in a variety of settings, allowing them to reap the benefits of their efforts and the therapeutic process. Moreover, the functionality of skills learned in therapy is important to participants as it facilitated a

generalization of those skills outside the therapy setting and motivated them to work hard to achieve their goals. Participants also expressed feelings of personal responsibility to demonstrate to their SLPs their investment in fluency therapy. By the same token, they expressed that both their SLPs' and their own positive perception of therapy was important to be able to invest themselves in the process of therapy. Overall enjoyment of therapy arose as a significant theme for the two younger participants, especially Ella, particularly because enjoyment provided a more desirable learning environment and created therapeutic buy-in. Max felt that he benefited simply from engaging in fluency therapy as well as learning about and taking action against stuttering was beneficial above and beyond the therapy employed by the SLP.

### **Theme II: Trust in Speech-Language Pathologists Important**

While analyzing the data, it became clear that all participants in the study felt that therapy was influenced by their trust in the SLP. This emergent theme addressed research question two in that it focused solely on the clinician factors that impact the development of a therapeutic alliance. The participants emphasized particular subthemes, including the SLP's ability to adjust therapy as needed, educate adolescent clients about stuttering, and push them to work hard in therapy. At one point in the interview, when discussing different common clinician factors that facilitate the development of a therapeutic relationship, Adam chuckled and stated that his clinician was "really good at what she does...so I trust her."

**Competence.** All of the participants commented on their expectation of clinician knowledge related to several aspects of fluency therapy. As evidenced by Adam's

statement, the participants did not feel the need to test their SLPs' competence and were assured of the SLPs' confidence after minimal demonstration of their knowledge:

I don't think you have to gain trust for a long time. I think if you like go in there for the first two weeks and you just feel like they know what they're doing then I think it's just easy to fall into what they're doing.

Ella expressed a similar sentiment when she said "so you have to kind of like trust them to know what they're doing." Max conveyed that he preferred an SLP demonstrated their competence overall "in some ways everything just knowing the strategies, just knowing how to use the strategies when you're talking to someone." It was important to all participants that their SLPs demonstrated overall competence in order to develop a sense of trust but it was not critical for them to have SLPs prove themselves.

**Speech-language pathologist invested in therapy.** All the participants wanted to know that their SLP was as invested in their fluency therapy as they were. Each participant expressed this desire in a different way. Ella explained that for an alliance to form she "want[ed] to feel like [the therapist] like cares" in order for a positive therapeutic alliance to form. Max expressed a similar thought, stating "I trust her that she will ... keep working with me and keep trying to help me progress." Adam commented on the need for an SLP to invest in fluency therapy and demonstrate that to adolescent clients, but differentiated between what was necessary and what was simply preferred:

If the therapist is dedicated, if that's the right word, to find something that works and they're just trying different things the personal relationship I think is just like an add on. Like if they really want to help you but they aren't on that super personal level I think it's just fine... But if it's kind of like a halfhearted thing where they are just like balancing all of the kids they have are people they have coming in therapy then that's when it doesn't work.

While Adam did not feel that a personal relationship was necessary, he did note that he needed to feel like his therapist was present, engaged, and invested in his therapy beyond

the bare minimum. Each of the participants expressed the importance of and their personal definition of the investment of their SLP in fluency therapy.

**Safe environment.** All three participants stressed the importance of fluency taking place in a safe environment, which was presented to be the responsibility of the SLP. Ella explained that she felt safe in her environment when it felt free of judgment and she was comfortable being vulnerable with the SLP: “I know I can be vulnerable around her and she won't like judge me.” She later added the component of trust to be included in her rating of a safe environment when she said, “Like being able to trust them ... just them kind of like not pointing out all your mistakes in trying to correct them. Like letting you try and correct yourself but they are still there and help.” Additionally, Ella explained that an SLP’s patience played an important role in the development of a safe environment:

Ella: ... if I was like teaching someone techniques and stuff I wouldn't like to be able to do what she does which is like let me try and stuff....

Researcher: So, the fact that she lets you...

Ella: Try and mess up and not like point it out and stuff. She just like helps me, like here's what you can do next time.

Max added to this theme by stating “a safe environment to kind of work in as well just makes [fluency therapy] more comfortable and easy.” Over time, Adam was able to become more comfortable with SLPs in general, whereas the other two younger participants were still developing a comfort level with each individual SLP. Adam explained how he was able to make this adjustment over time:

I think now it's a little easier than it was a couple years ago but I feel like I don't know it's kind of ... a pressure to impress the person like make them think he's doing well. At this point I don't care I can just do it. I'll walk in and stutter through the whole thing I don't care.

Overall, the participants expressed that a safe environment is an important component of the development of a therapeutic alliance and is based on the trust in, patience of, comfort with, and nonjudgmental demeanor of the SLP.

**Adaptive therapy.** Two participants expressed opinions as to the adaptivity of fluency therapy and its importance to them. Max detailed how his therapy has changed over time as his needs have changed:

So like once I had the stretches down then it kind of moved toward the rate thing and the speed because that was kind of a big thing of like if you talk really fast then you're gonna stutter more so.

Adam provided some description of how an SLP should go about making fluency therapy adaptive for adolescents who stutter:

...I've had things work I mean we've, I've had things work for the first time and then a couple times after that so obviously on the first time you realize that it worked so once you find that thing I think you gotta then kind of stop, not stop but ask them questions and then try to figure out if that is what you should be doing for a while.....and then be open for change.

Additionally, as Adam discussed his IEP goals, he showed frustration with their rigidity and desire for more adaptivity:

Adam: ...Since I have an IEP like you sit down at the beginning of the year and just set goals and those goals aren't really very flexible. No. So like it feels like you're working on the same goals even if your needs have changed.

Researcher: Okay, yeah.

Adam: Because the goals I have right now I can do like they're not, or it's something that I'm not really working on in private therapy because private therapy changes all the time, which is good.

Researcher: Right, as fast as you change.

Adam: Yeah.

Both participants who contributed to this subtheme felt that therapy, and by proxy their therapeutic alliance, benefitted from adaptability and regular adjustment to their ever-changing needs.

**Speech-language pathologists push adolescents in therapy.** All three participants expressed appreciation for being pushed in their use of fluency strategies and risk-taking with speaking. Max told the researcher that being pushed motivated him to work harder both during and outside of fluency therapy sessions:

Max: Yeah, and I felt like [my current SLP] got a little more serious when she needed to be serious a little more buckled down whereas [another SLP] never really had that.

Researcher: Okay, why was that important?

Max: Um, it kind of gave a little more motivation, a little more I've got to get to there before here.

Max further commented on his SLP's ability to push him appropriately hard in therapy to ensure that goals were targeted and he was achieving all that he could during a therapy session: "...she is serious when she needs to be serious like when um we just need to like nail this one strategy for like this one word or thing and then like goofy when it's lighter." Adam noted "If you're really close with the therapist I think they can push harder" when discussing how the therapeutic alliance influences the how much an SLP can push an adolescent to work and take speech risks both inside and outside of the therapy setting. Ella also explained how she pushes herself in therapy through taking risks with her speech, "I mean you kind of have take risks to be in therapy I guess to try out on a normal day basis." The participants developed this subtheme by expressing their thoughts that therapists need to push adolescents in therapy because it is motivating and necessary for therapy to be effective.

**Education.** Two participants also noted that they trust their SLP to educate them on the attitudes and emotions, and particularly the physiology of stuttering. In a description of what his SLP did to help therapy be as effective as possible Adam stated,



Like every once in a while when there's something you are working on, like [my SLP] will kinda bring up like how something works like technically and kind of mentally. I mean stuff like that ... I think really helps me just like to know ... that's making it better like how it works that is making it better like what I'm doing that affects this that's making it better.

