Clinical Focus

Using Solution-Focused Principles With Older Children Who Stutter and Their Parents to Elicit Perspectives of Therapeutic Change

Naomi H. Rodgers,[a] Ali Berquez,[b] Julia Hollister,[c] and Patricia M. Zebrowski[d]

Purpose: We previously presented findings from pretherapy solution-focused interviews regarding the therapeutic best hopes of older children who stutter (CWS) and their parents. The current follow-up study explored the same clients' solution-focused reflections 1 year later with respect to their perspectives of what changes had occurred over the course of therapy.
Method: Seven CWS (11–14 years old) and 12 of their parents, who were interviewed in the original Berquez et al. (2015) study, were interviewed again 1 year after they started therapy. These clients responded to open-ended, solution-focused brief therapy (SFBT)–style questions and rating scales. Their responses were qualitatively and quantitatively analyzed to identify what clients noticed had changed over the course of therapy.
Result: CWS and their parents reported changes spanning social communication abilities, cognitive-emotional skills, and speech management strategies. While these were consistent with their pretherapy best hopes, CWS and their parents identified additional, unexpected gains beyond the scope of what they originally hoped for at the beginning of therapy, including improvements in adaptive coping, academic experience, parent–child interactions, thoughts and feelings about stuttering, and personal growth.
Conclusion: SFBT can provide speech-language pathologists a framework for facilitating client reflections on positive signs of change that occur over the therapeutic process.

Changing a chronic problem that involves well-learned patterns of behaviors, thoughts, and emotions, such as stuttering, is a complex process. Furthermore, the heterogeneity with which stuttering develops over time, both within and between affected individuals, makes stuttering therapy a unique clinical challenge for speech-language pathologists (SLPs). This is especially true for adolescent clients who can be resistant to therapy (Shirk & Karver, 2003). In recent years, there has been a growing literature base regarding the ways that SLPs can facilitate client engagement and positive treatment outcomes for people who stutter. One way is to prioritize the therapeutic relationship in which the client is regarded as the "expert" of their own experience (Botterill, 2011). By honoring the client's beliefs about what constitutes positive change and the means to achieve it, therapy can be individually tailored to meet their unique needs and preferences. One powerful approach for eliciting client views of meaningful change is solution-focused brief therapy (SFBT). SFBT is a therapeutic framework conducive to defining what constitutes a positive therapeutic outcome from the client's perspective—first by establishing personally relevant goals and treatment strategies and then by eliciting self-reflection on what clients notice over the course of therapy (de Shazer, 1985). While SFBT aligns with counseling strategies indicated for use with young people who stutter (DiLollo &

[a]Department of Special Education and Communication Disorders, University of Nebraska–Lincoln
[b]Michael Palin Centre for Stammering, London, United Kingdom
[c]Department of Communication Sciences and Disorders, Loma Linda University, California
[d]Department of Communication Sciences & Disorders, The University of Iowa, Iowa City
Correspondence to Naomi H. Rodgers: naomi.rodgers@unl.edu

Editor-in-Chief: Brenda L. Beverly
Editor: Corrin G. Richels
Received June 5, 2020
Revision received September 16, 2020
Accepted September 18, 2020
https://doi.org/10.1044/2020_PERSP-20-00124

Disclosures
Financial: Naomi H. Rodgers has no relevant financial interests to disclose. Ali Berquez has no relevant financial interests to disclose. Julia Hollister has no relevant financial interests to disclose. Patricia M. Zebrowski has no relevant financial interests to disclose.
Nonfinancial: Naomi H. Rodgers has no relevant nonfinancial interests to disclose. Ali Berquez has no relevant nonfinancial interests to disclose. Julia Hollister has no relevant nonfinancial interests to disclose. Patricia M. Zebrowski has no relevant nonfinancial interests to disclose.

Manning, 2007), there is limited evidence for its practical implementation with older children and their parents. This clinical focus article provides practice-based evidence for the utility of using SFBT principles with older children who stutter (CWS) and their parents as an approach for eliciting their perspectives of therapeutic change.

