
Purpose: M. Blomgren, N. Roy, T. Callister, and R. Merrill (2005) used a multidimensional approach to evaluate treatment efficacy for the Successful Stuttering Management Program. While the article acknowledged that the treatment program under evaluation does not target a reduction in stuttering frequency, Blomgren and colleagues concluded that the therapy “was ineffective in producing durable reductions of core stuttering behaviors, such as stuttering frequency and severity.” In this response, it is suggested that Blomgren et al. used inappropriate treatment efficacy measures relative to the therapy program under evaluation, subsequently making the study’s data difficult to interpret.

Conclusion: It is suggested that stuttering treatment efficacy measures include client-reported treatment satisfaction data, efficacy measures relative to the goals and values of the therapy approach being evaluated, and data relative to the documented values and priorities of those within the stuttering population.

KEY WORDS: stuttering, Successful Stuttering Management Program, stuttering modification

We applaud the efforts of Blomgren, Roy, Callister, and Merrill (2005) to provide empirical support for the efficacy of stuttering treatment. Specifically, Blomgren et al. used a multidimensional approach to evaluate treatment efficacy for the Successful Stuttering Management Program (SSMP). Their protocol consisted of 14 fluency and affective-based measures used to assess changes in stuttering severity, self-perception of stuttering, locus of control, mood, and anxiety. While the data are a definite asset to the body of stuttering research literature, various aspects of the premise on which these treatment efficacy measures are based and interpreted may be inappropriate relative to the treatment objectives that are the foundation of the SSMP.

Although Blomgren et al. (2005) acknowledged the difficulty in identifying relevant outcome measures, the rationale for the measurements they identified is limited. Specifically, the rationale was based on “three primary components of stuttering—core behaviors (such as stuttering frequency and duration of stuttering moments), secondary behaviors (escape and avoidance behaviors), and affective aspects of stuttering (self-perceptions, attitudes, feelings, and anxiety levels; Guitar, 1998)” (p. 510).

Data from this study revealed that the SSMP produced sustained improvements in the areas of self-perceived avoidance and expectancy, as well as psychic and somatic anxiety. These data support many of the stated purposes and treatment objectives of the SSMP, which include acceptance of one’s stuttering; taking an overall responsibility for managing
stuttering; the elimination or reduction of avoidance behaviors; a reduction of word, sound, and situational fears; learning about the disorder of stuttering; increasing one’s self esteem and image; and the use of stuttering modification speaking strategies (“handling techniques”) such as voluntary stuttering (“negative practice”) to reduce the fear of speaking and “pull-outs” to move forward through moments of stuttering (Breitenfeldt & Lorenz, 2000).

According to Blomgren et al. (2005), results also indicated that the SSMP “was ineffective in producing durable reductions of core stuttering behaviors, such as stuttering frequency and severity” (p. 509). While these data were reported and interpreted, it was also recognized that “reduced frequency of stuttering was not an overt goal of the SSMP” (p. 520). Blomgren et al. ultimately concluded that “as a standalone program, the SSMP appears to be ineffective in producing durable improvements in stuttering behaviors” (p. 521).

While we find no fault with the data per se, we argue that Blomgren et al.’s (2005) interpretation of the data may be inappropriate relative to the stated therapeutic goals in which the SSMP are based. Specifically, these goals include approaching stuttering in nonavoidant ways and using stuttering modification strategies to move forward through moments of stuttering (De Nil & Kroll, 1996). As a result, a valid and important therapeutic objective for some clients who participate in the SSMP or other stuttering modification approaches may include increasing overt stuttering frequency as a means of desensitization to the fear of stuttering and reducing covert stuttering behaviors (Manning, 1999a, 1999b, 2000, 2003; Starkweather, 1999; Starkweather & Givens-Ackerman, 1997; Yaruss, 2001; Yaruss & Quesal, 1999). As Manning (1999b) has written, “Increased stuttering usually occurs with decreased avoidance. So, under certain circumstances, one sign of [therapeutic] progress could very well be an increase in the frequency of ... stuttering” (para. 4). Consequently, the use of stuttering frequency as an indicator of treatment efficacy may be an inappropriate and insensitive measurement relative to the treatment efficacy of the SSMP and other stuttering modification based therapies.

In short, any therapy based on stuttering modification (in its purest form) will likely be “partially successful” and “ineffective in producing durable improvements in stuttering behaviors” based on the multidimensional evaluation protocol used by Blomgren et al. (2005). As Stewart and Richardson (2004) noted, “From a therapeutic perspective, treatment effectiveness is the extent to which an intervention does what it is intended to do for a particular client or group of clients (Last, 1983)” (p. 95). Subsequently, Blomgren et al.’s (2005) decision to measure core stuttering behaviors as an indicator of treatment efficacy appears inconsistent with the therapeutic values and intentions of the SSMP.

In closing, we suggest that stuttering treatment efficacy measures should consider including (a) client-reported treatment satisfaction data (Guntupalli, Kalinowski, & Saltuklaroglu, 2006) such as self-efficacy rating scales (Ornstein & Manning, 1985; Wright, Ayre, & Grogan, 1998) and self-measurement ratings (Finn, 2003); (b) data relative to the documented therapeutic values and priorities of the treatment under evaluation (Stewart & Richardson, 2004), and (c) data relative to the values and priorities of those within the stuttering population (Hayhow, Cray, & Enderby, 2002). An example of this latter point can be found in survey research completed by 200 members of the National Stuttering Association. While this sample may not be representative of everyone within the stuttering population, Yaruss, Quesal, and Murphy (2002) reported, “The majority of respondents indicated that the most appropriate goals for both children and adults were to address feelings and attitudes about stuttering, regardless of any change in fluency, or to address both attitudes and speech fluency in combination” (pp. 234–235).


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