Max felt it was important to learn as much as possible in speech therapy because “it is a learning environment.” Moreover, in a comparison of two SLPs, Max expressed his preference for a more educationally in-depth therapy session rather than simply practicing previously known skills: “I know I learned a little bit more and kind of had more things to work on next time whereas here it was just kind of more like practice.” Furthermore, when Max explained that education regarding the physiology and psychology of his speech was important because:

Because then ... it's easier to ... have in your brain to know that there's a reason behind it. It's not as like, you're not just kind of like staring into an abyss of like what is this. Like I know I stutter but why? Because it's less ambiguous, you know there's a reason behind it.

It was important to two participants that they learn from their SLPs during fluency therapy sessions in order to feel motivated as well as better understand how stuttering physiologically occurs and how their behavior impacts their fluency.

**Summary of theme II: Trust in speech-language pathologists important.** The participants expressed their desire that their SLPs were knowledgeable in fluency overall so as to allow adolescents to trust them in therapy, but they did not feel that SLPs needed to extensively prove themselves. Furthermore, all participants felt their therapy benefitted from their SLP's investment in their fluency therapy and what that investment looked like. The participants expressed that a safe environment is an important component of the development of a therapeutic alliance and is based on trusting the SLP, patience of the SLP, comfort with the SLP, and a lack of judgment by the SLP.

Participants also felt that therapy and the therapeutic alliance was better due to their SLPs' efforts to constantly adjust fluency therapy to their needs. The participants also expressed their thoughts that SLPs need to push adolescents to work hard and take risks with their speech both inside and outside of therapy because it is motivating and necessary for therapy. It was important that participants learned about stuttering from their SLPs as it motivated and helped them to better understand how stuttering physiologically occurs and how their behavior impacts their fluency.

### **Theme III: Partnership & Collaboration in Therapy**

The third emergent theme was in regard to the partnership and collaboration necessary for adolescent fluency therapy, and which was supported by several subthemes and addressed the third research question. This theme focused on positive interactions that not only took place between the adolescents and their clinicians to grow or strengthen the therapeutic alliance, but also led to the development of trust in one another. Regarding the therapeutic alliance, Adam described how he felt an adolescent and SLP could work well together:

Adam: I think if both people are just collaborating and trying to get something done then I think that works.

Researcher: Yeah, okay. So how do you, and we've talked about this a little bit, how do you feel that having a sense of trust between you and the clinician helps build that working relationship?

Adam: I feel like just like with any partner you have like where you're working together at work or whatever and if you just realize that they're there to get it done too and that they know what they're talking about just as much as you think you do too it's...I think the working relationship is pretty good.

Max also stated, "I guess she trusts me that I'll try to use my stretches and my strategies when I can and I guess I trust her to help me through when I can't."

**Open dialogue.** This subtheme arose as a particularly strong one with multiple statements emphasizing its importance across all the participants.

Adam acknowledged that it took him time to become comfortable enough to contribute openly to the dialogue between him and his clinician. He also notes that an open dialogue and development of a therapeutic alliance occur simultaneously:

I think that ... it becomes a point that if I think I need something from them that they're open. I mean if they're trying to build a relationship with me I figure out that if I need something they're open.

During his interview Max became very animated when he provided an example of how open dialogue had helped him and his SLP to develop a better relationship, therefore leading to more effective therapy:

Max: Like if she knows how I was feeling about this one thing then I guess then she must know me a little bit better then I guess. And I guess she kind of like starts to formulate patterns around like how my...there was something really cool it came up. It's a little bit random to the question but um she figured out that every time I get in a play my speech always gets bad and I always set up an appointment with her. So that kind of thing where she like knows what's going on in my life and she kind of like makes the connections that we she can like see what's making it go down a bit...

Researcher: Does she make those before you do?

Max: Yeah. Definitely.

Researcher: That's interesting. Okay do you feel like that helps your therapy?

Max: Yeah.

Researcher: Okay, why do you think so?

Max: Um, I guess then because then to like narrow in on things for me and it's not just me who's like having to do all the work I guess, not all the work but like at some degree it helps me to like initiate, like doing my stretches in all my strategies that she can recognize when to do that. It's really helpful so yeah.

It should be noted that statements by all participants related specifically to the open dialogue that occurred during the formulation of common goals between themselves and their SLPs. Adam explained how he and his SLP discussed finding common goals to target in fluency therapy:

I've kind of tried that I told them this is what's happening and this is kind of what I want to happen and they either kind of help me with that or they just kind of guide me in the right direction.

Max made a similar statement regarding the development of common goals for his fluency therapy when he said, "I guess when you talk about like where you want your speech to be in the next month or like what you want to focus on I guess and like really like try to work on I guess." Ella made similar points, with the addition of how it is also a critical check in:

We I mean in the beginning we talked about how to, what my goal was and stuff and basically where like in the beginning of the sessions we just like talk about like how I'm doing and stuff how can I like improve on like that situation if it ever happens again you know like kind of have my strategies and like use them and stuff.

Altogether the three participants communicated that an open dialogue was essential to develop a therapeutic alliance, particularly as it related to goal selection and targeting.

**Independent communication.** This subtheme arose from comments made by two participants in which they emphasized that it was important that they collaborate with their SLPs to work toward independent use of what they learn in therapy when their SLP is not present to help them communicate. Ella succinctly stated her feelings regarding the importance of an SLP facilitating independent communication: "You are not going to have them by your side like every second that we talk." Adam provided information regarding what he felt his SLPs had done to help him communicate better in general and

his immediate answer was focused on how his SLPs had helped him communicate more independently:

Adam: I think this is, I've learned this by myself and with the help of some of my therapists, but I've learned for example just as an example with teachers like I've learned how to kind of work it in a way like I can communicate with them where it's easiest for me. Like I don't think anything that I do is a huge bother to them but I think I've kind of made it work to where I get what I want like in terms of like talking to them and in terms of like, I'm not really sure what I'm saying, but like how our communications kind of work.

Researcher: Like the conversations and...

Adam: Like if it's alone or in front of people or like and if it's through email and in person obviously.

Researcher: Right, so you set up the situations so that they reduce the stress for you?

Adam: Like my therapists kind of gave me the idea of trying to kind of work with that and kind of utilize different kinds of resources to kind of talk to teachers and stuff, but I think over time I've kind of... I think I've made that work pretty well.

When the researcher asked Adam to discuss anything that his SLPs have done to hinder therapy, Adam became slightly uncomfortable but clearly had an opinion on the matter. He expressed some frustration at the times when SLPs did not allow him to communicate as independently as he desired:

Adam: Um, like nothing against speech therapist but like if they do it for you and it's coming from a speech therapist it's kind of like alright, I mean I could have done that but that's fine. I mean like I didn't have to do it but, I don't know it's just...

Researcher: What's an example of that so I can picture it?

Adam: Like they haven't really had too many examples of that but let's just say if there was a teacher, sorry I keep using that example but... Let's just say if there is a teacher that was really getting, wasn't really understanding what I was needing and then like a therapists kind of intervened, it would kind of make it a bigger deal than it is. Like something coming from a speech therapist so it must be a big deal. Kinda just like if it was just me I could have just said like hey I need you to do this for me or not need to do this but this would be really helpful.

Researcher: Yeah, like this might work better than what you're doing now?

Adam: Yeah. That would just make it like they would either go all okay or let's discuss another way to do this but if a speech therapist kind of intervenes then it's like oh this is a really big deal when I, when it could be but I don't really want to make it seem that way.

Both Adam and Ella expressed their goal of communication independent of their SLP and their appreciation of an SLP who encouraged and allowed them to communicate independently.

**Summary of theme III: Partnership and collaboration.** While this theme only contained two subthemes, these subthemes were very strong and demonstrated the participants' emphasis on partnership and collaboration. All the participants emphasized that an open dialogue was an important part of developing a therapeutic alliance with their SLP, particularly with selecting and targeting goals for therapy. Two participants also expressed their desire for an SLP to facilitate independent communication and their appreciation of an SLP who encouraged and allowed them to communicate in this way. These participants indicated that allowing for and promoting independent communication was an important part of the collaborative partnership of fluency therapy.