SFBT

SFBT is a mainstream psychotherapeutic intervention that has been used by many practitioners outside the field of psychotherapy (George et al., 2015). In the field of speech-language pathology, there is evidence supporting its effectiveness with individuals with aphasia (Northcott et al., 2016), parents of children receiving early intervention for language impairments (Andrews & Andrews, 1993; Briggs, 1998), and people who stutter (Cook & Botterill, 2005; Kelman & Nicholas, 2020; Nicholas, 2015). The literature regarding the use of SFBT with clients who stutter often describes an integrated approach in which SFBT principles are fused with speech management strategies and/or cognitive-behavioral therapy (Fry, 2013; McNeill, 2013).

SFBT is an outcome-centered approach that represents a paradigm shift from the traditional therapeutic focus on problem formulation and resolution (de Shazer & Dolan, 2012). Rather than deconstructing a client's problem, therapists use SFBT to coconstruct a desired outcome with the client (George et al., 2015). The primary tenets of SFBT include a positive, respectful, solution-focused approach where the therapist "leads from behind"; looking for times when the client has previously solved their problem, even if for a short time; looking for exceptions to the problem; using questions as the primary communication tool rather than offering interpretations or direct confrontations to the client; focusing these questions on the present and future rather than the past; validating what the client is already doing well, while acknowledging how difficult their problems are; and encouraging the client to do more of what is already working (de Shazer & Dolan, 2012). Therapists implement these principles through posing structured questions to elicit "solution talk" from the client (George et al., 2015, p. 4). SFBT-style questions assume that solutions are already happening by reinforcing a client's strengths, resources, and possibilities for the future (Milner & O'Byrne, 2003). Integrating an SFBT framework in stuttering intervention requires the SLP to actively listen to what their clients describe is most important to them. In fact, listening, rather than informing and persuading (Luterman, 2016), is the essential ingredient in the SFBT process. Goals for therapy and the methods for attaining those goals emerge from the dialogue between the therapist and client.

In recent years, skilled SLPs and those involved in the stuttering self-help community have begun to move away from the notion of "expert professional" toward "expert person who stutters" (Botterill, 2011), which highlights the importance of "involving people with communication impairments in defining not only their lived experience, but also in determining what therapy, if any, is personally meaningful, timely, and effective" (Bailey et al., 2015, p. 17). This "expert person who stutters" orientation aligns with the SFBT perspective that the client–therapist relationship is egalitarian; the clinician's role is to elicit what the client wants from therapy and their plan to achieve those goals (George et al., 2015). The clinician guides the client to be specific, detailed, concrete, and realistic about their expectations for therapy —also known as their "best hopes" in SFBT parlance—and the signs of progress that they will notice. It is proposed that the clearer the client can articulate what they hope to gain from therapy, the easier it is for them to determine when they are ready to end (de Shazer, 1985).

SFBT offers a complementary framework to other counseling-based approaches that are often used in stuttering therapy to address the client's cognitive and affective needs. For instance, there is a growing literature base on the application of cognitive-behavioral therapy (Kelman & Wheeler, 2015; Menzies et al., 2008, 2009), acceptance and commitment therapy (Beilby et al., 2012; Freud et al., 2019; Harley, 2015), avoidance reduction therapy for stuttering (ARTS; Sisskin, 2018), and mindfulness (Boyle, 2011; Emge & Pellowski, 2019; Harley, 2018) to stuttering therapy. Together, these therapeutic frameworks highlight the benefits of using counseling-based approaches to address both overt and covert aspects of stuttering. SFBT offers its own advantages, described in the following subsections.

Details the Client's "Preferred Future"

SFBT-style conversations facilitate a shared understanding of what the client desires from therapy. These discussions enable clients to identify their best hopes from therapy and the details of those desired outcomes—what is known in SFBT terms as the client's "preferred future." To elicit these ideas, SLPs ask clients:

- "What do you hope to achieve from therapy?"
- "What will those changes look like?"
- "What difference will that make?"

In considering these prompts, clients begin to visualize the possibilities and what things will look like when they have made those changes. The aim of these initial conversations is to establish clear and specific signs that they can be noticing as they move through the therapeutic process.

