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Client perceptions of effective and ineffective therapeutic alliances during treatment for stuttering

Laura W. Plexico [a,*], Walter H. Manning [b], Anthony DiLollo [c]

[a] *Auburn University, Department of Communication Disorders, 1199 Haley Center, Auburn, AL 36849, United States*
[b] *The University of Memphis, United States*
[c] *Wichita State University, United States*

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Abstract

The treatment components that contribute to and account for successful therapeutic outcomes for people who stutter are not well understood and are debated by many. The purpose of this phenomenological study was to describe in detail the underlying factors that contribute to a successful or unsuccessful therapeutic interaction between clients and their clinicians. Twenty-eight participants, 19 men and 9 women, who had received from 6 months to more than 12 years of therapy for stuttering were studied. The participants were asked to consider their experience with one or more speech-language pathologists with whom they had received fluency therapy and to describe the characteristics that made that individual effective or ineffective in promoting successful change in their ability to communicate. Analysis of these data resulted in 15 primary categories. Finally, the essential structure of an effective and ineffective therapeutic interaction was described. Results highlighted the importance for effective therapy of understanding the stuttering experience, forming a positive client–clinician, alliance, and being knowledgeable about stuttering and its treatment.

Educational objectives: The reader will be able to: (1) describe, from the perspective of a select group of adults who stutter, the themes associated with an effective therapeutic interaction, (2) describe, from the perspective of a select group of adults who stutter, the themes associated with an ineffective therapeutic interaction, and (3) describe the ways in which an effective or ineffective therapeutic interaction could impact a person who stutters.
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1. Introduction

Historically, qualifications of clinicians for certification in the field of speech-language pathology (and indeed for most clinical fields) are determined by using quantitative criteria such as the number of courses taken, degrees awarded, supervised clinical hours, and the successful completion of regional or national exams. For example, speech-language pathologists who specialize in the area of fluency disorders (stuttering) are required to maintain an active clinical practice and to accumulate a minimum of 45 h of continuing education every three years. Although such quantitative requirements are typically used to distinguish those who have advanced qualifications from those who do not, it is clear that even among groups of specialists some clinicians are considerably more effective than

* Corresponding author. Tel.: +1 334 844 9620; fax: +1 334 844 4585.
E-mail address: lwp0002@auburn.edu (L.W. Plexico).

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others in their ability to bring about a successful therapeutic outcome (Cooper & Cooper, 1965, 1985; Manning, 2010).

The treatment components that contribute to and account for successful therapeutic outcomes for people who stutter are not well understood and are debated by many. Most attempts to understand how successful therapeutic change occurs for those who stutter have focused on assessing the traits of people who stutter that are thought to increase the likelihood of successful stuttering management or the nature of the treatment protocol. Recently, some have suggested that a successful therapeutic outcome is best explained by factors that are found in several treatment protocols (Herder, Howard, Nye, & Vanyckeghem, 2006; Manning, 2006; Manning & Dilollo, 2007). This view has been informed by investigations in the fields of psychotherapy and counseling (e.g., Frank & Frank, 1991; Rosenzweig, 1936; Smith & Glass, 1977; Wampold, 2001) which led to the development of the *common factors model* (also referred to as the *contextual model*) of therapeutic change. This model appears to provide a more complete understanding of the components that contribute to a successful therapy experience than the "default" medical model (see Wampold, 2001). The medical model for explaining therapeutic change stipulates that specific ingredients (or protocols and associated techniques) are essential for a successful treatment outcome, regardless of who delivers these ingredients. With the common factors model, the qualities of the clinician, rather than specific therapy ingredients, are critical for a successful treatment outcome. Wampold (2001) says it succinctly: "The central issue for differentiating the medical model and the contextual model is to estimate the degree to which the therapist affects the outcome of therapy. . ." (p. 185).

Although the delivery of treatment is seen as a necessary component for therapeutic change, the specific ingredients of that treatment are not paramount. Specific treatment procedures or techniques are only perceived as advantageous to the client because of the meaning attributed to those procedures, not because of their specific behavioral effects. Furthermore, the common factors model suggests that several factors are shared by many empirically validated or informed treatment approaches (Wampold, 2001). Two of these "common factors" identified by Wampold and his colleagues include the client–clinician alliance and clinician competence. In this way, this model aptly accounts for how more than one treatment method can have efficacious results for a particular problem (e.g., Lambert & Bergin, 1994; Smith, Glass, & Miller, 1980; Stiles, Shapiro, & Elliot, 1986).

Investigations employing statistical techniques of meta-analysis and hierarchical linear modeling (HLM) have supported the common factors model of therapeutic change. These studies permit discerning outcome variance at the clinician level as well as the treatment level. For example, when attempting to identify the effects for various therapeutic aspects of psychotherapy, Brown (2004) and Wampold (2001) both found that "clinician effects" account for a much greater proportion of the variance compared with "treatment effects". In fact, there is a large body of evidence suggesting that the therapeutic relationship or working alliance between the clinician and client is of *primary* importance to the outcome of therapy (Bachelor & Horvath, 1999; Blatt, Zuroff, Quinlan, & Pilkonis, 1996; Bordin, 1979; Burns & Nolen-Hoeksema, 1992; Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997; Horvath, & Symonds, 1991; Krupnick et al., 1996; Martin, Garske, & Davis, 2000).

1.1. Therapeutic alliance

The therapeutic alliance has been referred to as the "quintessential integrative variable" of therapeutic change (Wolfe & Goldfried, 1988, p. 449). The therapeutic alliance is often thought of as a single construct that refers to the collaborative, healthy, and trusting relationship established between the client and clinician (Frank & Frank, 1991) and reflects the idea that the clinician and client will come to an agreement about the goals of therapy and will share an understanding of the therapeutic process (Ahn & Wampold, 2001; Bordin, 1979; Gaston, 1990; Horvath & Symonds, 1991; Saunders, Howard, & Orlinsky, 1989; Wampold, 2001).

Horvath and Symonds (1991) and Martin et al. (2000) each conducted meta-analyses to further investigate the effect that the therapeutic alliance has on treatment outcome. Horvath and Symonds analyzed 20 data sets published between 1978 and 1990 with the goal of answering two questions. They examined the relationship between the therapeutic alliance and therapeutic outcome, followed by an investigation of whether specific therapy variables influenced any observed alliance-outcome relationship. They found an overall effect of .26 using an aggregated correlation coefficient to estimate effect size (equivalent to a *Cohen's d* of .5385). This medium-sized effect suggests a relationship between the quality of the therapeutic alliance and the therapeutic outcome. When examining the effect of specific therapy variables they found that length of treatment and the specific type of treatment did not significantly influence the relationship between the therapeutic alliance and treatment outcome.

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