#### **Theme IV: Building a Therapeutic Alliance**

Another emergent theme that surfaced was related to the therapeutic alliance and its development between the adolescent and the SLP. The third and fourth research questions were addressed in this theme in that both negative and positive interactions were brought to light regarding the formation of a client-clinician relationship. The building of relationships takes time and consistent interaction according to all the participants, although the amount of time it would take to build a relationship varied

across participants. Ella estimated that she could develop a comfort level and beginnings of a therapeutic alliance in “probably about a month.” Adam differed when he explained that “to get on that level where you're like trying to improve yourself in front of her that would be a couple of weeks probably.” This time frame was considerably different from Max who stated that it would take him “probably with pretty like regular sessions probably like a couple of months.” Max also explained how time and regular interactions have led to the therapeutic alliance between him and his SLP when he said, “I guess just like the consistency of being like if you see someone every week for like five years you’ll kind of get a relationship with them.”

**No perfect speech-language pathologist.** This subtheme emerged when the researcher prompted participants to compare and contrast their clinicians, which led to discussions of all the details of each SLP’s therapy styles that the participants preferred or disliked. When Max discussed working with different SLPs, he commented that each SLP targeted “maybe the exact same strategies but I guess just take the approach was a little bit different with everybody I guess. They just have different styles.” Adam was asked to imagine and describe the perfect SLP to work with and he stated the following:

I don't really think there is one. I mean I know that sounds kind of deep but I think that is how it is. There's... Like take [my SLP], she's honestly really good at what she does and I've found a lot of success but there are other SLP's who could, that I could probably find a good amount of success with too, so it isn't like there is one type of thing that kind of works for me. It's kind of weird because I think... I don't think there's one thing that works for everybody and I don't think that everybody can find success with one thing either.

Adam also described the differences between SLPs and how that affected his fluency therapy:

Adam: I mean I think it just depends on the personality, like if the person’s more talkative you get more like just talking about how your day was. I mean that also

means you can work on your stutters doing that obviously but some of it is more, I mean, some therapists do it more structured like reading it and then we're doing this and then we're doing this and some are just more based off conversation.

Research: Okay, do you have a preference one way or the other?

Adam: Um, I think a mixture of both is good because you gotta know how to do it in conversation but I think the structured part is good to help you like build a foundation.

Adam also explained an example of how a stressful situation arose for him and his SLP attempted to alleviate the stress but was not successful, but he understood and appreciated her efforts:

Adam: I think what I was thinking was that it was helpful in the moment like it would take all the pressure off getting up there and talking in front of everybody but in the long run it was the same thing like I would be like if I didn't do it or if I showed the video everybody would be still be looking at someone else reading it like not me. Like all the other kids did it I didn't. So I was thinking there isn't really a way to do this well without me just doing it, which I didn't really want to do.

Researcher: Right, because you weren't ready at that point.

Adam: Yeah, so I was just thinking that whatever makes it easiest for me at this point I want to do.

The above information indicates that adolescents do not expect perfection and understand the nuances of different SLPs and how those impact fluency therapy, even in the face of frustrating situations such as Adam's.

**Sharing personal information.** The participants were in full agreement that the development of a personal relationship was improved when each party shared some personal information and showed interest in the other's life, while still keeping professional boundaries intact. Adam explained how important it was to the development of a relationship that his SLP inquired and cared about his personal life, "Here I come in and think it is also their job to work with you but they care more about like personal stuff



and about like how things are going everywhere else.” Ella described the process of getting to know her SLP, “I just kind of like getting comfortable with each other I don't know. Yeah and yeah pretty much just like it's kind of like sharing stories I guess.” She expressed similar feelings to Adam about her SLP asking about her personal life and the effect it had on her interaction with that SLP. She mentioned that she and her SLP talked about their personal lives at the beginning of the session, “She just like in the beginning kind of like a check she will ask me how's school going, how was your weekend, what did you do?” She went on to explain how therapy would be impacted without that “check:”

It would probably be a little bit more...I probably wouldn't be like as open because usually when I meet people for like the first time I'm kind of shy and then I'm like, I don't know I open up more.

Ella emphasized the point that building a relationship with an SLP as she outlined above “kind of makes it like normal just like hanging out or something,” indicating that building a relationship with an SLP needs to be similar to what would occur with any other adult. Max also appreciated a comparable interaction with his SLP, who showed her personal investment by attending his extracurricular functions “I guess she like knows what's going on in my life, like she comes all the school plays and all that kind of stuff so yeah it's not just like a therapist.” Max mentioned that in addition to simply asking about his personal life “as like practice too she [said] tell me about your day or your week or your class schedule.” He found it important that his SLP used the time during which they were sharing personal information and developing a relationship as an opportunity to practice different speech strategies. As was previously stated, adolescents sharing of personal information and perceiving that an SLP cares about them on a personal level

was integral in the development of a therapeutic alliance.

**Positive experiences lead to therapeutic alliances.** Two participants made a connection between the positive experiences that occurred as a result of therapy and the therapeutic alliances they developed with their SLPs. Ella discussed how success with her fluency (i.e. development of more fluent speech) both in and out of therapy sessions gave her confidence in her speech:

I think also like gaining more confidence. I don't know I feel like when you talk with um techniques it like helps your confidence because you know like when you get stuck on it you go oh I can do it.

Ella later elaborated that “[my SLP is] like helping me get to yeah get to like my goal of smooth talking” when discussing how successfully working toward a common goal helps to build a relationship. When commenting on the successful development and discussion of common goals and treatment targets, Adam noted, “I think that kind of builds the relationship because I think kind of through that you just kinda learn more things about each other.” Both Ella and Adam remarked on how their therapeutic alliances were built on positive interactions in therapy and gaining confidence through the success of therapy.

**Therapeutic alliances lead to more effective therapy.** This emerged to be a strong sub-theme with all the participants providing multiple statements each in relation to therapy effectiveness being improved with a therapeutic alliance. When asked to discuss the effect that a therapeutic alliance has on therapy Ella expressed her opinion on its effects on generalization of skills to untrained contexts:

Because I mean if it was like a stranger and I was practicing or I didn't like my therapist I would probably wouldn't be as motivated to like try and stuff. But since I do it's like fun to practice and um yeah just... Yeah it's like a fun practice because they just seem like a friend and so then when you go with your friends and stuff it's like nothing new.

Ella also stated that she thought “it help[ed] because I’m more comfortable with her and it helped because I’m not like scared to try new things out and mess up yeah because she’s pretty supportive.” Correspondingly, Max felt that due to his therapeutic alliance he was able to receive more targeted therapy, particularly regarding attitudes and emotions:

I guess like how like she can like read my emotions little bit better, kind of like I don't know it was just like a little bit more difficult with them in that way, in some ways. You're like not really sure where is, what, how to like act with them in some way as far as...should I get frustrated or just kind of like keep it in or just yeah or be like laughy or...

Additionally, Max stated that having a level of comfort between him and his SLP allowed him to be more natural in his stuttering, thereby helping the SLP to better target issues specific to his stuttering. Similar to Max, Adam also commented on how a therapeutic alliance with his SLP impacted his behavior in therapy:

I think, I think now it's a little easier than it was a couple years ago but I feel like I don't know it's kind of more of like a pressure to impress the person like make them think he's doing well. At this point I don't care I can just do it. I'll walk in and stutter through the whole thing I don't care.

Specific to the discussion of attitudes and emotions, Adam explained how he felt having a good therapeutic alliance helps facilitate that conversation:

I think if you bring up once in a while then I think it's really helpful. Like I'll give a presentation and it won't go that well and all come to therapy and she'll ask how it went and I said not good. I'm not sure if it, I think it seems this way and I think it is true, I think I'm pretty hard on myself so I mean [my SLP] will say don't be so hard on yourself, give yourself a break and I'll be okay and I'll just than I'll keep thinking about it. But I think it takes the person that you're really comfortable with to bring it up and actually improve it and just say don't be so hard on yourself like that.