Turns Things Around

When clients are asked to describe their best hopes from therapy, they often describe the "absence" of something (e.g., stuttering, anxiety). To frame this type of "problem"-focused statement into a "solution"-focused statement, the SLP implements "The Great Instead." For example, the SLP might ask the client:

- "When you are not stuttering so much, what will you be doing **instead**?"
- "When you are less anxious, how will you be feeling **instead**?"

The word "instead" is conceptualized as "a sort of linguistic doorway that invites clients who have answered with a negation to walk right into a nice description of the solution" (Ratner et al., 2012, p. 70).

Broadens Their Perceptual Field

Initially, clients who stutter often describe their preferred future as one in which they are more fluent. From a personal construct perspective (Kelly, 1955), SLPs can help clients to "broaden [their] perceptual field" (Dalton & Dunnett, 1995, p. 62). For example, the clinician might ask:

- "What would increased fluency mean to you?"
- "What difference would that make?"

The client may then explain, for instance, that increased fluency would lead to increased well-being and participation. As such, this coconstructing of meaning promotes an attentional shift toward the bigger picture and can clarify the client's values. As clients are encouraged to notice signs of their preferred future already happening, they often began to notice more of it (Harley, 2018).

Coconstructs Meaning

Clients and SLPs work collaboratively to coconstruct the client's vision of their "preferred future" by drawing on their past successes, strengths, and resources to make that vision more tangible (Franklin et al., 2017). SLPs can ask: SLPs use the client's exact words in their conversations to foster the coconstruction of meaning, which also serves to strengthen the therapeutic alliance.

- "What does that show you about yourself?" (identity question)
- "How did you manage that?" (strategy question)

Helps Clients Notice Small Signs of Progress

Describing small signs of progress is an integral part of SFBT. It celebrates small shifts in a positive direction and recognizes that "a small change in any part of the system can ripple into larger changes" (Murphy, 1996, p. 185). By having clients identify the small signs that things are moving in their desired direction, clients begin to focus their attention on positive outcomes. This SFBT-style conversation is one of detailing and broadening as the SLP can "'zoom in' for detail or 'pan out' for breadth" (Ratner et al., 2012, p. 100).

Uses Scaling to Build a Progressive Narrative

Scaling is "an anchoring tool that allows clients to measure, assess and evaluate their own situations" (Berg & Dolan, 2001, p. 9). Clients routinely complete one to 10 visual analogue scales, where 1 = *their best hopes are not at all realized* and 10 = *their best hopes are fully realized*. Clients are prompted to place a hashmark along the scale indicating where things are in that present moment. Following, SLPs can foster discussion about what helps the client to be at that point rather than at 1. Following, the SLP can ask the client to mark where will be "good enough" (Ratner et al., 2012, p. 123). The scale serves as a resource for reflecting on changes that have already occurred and for noticing the things that are moving in the client's desired direction.

Meeting the Therapeutic Challenges and Needs of Older CWS

One common obstacle in working with older CWS is that they are often referred to therapy by their parents or teachers, which, as they enter the teenage years, conflicts with their increasing desire for independence and autonomy from adults (Shirk & Karver, 2003). This ambivalence can make older CWS appear unmotivated to be in therapy (Floyd et al., 2007). This can be exacerbated if the SLP appears to not truly understand the experience of stuttering (Manning & DiLollo, 2007). One way to address this need is to foster CWS' sense of ownership of their therapy process by tailoring treatment goals based on what they deem is personally meaningful (Caughter & Dunsmuir, 2017; Ingham et al., 2012). This is likely to promote adherence to the therapy plan and positively influence treatment outcomes for young people who stutter. However, there needs to be greater consensus in the research as to what constitutes successful stuttering therapy and how to measure it (Baxter et al., 2015).

While some approaches detail what therapy should include for the school-age child (e.g., Cook & Botterill, 2005; Yaruss et al., 2012), there are limited studies that identify what older CWS and their parents personally want from therapy and what "they" consider to be important changes. In our preliminary study (Berquez et al., 2015), we reported that, at the outset of therapy, older CWS hoped to change their thoughts and feelings about stuttering and themselves, increase their verbal participation, make communication-related changes, and increase their socializing and support. Cooke and Millard (2018) identified 21 outcomes that 8- to 14-year-olds who stutter considered to be priorities. Similar to the Berquez et al. (2015) findings, these included cognitive-affective changes (e.g., feeling more comfortable and independent), behavioral changes (e.g., talking more in class, talking more fluently with friends), and changes in those around them (e.g., parents knowing how to help, teachers giving them more time).

To this last point, involving parents in their children's therapy process is paramount for both the CWS' and their parents' benefit (DiLollo & Manning, 2007). Not only do parents express feelings of dissatisfaction with therapy when they have not been involved in their child's therapy process (Plexico & Burrus, 2012), but parents play a key role in modeling resilient behaviors for their CWS (Caughter & Crofts, 2018). Research has shown that when parents are involved in their child's therapy, they report talking more openly and worrying less about stuttering, treating the CWS the same as their other children, granting their CWS more independence, and giving them more responsibility (Berquez & Kelman, 2018; Biggart et al., 2006; Cook & Botterill,

2005). Indeed, the parents in our preliminary study (Berquez et al., 2015) reported that they hoped their CWS would change their thoughts and feelings about stuttering and themselves, make communication changes, and increase their socializing and support. Parents also have hopes for themselves as they go through the therapy process and may wish to improve how they cope with their child's stuttering, receive education and support related to stuttering, and change their family dynamics. Across these studies, emphasis is placed on the client's perspective rather than the therapist's or researcher's assumptions about what is important for clients in therapy. In addition to eliciting clients' expectations for therapy, SLPs can also probe clients along the therapeutic process regarding their perspectives of change so far.

Purpose of This Study

This mixed-method follow-up study examined the perspectives of therapeutic change from older CWS and their parents who had been in therapy for 1 year. Our research questions were (a) what changes did CWS and their parents notice 1 year after they started therapy, and (b) how did their perspectives of change 1 year later compare to their pretherapy best hopes? By comparing their perspectives at these two time points, we considered whether holistic outcomes were achievable and whether they were considered to be clinically significant changes for the older CWS and their parents, from their perspective. While this is not a treatment effectiveness study, this study is grounded in a practice-based evidence framework in which we examined the effects of routine clinical practice (Wambaugh, 2007).

Method

These data were collected as part of routine clinical practice and were stored and analyzed in accordance with the European Union's General Data Protection Regulation. While further Health Research Authority (National Health Service) ethical approval was not required to explore these data in this context, all families provided additional consent for archive materials to be utilized in research and service evaluation studies.

Participants

The participants in this therapy program were seven CWS (five boys, two women) between the ages of 11;9 and 14;3 (years;months; M = 13;2) and their parents (n = 12) from across the United Kingdom. For five CWS, both parents attended the therapy program. For two CWS, just their mothers attended. Six CWS had attended previous speech-language therapy described as a mixture of family-based therapy and direct speech management. Table 1 displays pertinent participant information.

Therapy Program

Framework and Regimen

Although this was not a treatment efficacy study, an overview of the intervention is relevant. This intensive group therapy program is intended for 10- to 14-year-olds who stutter and their parents. The broad goals of this established program are to help clients develop and strengthen their social communication abilities, cognitive-emotional responses to stuttering, and speech management strategies (Cook & Botterill, 2005; Millard, 2011).

The participants met for group therapy for 4.5 hr every weekday for 2 weeks, for a total of 45 hr over 10 days. After the 2-week intensive group component of the program, clients attended four subsequent group follow-up days scheduled over the course of 1 year: 6 weeks post, 4 months post, 8 months post, and 1 year post. SFBT worksheets were completed with each child who stutter and their parent at each follow-up day. The primary focus in this study was data from the SFBT worksheet at the 1 year post time point, with a brief comparison to the SFBT data collected during pretherapy interviews (previously reported in Berquez et al., 2015) in order to assess the extent and type of change that the CWS and their parents noticed.