The development of a therapeutic alliance was noted to be beneficial to the effectiveness of therapy in that it facilitated the production of more natural stuttering patterns, faster

generalization to untrained communication settings, and better targeting of attitudes and emotions surrounding stuttering, all leading to more efficient fluency therapy.

**Fluency therapy in the school setting.** While only one participant spoke to it, this theme arose from multiple statements involving school-based fluency therapy. Adam had not been able to develop positive therapeutic alliances with school-based SLPs or experience success with school-based fluency therapy. Adam commented that he had found that he “didn’t make consistent progress” in a school setting:

I wouldn't say that I hated it and I wouldn't say that they're as good as private obviously. I mean I'm not sure if it's obvious. They aren't... I think they're pretty good at what they do in the experience that I've had but I think that private therapy is a lot more helpful.

Adam went on to explain that he preferred private therapy due to minimal adaptivity of school-based fluency therapy as well as an overall lack of personal interest on the part of said SLPs.

I have an IEP. Like you sit down at the beginning of the year and just set goals and those goals aren't really very flexible. No. So like it feels like you're working on the same goals even if your needs have changed...Because the goals I have right now I can do like they're not, or it's something that I'm not really working on in private therapy because private therapy changes all the time, which is good.

Adam also felt that school SLPs showed an overall lack of personal interest toward him:

They would just be asking how, like how it was going in school and like how I was handling certain situations AT school and what I was doing to make it better AT school and just like, I don't know, just like the overuse of, not the overuse but the over focus on school.

The above point was reiterated when Adam made a comparison between his private and school SLPs:

The school SLP's I don't feel like really care a lot. I mean I don't want to sound mean there, but I feel like that isn't what they're there to do. But like [my private SLP] she's there to like help me with everything surrounding [stuttering].

When prompted to explain what all he wanted his SLPs to care about Adam responded, “other than [school] it's just more of more of an interest of like at home also and what's making [stuttering] better or worse.” Adam went on to say that he didn't feel that fluency therapy was appropriate in a school setting. When asked to explain why he felt that “the only thing that's keeping it from being therapy is just the school setting,” Adam stated:

Maybe it's because I think that this is part of the school setting but it's kind of not too. But there are people that are above the therapist telling them what to do and telling them like how long you can and cannot meet.

He did explain that he did not dislike school therapy in its entirety but said, “I still take it as an opportunity to just like practice that it isn't really anything more than practice with an SLP. It isn't therapy with an SLP it's more like practice with them.” Furthermore, Adam expressed his appreciation for his school SLP at the time of the interview maintaining continuity between private therapy and school therapy:

Like my SLP at school right now asked me what I did in private therapy that week and then we would work on that...Because I think she sees that too. Like she sees that it changes a lot. And she told me that like what she does is she doesn't want it to be any different than what I'm doing here which I think is good.

While Adam expressed some frustration with school-based fluency therapy and the lack of interest in him personally, he also expressed an understanding of how the regulatory system worked that limited what could be done in the school setting. He went on to state that he felt that fluency therapy was not appropriate in the school setting due to his perception of and level of investment in school-based fluency therapy.

**Summary of theme IV: Building a therapeutic alliance.** Adolescents do not expect perfection and understand the nuances of different SLPs and their impact on fluency therapy. One participant expressed negative feelings regarding school-based fluency therapy, noting that it was inflexible, ineffective, and inappropriate. It was

important to the participants to share personal information with their SLPs and feel that the SLPs cared about them personally in order to develop a therapeutic alliance. Two participants also commented on how the therapeutic alliances they developed with their own SLPs were built through positive interactions in therapy sessions and by gaining confidence through the success of therapy. Participants noted a therapeutic alliance to be beneficial to the effectiveness of therapy in that it prompted the production of more natural stuttering patterns, faster generalization to untrained communication settings, and better targeting of attitudes and emotions surrounding stuttering, all leading to more efficient fluency therapy. The themes and subthemes that emerged in interviews are depicted in Figure II. Theme I and Theme II addressed clinician factors and client factors respectively; Themes III and IV both addressed the building and maintenance of the client-clinician relationship.

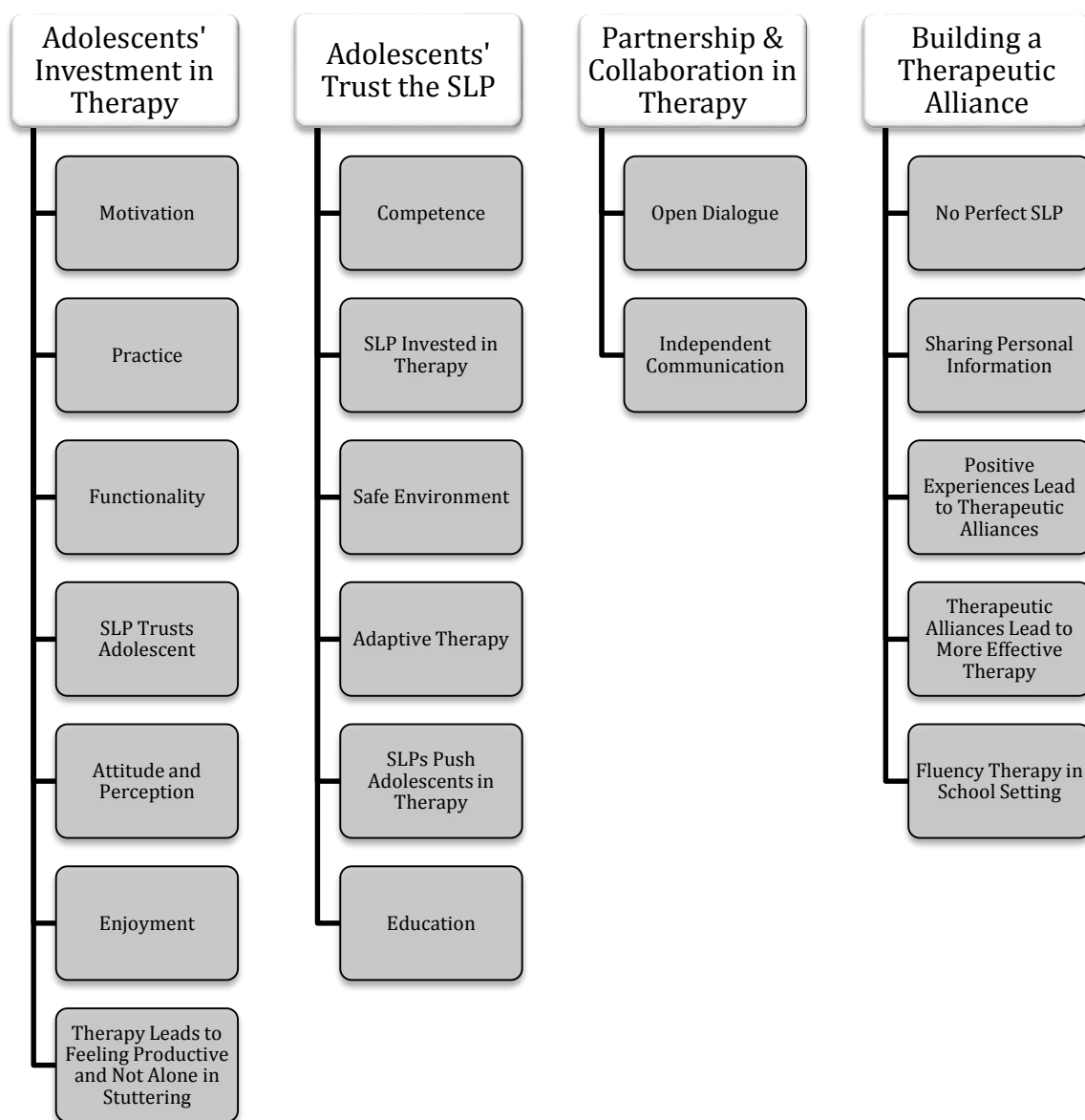


Figure 2. Themes and Subthemes Related to Adolescents' Perspective of the Therapeutic Alliance

### Summary

Four main themes were derived from the participants' interviews: adolescents' trust the SLP, adolescents' investment in therapy, partnership and collaboration in therapy, and building a therapeutic alliance. Analysis and decomposition further

illustrated their complex relationships with the adolescents' progress and motivation.