Data Collection

The SFBT worksheets included two components (adapted from de Shazer, 1985): (a) a blank space for clients to free list their responses to a set of verbal prompts provided by the SLP related to their best hopes (see Table 2) and (b) a 1–10 best hopes rating scale. The 1–10 rating scale was a 100-mm visual analogue scale where 10 on the right anchor indicated *best hopes are fully realized* and 1 on the left anchor indicated *best hopes are not at all realized*. Clients were prompted to place a hashmark along the visual analogue scale to quantify the degree to which their best hopes were realized at that point in time. The millimeter distance from the left anchor to the hashmark was measured and recorded. Each child who stutter completed their SFBT worksheet one-on-one with their SLP, who acted as their scribe. Parents completed their own SFBT worksheet in response to verbal prompts.

Data Analysis

The SFBT worksheets completed at the end of therapy were analyzed using a mixed-method approach.

Qualitative Data

The qualitative portion of the SFBT worksheets were analyzed using a combination of applied thematic analysis (Attride-Stirling, 2001) and reflexive thematic analysis (Braun & Clarke, 2019), which are forms of inductive, exploratory data analysis. *Applied thematic analysis* is a content-driven approach to describing and categorizing both implicit and explicit themes within textual data without any preconceived ideas about what themes and ideas lay within the text (Guest et al., 2012). We utilized thematic

Table 1. Pertinent participant information.

ID	Sex	Age (years; months)	Domestic status	SFBT Best Hopes Rating[a]					
				CWS		Mother		Father	
				Pre	Post	Pre	Post	Pre	Post
CWS 1	M	12;2	Lives with mother and stepfather; both attended	67	87	19	89	40	70
CWS 2	M	13;2	Lives with mother and father; both attended	32	76	27	72	71	76
CWS 3	M	11;9	Lives with mother and father; both attended	41	61	10	80	14	83
CWS 4	M	13;7	Lives with mother and father; both attended	36	90	72	94	79	97
CWS 5	F	12;10	Lives with mother and father; both attended	37	60	67	86	52	92
CWS 6	F	13;5	Lives with mother; father not involved; mother attended	60	67	72	62	—	—
CWS 7	M	14;3	Parents separated; mother attended	64	84	22	69	—	—

Note. SFBT = solution-focused brief therapy; CWS = children who stutter; M =male; F = female.

[a]Measurement from the leftmost end to the client's hashmark along the 100-mm visual analogue rating scale where higher values indicate best hopes are closer to being fully realized.

networks to guide our organization and presentation of the data. The thematic networks we constructed display three levels of themes: basic themes, organizing themes, and global themes (Attride-Stirling, 2001). *Basic themes* are items that are directly extracted from the written data and, on their own, provide a very narrow perspective on the text as a whole. Basic themes begin to take on meaning when they are read within the context of other basic themes and when they are combined with related basic themes to form organizing themes. *Organizing themes* are construed from clusters of related basic themes. These midorder themes begin to illustrate trends that are gleaned from the textual data. Related organizing themes are then grouped together to form global themes. *Global themes* are higher order themes that reflect an overall summary or assertion represented by related clusters of organizing themes.

The first step of the analysis was to enter each data item (i.e., each bulleted point from the clients' SFBT worksheets) into a spreadsheet. Since clients were prompted to free-list their ideas on the SFBT worksheets, the texts were already segmented for coding.

Table 2. Solution-focused brief therapy prompts posed to children who stutter (CWS) and their parents.

Interview	Client
Pretherapy	
What are your best hopes from therapy?	CWS, parents
What are your best hopes for yourself?	CWS, parents
What difference will that make?	CWS, parents
What are your best hopes for your child?	Parents
What difference will that make?	Parents
Posttherapy	
What have you been pleased to notice?	CWS, parents
What difference does that make?	CWS, parents
What are others noticing?	CWS, parents
What is helping you to be at that point?	CWS, parents
What will be good enough?	CWS, parents
What is helping your child be at that point?	Parents
What difference does that make?	Parents