The results were a clear indication of factors that affect the development of a therapeutic alliance and the effects that alliance has on the effectiveness of fluency therapy for these participants.



## **CHAPTER V**

### **DISCUSSIONS AND CONCLUSIONS**

The purpose of this study was to uncover and understand the perceptions of adolescents who stutter regarding the therapeutic alliance they have formed with their current and previous clinicians and the impact that client and clinician factors had on the forming and maintenance of those relationships. The study was in part motivated by a lack of evidence specific to the formation of therapeutic alliances between SLPs and adolescents who stutter. This study was intended to educate SLPs as to what adolescents highlight as important for their fluency therapy and a therapeutic alliance with their SLP.

#### **Discussion of Results**

During the phases of data collection, analysis, review, and report, it became evident that there were various factors that adolescents who stutter encountered during the development of the therapeutic alliance.

#### **Client Factors**

The common factors model has been used historically to analyze clinician factors; however, this study suggests that it can be applied to clients. Client factors were accounted for almost entirely under the “adolescents’ investment in therapy” participant-identified theme and answered research question one regarding the adolescents’ perceptions of their own contribution to fluency therapy. It became easier for adolescents to invest in therapy when progress, even minor progress, was made. Participants in this

study felt an obligation to their clinicians to put in an effort equal to match that of the clinician in order to develop and maintain the therapeutic alliance. This is in line with Gurland and Grolnick's (2008) findings that the therapeutic alliance is dependent upon both the clinician and the client.

All participants in this study were highly motivated to improve their fluency, which allowed them to more easily invest in fluency therapy. The participants were intrinsically motivated, indicating that all their intrinsic needs (i.e. autonomy, competence, and relatedness) were met by the clinician in therapy according to the self-determination theory (Ryan & Deci, 2000). Based on the participant interviews, an adolescent's ability to invest in therapy is dependent upon the fulfillment of his/her intrinsic needs and, by proxy, level of motivation (Ryan & Deci, 2000).

Practice was considered to be the largest contribution that an adolescent could make to improve the therapeutic outcome. It is possible that participants felt that practice was the concrete manifestation of their investment in the therapy. Participants also considered their practice of strategies learned in therapy sessions to be dependent upon the functionality of those tools. According to the participants of this study, it was important that what was learned in therapy was highly functional and could easily be implemented into daily communication situations. Without this functionality, the adolescents found it difficult to invest in therapy or practice and did not feel like therapy was beneficial.

According to the participants, as they invested in therapy, they felt the responsibility to demonstrate their trustworthiness to their SLPs, particularly through their investment in therapy and practicing of strategies learned in therapy. Because

participants placed so much value on trust in the therapeutic alliance with their clinician, it stands to reason that they would have considered the clinician's trust in the client to be valuable as well. This theme is in line with Gurland and Grolnick's (2008) findings that both the clinician and client need to trust one another in order for the therapeutic dyad to successfully develop a relationship.

Seeing as how the two younger participants focused on enjoying therapy, it may be possible that fluency therapy needs to adjust to the different ages within the teen population. The older participant projected a more serious demeanor in which he wanted to work on his speech without the distraction of games. While not a particular focus in the literature, Manning (2006) noted that the inclusion of humor into therapy sessions facilitated development of and strengthened the client-clinician relationship as well as improved the mood of a therapy session. This mood was noted by participants to be vital to their enjoyment and therefore investment in therapy and relationship with their clinician. In addition to humor, the participants noted the attitude projected in therapy to contribute to the mood of therapy. The participants commented that they modeled their own perceptions after those of their clinicians, indicating it was important that the SLP had a positive attitude in order to invest in therapy. Blood (1995) and Daly et al. (1995) provided several recommendations for SLPs specific to the fluency therapy for adolescents in which a positive attitude is included. They suggested that a clinician model positive self-talk and self-describing, which projects a positive attitude toward stuttering and the outcome of therapy (Blood, 1995; Daly et al., 1995). This area in which client factors are impacted significantly by clinician factors implies that not all

client and clinician factors may be addressed separately as research questions one and two may suggest.

### **Clinician Factors**

The common factors model is defined as the model under which components or dimensions of treatment that are not particular to any specific treatment are integral in successful therapeutic outcomes (Lambert & Bergin, 1994). These general clinician actions are discussed below as they relate to participant-identified themes. According to Messer and Wampold (2002), the factors common across clinicians may be more powerful in determining the effectiveness of comparable therapeutic techniques, which aligns with participant report.

The participant-identified theme “adolescents trust the SLP” accounted for the bulk of the clinician factors addressed by the participants. A clinician factor is SLP facilitation of the adolescents’ perception of each of the intrinsic needs of self-determination theory (Ciraky, 2013). Martin et al. (2006) found that adolescents prefer adults to possess “helping” qualities such as openness, recognition, guidance, trust, freedom, identification, time shared, and familiarity. Martin et al. (2006) hypothesized that these findings would generalize to the clinical setting, which was an accurate assumption according to the participants of this study. All the above listed helping qualities were mentioned, though not in those exact terms, to be desirable clinician characteristics.

It was noteworthy that none of the participants felt the need for SLPs to prove themselves, but rather, they allowed a level of comfort to develop with the clinician over time. The participants believed a clinician was competent until proven otherwise; that is

to say if the SLP had not proved incompetent, the adolescents presumed he/she was a competent clinician.

Participants wanted to know that their SLP was invested in their fluency therapy would work as hard as they were working to make progress. In addition to the ability to work hard, a clinician needed to also demonstrate their focus on the client during therapy sessions. Adam mentioned his preference for a clinician to be focused on him and his therapy, which was also supported by Karson and Fox (2010) who stated that a clinician's ability to minimize personal distractions is a skill that underlies common factors.

The participants also wanted a space to work on their fluency that was free of judgment, which has been found to be an important part of therapeutic alliance formation, particularly with sensitive-tempered adolescents as those who stutter can be (Errington, 2015; Katz 1999). That is to say adolescents, including those in this study, wish to be accepted and approved of by adults who are nonjudgmental in the setting (Katz, 1999). Moreover, the participants indicated that they needed and wanted their clinicians to accommodate and/or compensate for their personality traits. The participants specifically mentioned their own personality traits for which clinicians needed to compensate in order to provide a safe environment in which they could be themselves. Katz (1999) suggested clinicians adjust therapy techniques based on adolescents' temperament.

Adolescents became frustrated when therapy did not adjust to their needs. This theme directly aligned with Manning (2006) who stated that the ability to make clinical adjustments was dependent upon clinical decision making skills, both of which contributed to a clinician's effectiveness. It should be noted that participants related a

clinician's ability to educate them to the clinician's overall knowledge of stuttering. Therapy was considered to be more productive if the adolescent left a session feeling as though they had learned something. Manning (2006) outlined that it was important for a clinician to possess the ability to provide clear and educational information, which relates directly with a participant-identified theme. The adolescents interviewed for this study emphasized that they wanted to learn about the physiology and psychology of stuttering (i.e. how attitudes and emotions affect fluency). Katz (1999) also found that adolescents desired a setting in which they can learn about themselves and their speech. This emphasis by participants and previous research suggests that a clinician's ability to educate a client needs to be a focus of fluency therapy for adolescents.

Karson and Fox (2010) posited that clients desire that their clinicians maintain professional relationships rather than friendships. In these professional relationships, adolescents are comfortable with and prefer to be pushed to achieve their best in therapy. The participants demonstrated this and an understanding that they would not work hard enough to make significant progress unless someone pushed them to do so.

Katz (1999) suggested that an adolescent client should not feel that a clinician is detached, disinterested, insensitive, or displaying signs of hostility or anxiety in order to form a therapeutic alliance more easily with that clinician. If an SLP displays the above listed qualities, an adolescent may not feel the clinician is providing a safe environment, which the adolescents involved in this study, noted to be valuable in trusting an SLP.

### **Therapeutic Alliance**

The formation of a therapeutic alliance or a "collaborative, healthy, and trusting relationship established between the client and clinician," (p. 334, Plexico et al., 2010)

was discussed extensively in interviews with participants. Ebert and Kohnert (2010) found this relationship to be more highly valued among clients than clinician characteristics. Zebrowski and Wolf (2011) along with Manning (2001) found that because of the highly interactive nature of fluency therapy, particularly the counseling component (Guitar, 2014), the therapeutic alliance was particularly important to its success. The participants of this study found this to be true as well, leading to the emergence of the themes “building a therapeutic alliance” and “partnership and collaboration in therapy.” Based on participant interviews, it was determined that as the therapeutic alliance is developing so too is the adolescents’ trust in the SLP, both of which contribute directly to the adolescents’ progress in therapy.

Open dialogue emerged to be an especially integral part of successful therapy according to the participants in this study. Interactions in therapy are dependent upon open dialogue between the client and clinician to create therapeutic opportunities and contribute to the development of a strong therapeutic relationship (Errington, 2015; Flasher & Fogle, 2012), contributes to the development of a strong therapeutic relationship. The development of a client-clinician relationship is closely tied to counseling and open dialogue in that a clinician needs to be in the process of establishing or already have in place a strong relationship (Flasher & Fogle, 2012). Moreover, Manning (2006) supported this theme in that he emphasized how important it is for a clinician to be able to express thoughts about treatment to include the client in the analysis and planning of therapy.

The facilitation of independent communication is particularly important according to self-determination theory in that autonomy is one of the three intrinsic needs upon

which intrinsic motivation is dependent (Ryan & Deci, 2008). Without the fulfillment of this need, the adolescents would feel a lack of motivation because their needs would not have been met (Ryan & Deci, 2008). The participants expressed this sentiment, reasoning that independent communication was the ultimate goal of their fluency therapy and was the reason they were motivated.

Participants acknowledged that there was no such thing as a perfect SLP and they had no such expectations. In order to develop a therapeutic alliance with a clinician, the participants noted that an exchange of personal information was required. All participants mentioned that their SLPs began sessions with this exchange of information, which meets the intrinsic need of relatedness from self-determination theory (Markland et al., 2005). It is motivating for clients to feel a fulfillment of connection with their clinician through purposeful engagement such as sharing personal information (Markland et al., 2005). As described by the participants, if this intrinsic need was not met, their well-being would not be fully intact, and their level of motivation in fluency therapy would be decreased due to a disconnect between themselves and their clinician (Ryan & Deci, 2000).

As has been noted in previous research, the participants in this study emphasized that the client-clinician relationship led to more effective therapy (Ebert & Kohnert, 2010; Manning, 2001; Zebrowski & Wolf, 2011). Success in therapy and the development of a relationship were found to be mutually beneficial. Participants noted that positive experiences such as progress in therapy facilitated the development and maintenance of the therapeutic alliance, which aligns with findings by Copper et al. (1972). In their research, Cooper and colleagues (1972) found that there was a



relationship between the formation of a positive therapeutic alliance and a client-clinician pair in which the client made measurable progress.

Figure III provides a framework for the discussion of results and takes into account the reciprocal relationships between different factors that occur during the formation of a therapeutic alliance.

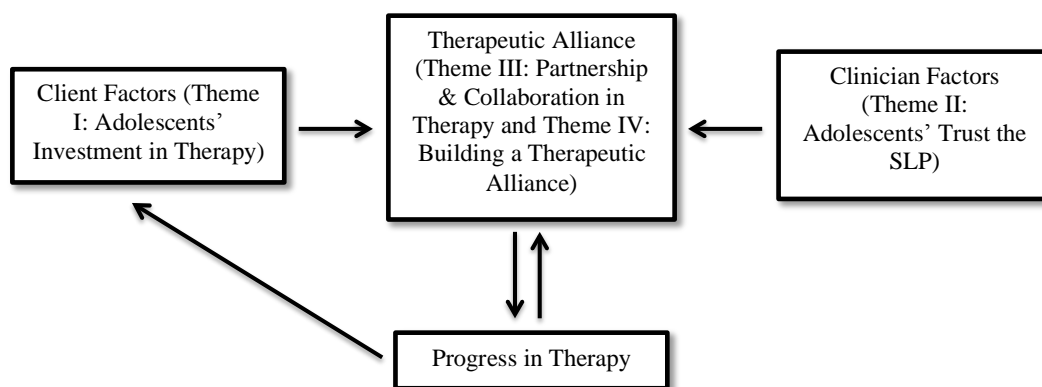


Figure 3. Relationships Between Themes and Progress Made in Therapy

### **Implications of the Results: Suggestions for Fluency Therapy with Adolescents**

The participants of this study provided rich insight into their experiences and explained how those experiences could be best utilized to foster their success in therapy. Resoundingly, participants of the study voiced their opinion that fluency therapy benefits from a collaborative partnership characterized by open dialogue. This partnership both facilitated and benefitted from the formation of a client-clinician relationship, in addition to leading to progress. This information indicates that adolescents benefit from having productive conversations with their clinicians, particularly regarding therapy goals but also simply through sharing personal information.

In addition, the results of this study indicated that an adolescent prefers to dictate the general direction (i.e. final goal) of therapy, but prefers that the clinician provide guidance as to how to achieve that goal. Adolescent fluency clients maintain a strong sense of trust in the professional adult in this regard as was demonstrated by their desire for the SLP to select the treatment strategies used in therapy to achieve the predetermined goal.

Adolescents also trust their clinicians to be competent and make clinical decisions to adjust therapy to their needs. Per the results of the study, it is recommended that in order to facilitate the investment of adolescents in therapy, clinicians should make adjustments to the plan of treatment as often is appropriate to meet adolescent clients' needs. This adaptivity and focus on the adolescents would allow clinicians to demonstrate their investment in the adolescents and better facilitate the development of a therapeutic alliance. In order to demonstrate full investment in their adolescent fluency clients, SLPs can make an effort to get a sense of each client as a person beyond their fluency and success in therapy.

Clinicians treating adolescents who stutter may also speed a client's investment in therapy by producing quick and noticeable results. While those results may not contribute to the client's long-term fluency (e.g. choral speech), the positive experience of fluency will help facilitate the development of a therapeutic alliance, and ultimately lead to long-term progress.

While this study was specific to adolescents who stutter, it is conceivable that the results would generalize to adolescents receiving speech-language intervention beyond fluency disorders. In these cases, an SLP can begin treatment with each adolescent by

developing goals and clearly outlining each individual's responsibilities and expectations regarding one another and the intervention. This dialogue should be maintained beyond the development of a treatment plan and ultimately lead to open communication and a collaborative partnership between both parties.

### **Limitations of the Present Study**

The information gathered from this study provides valuable information regarding the development of a therapeutic alliance with adolescents who stutter. However, there were limitations to this study that should be considered. Only a small number of participants ( $n = 3$ ) were interviewed. Although this number of participants was appropriate given the type of research conducted, this should be taken into account when considering result generalizability.

Due to the qualitative nature of this study and the inherent presence of the researcher in all aspects of the study, there was a degree of subjectivity present in the data collection, analysis, reporting, and discussion of the results. While all attempts were made to minimize any researcher bias, this is important to acknowledge. Also, the nature of the researcher's age difference and the participants' lack of familiarity with the researcher may have altered the level of candidness exercised by the participants during the interviews, despite assurances that all information shared was private and for research purposes only.