The second step was for two coders (first and third authors) to independently code the data. They read through the data to examine commonalities, differences, and relationships among the data points. Through familiarization with the data, they began to color-code data points that demonstrated similar concepts (e.g., "my confidence has gone up loads" and "I have more confidence" were tagged with one color). They then compiled the data items with the same color code to form basic themes. Once all the data items were organized into basic themes, the basic themes were grouped based on similarities (e.g., "increased confidence," "pride in self," "in a better space with stuttering") to form the organizing themes (e.g., "changed thoughts and feelings about stuttering and themselves"). When considered together, the organizing themes collectively formed the global themes of signs of change that clients noticed at the end of therapy. The two coders completed Step 2 independently and then came together to discuss the basic and organizing themes that they each developed. At this point, the analytic process became collaborative. In line with reflexive thematic analysis (Braun & Clarke, 2019), the finalization of the basic and organizing themes was cooperative and iterative as the two coders constructed a richer, more nuanced interpretation of the data together.

The third step was to build the thematic networks. The finalized basic, organizing, and global themes were arranged in a weblike presentation with basic themes on the outside, organizing themes more centrally, and the global theme at the focal point. The purpose of this weblike presentation of themes was to remove allusions of hierarchy among the themes and to display the interconnectivity among themes (Attride-Stirling, 2001).

The fourth step was to identify clients' perspectives of therapeutic change through reflexive thematic analysis. To do so, the two coders compared the 1 year posttherapy thematic networks to the pretherapy thematic networks (as reported in Berquez et al., 2015) to collaboratively identify overlapping basic and organizing themes that were deemed to express the same idea across the two time points. This

allowed them to examine the breadth and depth of what constituted client-perceived change. In the thematic networks that follow, *n* represents how many participants contributed to that data point at 1 year post. If a participant reported more than one similar data point (e.g., CWS1 stated "I'll be happy" and "I'll always be happy"), they were included only once for the *n* count. To ensure that an organizing theme was sufficiently supported, an organizing theme was only created if there were at least two basic themes that contributed to it. Therefore, some basic themes were excluded from the finalized thematic networks if they did not contribute to a well-supported organizing theme.

Quantitative Data

Another metric of therapeutic change was comparing clients' 1–10 rating scales that were collected on the first and last day of therapy. On Day 1, clients were asked to indicate how close they were to realizing their best hopes. One year later, clients were asked the same question. They responded by placing a hashmark along a 100-mm visual analogue scale. We then measured the millimeter distance from the left anchor to the hashmark, and these values were compared across the two time points to quantify the degree of change. A paired-samples *t* test was conducted to compare the mean visual analogue ratings between the two time points. The data were normally distributed at both time points: $W(19) = 0.93$, $p = .16$, for the first day, and $W(19) = 0.95$, $p = .36$, for the last day.

Reliability

The data were analyzed by the first and third authors who have clinical and research expertise in stuttering. Neither were employed by the treatment center nor participated in the therapy program, although they do have working professional relationships with several clinicians at the clinic where the therapy program took place. The first and third authors had also analyzed the data in the prequel Berquez et al. (2015) study. As such, as much as they attempted to suspend their biases in the present analysis, potential influence of those biases was unavoidable. However, avoiding bias and demonstrating coding reliability in a qualitative paradigm and reflexive thematic analysis is often not feasible nor recommended; Braun and Clarke (2020) argue that "meaning and knowledge are understood as situated and contextual, and researcher subjectivity is conceptualised as a *resource* for knowledge production, which inevitably sculpts the knowledge produced, rather than a must-be-contained threat to credibility" (pp. 7–8).

Because these clinical data were retrospectively analyzed from routine collection at a previous time point, post-study member checking was not feasible. Member checking is one approach to ensuring validity of qualitative research whereby the findings are shared with the participants to elicit their opinion about whether the research findings accurately reflect their views, feelings, and experiences.

Results

The results are provided in the order the research questions were posed. First, what changes did CWS and their parents notice 1 year after the start of therapy? The themes that were developed from this analysis are depicted in the thematic networks displayed in Figures 1–3. Second, how did their perspectives of change at the end of therapy compare to their pretherapy best hopes? The gray-shaded areas in the thematic networks (see Figures 1–3) represent the best hopes that were identified pretherapy and again 1 year later. For example, for the CWS, "talking more in school" was a basic theme in both pre- and posttherapy. This indicated that, at the beginning of therapy, CWS hoped that they would talk more in school, and 1 year later, they noticed that they *were* talking more in school. Therefore, this box in the thematic network was shaded (see Figure 1) as it was deemed to be a best hope that was realized.