Due to the low incidence of stuttering, and unforeseen insurance coverage limitations, there were a limited number of adolescents to which the researcher had access who were eligible for the study. Despite the researcher's efforts to diversify the clinicians of study participants, due to the difficulty in finding eligible participants, two

participants received therapy from the same clinician and the other participant received therapy from that clinician's business partner. It is important to note that both clinicians received their education from different universities, but share similar theoretical perspectives regarding fluency treatment. Two participants had never received fluency therapy through their schools and could not speak to a theme identified by the other participant. Participants' self-rating of stuttering severity was inconsistent with researcher observations, indicating that self-reporting of stuttering severity was not completely accurate and may have impacted results. Lastly, all participants demonstrated similar levels of motivation, which limited the ability of the researcher to gather information as to what impacted an adolescent's level of motivation both positively and negatively. This homogeneity may also be due to the simple fact that adolescents who are not motivated in therapy are less likely to be there in the first place, and therefore did not meet the inclusion criteria for this study. Ideally, participants would have presented different motivation levels to provide varied information.

### **Recommendations for Future Research**

The goal of this research was to add to the body of evidence related to the development of the therapeutic alliance between an SLP and an adolescent who stutters. However, given the lack of evidence in this area, this study is a jumping-off point for future research on this topic. Based on this study, there are a number of suggestions for future lines of research.

Future researchers might consider interviewing younger school-age children. As one participant mentioned that as a younger child he was not invested in therapy and then became invested later, it warrants further investigation. It should be noted that

adolescents struggled to comprehend and/or express certain concepts that arose during the interviews, indicating that the research format would likely need to be changed for school-age children.

Because all the adolescents interviewed for this study were highly motivated to improve their speech, it was not possible to gain perspective on a lack of motivation. In future studies, researchers may find more information relating to adolescent motivation if participants present with more diverse perspectives on fluency therapy. This may come from also interviewing adolescents who stutter and have concomitant speech and/or language disorders in future research.

In order to better understand the perspectives of each participant, future researchers may consider utilizing a standard measure of stuttering severity. Because research participants' perceptions of their own stuttering severity differed from the researcher's informal rating, an objective severity rating may provide additional insight into participant experiences.

One independent theme that emerged was "therapy leads to feeling productive and not alone in stuttering," which was reiterated by the same participant in multiple interviews. The importance of this theme to one participant suggested that it would also be important for other adolescents to feel they were taking action toward improving fluency through involvement in therapy and have the SLP's support in doing so. Additional research into this area may uncover more in depth information on this theme.

Another independent theme that arose across multiple interviews was "fluency therapy in the school setting." This participant also had strong feelings in this area, which merits further investigation specifically into school-based fluency therapy.

## Conclusion

The main themes that arose in this study answered the four research questions that focused on client factors, clinician factors, and the client-clinician relationship. Client factors involved in the development of the client-clinician relationship were related to the adolescents' level of trust in their clinicians specifically regarding motivation, practice, functionality, attitude, enjoyment, and the SLP's trust in the adolescent. The clinician factors that impacted therapy were related to the participants' trust in their SLP particularly as it pertained to clinician competence, a safe environment, adaptive therapy, education, the SLP's investment in therapy, and being pushed in therapy by the SLP. While factors common to clients and clinicians contribute to the therapeutic alliance, client-clinician interactions such as sharing personal information, having a partnership with collaboration, and open dialogue that leads to independent communication also affect development of the therapeutic alliance. Additionally, participants noted that positive experiences (e.g. progress) facilitate therapeutic alliance formation, which leads to more effective therapy. Given the information learned and provided here, SLPs can develop therapeutic alliances more quickly and make greater gains in therapy with adolescents who stutter. This can be done through the clinician's demonstration of competence and investment in the adolescent as a person as well as their progress in therapy. SLPs can further develop therapeutic alliances by creating a safe environment in which partnership and collaboration occur frequently and easily between the adolescent and clinician. It is also important for a clinician to facilitate an adolescent's independent communication, education on stuttering, and development of the client-clinician relationship in order to encourage intrinsic motivation for improvement through therapy.

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**APPENDIX A**  
**ADOLESCENT INTERVIEW QUESTIONS**

The researcher asked each participant the numbered questions, but the bulleted questions will be optional follow-up questions.

- 1) I need to get some general information from you before we start. Can you tell me your stuttering severity level: mild, moderate, or severe? How long have you been in therapy? How many speech therapists have you seen over that time?
- 2) Can you tell me a bit about yourself?
- 3) Can you describe your stuttering and how it has changed?
- 4) What have been your experiences of stuttering as a teenager?
- 5) Tell me about your experiences of stuttering therapy as a teenager?
  - Can you tell me about your reasons for pursuing or not pursuing therapy during adolescence?
  - Tell me about some of the barriers you've encountered to pursuing therapy?
  - What are you working on in therapy and what have you worked on up to this point?
- 6) Tell me about the success of your speech therapy.
  - What contributed to treatment success?
  - What contributed to not so successful treatment?
  - What is most helpful in therapy?
  - What is the least helpful?
- 7) What parts of therapy did you prefer? What did you not like?
  - What are some of your favorite things about therapy?
  - What are your least favorite things about therapy?

- Tell me about when therapy was frustrating for you.
  - Tell me about a big moment that you had in therapy, when everything just clicked.
- 8) If you could design your own fluency therapy, what would it look like and how would you make it better?
- 9) Can you describe your past and present SLPs to me?
- What does your SLP do that impresses you? What about past SLPs?
  - What are some things that your SLP does that you don't like?
  - If you could build your own SLP what would he/she be like?
- 10) What would you suggest to future SLPs for improvements to stuttering therapy for teens?
- 11) What do you do that helps therapy be successful?
- Can you tell me what you are like during therapy?
- 12) Tell me about some things you could do to make it more successful.
- What are some things that you do or have done that kept therapy from being successful or moved you backwards?

**APPENDIX B**

**INTERVIEW TRANSCRIPT DYSFLUENCY CODE**

- Repetitions
  - 1-2 repetitions \*
  - 3-4 repetitions \*\*
  - 5+ repetitions \*\*\*
  - { } contain repeated speech
  
- Blocks
  - <1 second \
  - 1-2 seconds \\
  - 3-4 seconds \\\
  - 5+ seconds \\\\
  
- Prolongations
  - <1 second >
  - 1-2 seconds >>
  - 3-4 seconds >>>
  - 5+ seconds >>>>

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From: Yaruss, J. Scott [mailto: ]  
 Subject: RE: Permission to use figure from Yaruss & Quesal (2006)  
 Date: October 10, 2014 at 10:50 AM  
 To: Riggenbach, Kelli [mailto: ]

Hi Kelli - Thanks for your email and kind words. I'm glad you found the figure to be helpful. It's actually adapted from a more detailed version of the model published in 2004 (paper attached).

You're absolutely welcome to use the figure in the thesis. If you go to publish that thesis, though, you'll need permission from Elsevier (journal publisher) - the journal owns the figure, not us. You can use it in your academic work based on fair use copyright laws, but for publication or distribution, you'll need formal permission. (Elsevier will have an approval process that they'll need you to go through, but it shouldn't cost anything since it's academic use.)

Let me know if I can do anything to help. Good luck with your work, and please say hi to [redacted] for me.

Take care,  
 Scott

-----  
 J. Scott Yaruss, Ph.D., CCC-SLP, ASHA Fellow  
 Board-Certified Specialist in Fluency Disorders

Workshops and seminars: [www.Yaruss.com](http://www.Yaruss.com)  
 NEW! Practical treatment guides for helping children who stutter: [www.StutteringTherapyResources.com](http://www.StutteringTherapyResources.com)

Associate Professor and Director of MA/MS Programs in Speech-Language Pathology,  
 Communication Science and Disorders, University of Pittsburgh  
 Coordinator of Clinical Research, Audiology and Speech-Language Pathology, Children's Hospital of Pittsburgh (CHP)  
 Co-Director, Stuttering Center of Western Pennsylvania

Mail: [redacted]  
 Phone: [redacted]  
 Email / Web: [redacted]

Stuttering Center of Western Pennsylvania: <http://www.StutteringCenter.org>  
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-----Original Message-----

From: Riggenbach, Kelli [mailto: ]  
 Sent: Friday, October 10, 2014 1:37 PM  
 To: Yaruss, J. Scott  
 Subject: Permission to use figure from Yaruss & Quesal (2006)

Dr. Yaruss,

My name is Kelli Riggenbach and I am one of [redacted] graduate student in speech-language pathology at the University of Northern Colorado. I am currently working on the review of literature for my thesis, which will look at the perceptions of adolescents who stutter regarding their relationship with their clinician and factors within themselves and their clinicians that impact the effectiveness of fluency therapy.

In my research I came across one of your research articles written with Dr. Robert Quesal - "Overall Assessment of the Speaker's Experience of Stuttering (OASES): Documenting Multiple Outcomes in Stuttering Treatment" published in 2006. I would like to incorporate Figure 1 (shown below) from that paper into my literature review and wanted to request your and Dr. Quesal's permission to include it. I love how well it illustrates the complex nature of stuttering and its implication on an individual's life. I believe that this understanding will allow readers to better understand the how involved and broad fluency therapy can be as well as appreciate the relationship between client and clinician.



**APPENDIX D**  
**INSTITUTIONAL REVIEW BOARD APPROVAL**



UNIVERSITY of  
NORTHERN COLORADO



*Institutional Review Board*

DATE: February 5, 2015

TO: Kelli Riggenbach  
FROM: University of Northern Colorado (UNCO) IRB

PROJECT TITLE: [694662-3] A Qualitative Analysis of the Therapeutic Alliance from the Perspective of Adolescents who Stutter

SUBMISSION TYPE: Revision

ACTION: APPROVED

APPROVAL DATE: February 5, 2015

EXPIRATION DATE: February 5, 2016

REVIEW TYPE: Expedited Review

Thank you for your submission of Revision materials for this project. The University of Northern Colorado (UNCO) IRB has APPROVED your submission. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of February 5, 2016.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Sherry May at 970-351-1910 or [Sherry.May@unco.edu](mailto:Sherry.May@unco.edu). Please include your project title and reference number in all correspondence with this committee.

**Hello Kelli,**

**I am the final reviewer on your IRB application. Thank you for an well written application. The first reviewer, Dr. Helm, provider her approval. I am approving your application as well and wish you the best in your research.**

**Sincerely,**

**Nancy White, PhD, IRB Co-Chair**

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Northern Colorado (UNCO) IRB's records.

**APPENDIX E**  
**PARENT CONSENT FORM**



CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH  
UNIVERSITY OF NORTHERN COLORADO

Project Title: A Qualitative Analysis of the Therapeutic Alliance from the Perspective of Adolescents Who Stutter

Primary Researcher: Kelli Riggenschach, Graduate Student  
 Phone: (719) 850-1844 E-mail: rigg1777@bears.unco.edu  
 Research Mentor: Kimberly Murza, Ph.D., CCC-SLP  
 Phone: 970-351-1084 Email: kimberly.murza@unco.edu

**Purpose and Description:** The purpose of this study will be to investigate the characteristics of speech-language pathologists (SLP) treating adolescents who stutter that are perceived to be effective or ineffective in promoting successful change in the adolescents' ability to communicate. Over one to four sessions, the primary researcher will interview your child. The interview will last between 30 minutes and 1 hour. The questions for the interview will focus primarily on your child's perceptions of experiences with stuttering, fluency therapy, and their speech therapist. Questions will also relate to what your child thinks makes fluency therapy successful.

All interviews will be audio recorded, so responses obtained can be saved for further analysis. Thematic analysis will be used to create themes based on common responses elicited during the interviews. The questions that will be asked in the interviews do involve very minimal risk, but they are comparable to that encountered in a speech therapy session in which autobiographical information is revealed. The questions being asked in the interview may elicit some emotional discomfort, such as painful memories. For example, questions your child may be asked include: when you knew you stuttered, if you can recall any stuttering moments that affected you in a positive or negative way, and questions like who is part of your support group? In the event that emotional upset occurs, referral to counseling services will be provided. Participants will only be asked to answer questions they feel comfortable with. Participants have the option of stopping the interview at any time. If this interview upsets you or your child at all, feel free to contact the University of Northern Colorado Counseling Center at (970) 351-2496 during office hours or at (970) 351-2245 after hours for Emergency Services.

You and your child might not personally benefit from this research, but it could potentially benefit the profession of speech-language pathology. There remains a lack of research in the area of perceptions of client-clinician relationships in fluency therapy. Your child's responses along with those responses from other study participants could help speech-language pathologists design therapy programs that address these issues. At the end of the study, I am happy to share the results of our study with you at your request. I will take every precaution in order to protect your child's confidentiality. This includes assigning a participant pseudonym to your child. Only my research mentor and I will know the name connected with pseudonym and when I report data, your child's name will not be used. Data collected and analyzed for this study will be kept in a flash drive that requires a password to obtain information. When the data have been analyzed and the study is done, data obtained from the interviews will be kept by the advisor of the present research in her office only accessible by her, for a period of 3 years and after that data and consent forms will also be destroyed.

page 1 \_\_\_\_\_  
(participant initials here)

Participation is voluntary. You may decide not to allow your child to participate in this study and if your child begins participation he/she may still decide to stop and withdraw at any time. Both yours and your child's decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Your child's participation-related decisions will not affect his/her treatment at the clinic. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to allow your child to participate in this research. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact Sherry May, Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1910.

---

Guardian's Signature

Date

---

Email Address

Phone Number

---

Researcher's Signature

Date

**APPENDIX F**  
**CHILD ASSENT FORM**



ASSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH  
UNIVERSITY OF NORTHERN COLORADO

Project Title: A Qualitative Analysis of the Therapeutic Alliance from the Perspective of Adolescents Who Stutter

Primary Researcher: Kelli Riggenbach, Graduate Student  
 Phone: 719-850-1844 E-mail: rigg1777@bears.unco.edu  
 Research Mentor: Kimberly Murza, Ph.D., CCC-SLP  
 Phone: 970-351-1084 Email: kimberly.murza@unco.edu

I am doing a study to learn about what teenagers who stutter think about their speech therapists and how they make your speech therapy helpful. I am asking you to help because I don't know very much about what people your age think about what their speech therapists do to make therapy help or not.

If you agree to be in my study, I am going to ask you some questions about your speech, speech therapy, and your speech therapist. I want to know what you think makes a speech therapist help your speech or not. For example, I will ask you what your favorite things are about your current speech therapist. All information that you share with me will be kept confidential from your past or current speech therapists and your parent/guardian. If I feel that you or someone else is in immediate or soon will be in danger I will need to tell your speech therapist or parent/guardian.

You can ask questions about this study at any time. If you decide at any time not to finish, you can ask me to stop. The questions I will ask are only about what you think. There are no right or wrong answers because this is not a test.

If you sign this paper, it means that you have read this and that you want to be in the study. If you don't want to be in the study, don't sign this paper. Being in the study is up to you, and no one will be upset if you don't sign this paper or if you change your mind later.

Your signature: \_\_\_\_\_ Date: \_\_\_\_\_

Your printed name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of person obtaining consent: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of person obtaining consent: \_\_\_\_\_ Date: \_\_\_\_\_

**APPENDIX G**  
**ADOLESCENT COUNSELING SERVICES**  
**REFERRAL LIST**



## Adolescent Counseling Services Referral List

Changing Tides Counseling

1355 S. Colorado Blvd. C-100  
Denver, CO 80222  
720-496-0568

Denver Teen Counseling

6901 S. Pierce St.  
Suite 235  
Littleton, CO 80128  
and  
7200 E. Hampden Ave.  
Suite 205  
Denver, CO 80224  
303-933-5800

South Denver Psychotherapy

2305 E. Arapahoe Rd.  
Suite 242  
Centennial, CO 80122  
303-730-1144

Integrative Therapy Solutions

1756 High St.  
Denver, CO 80218  
303-388-8144