What Changes Did Clients Notice at the End of Therapy?

CWS' Perspectives of Change

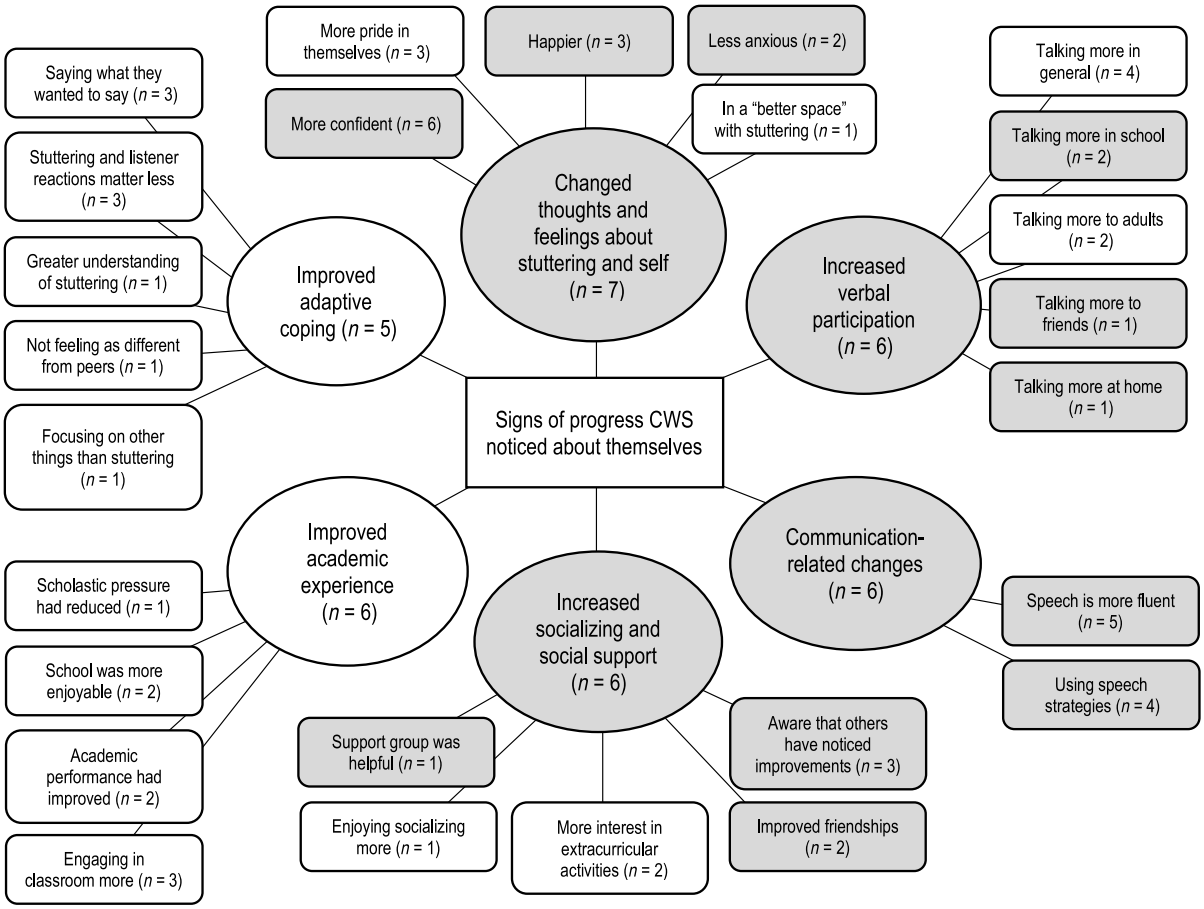
There were 79 raw units gathered from the CWS worksheets regarding signs of change 1 year after the start of therapy ($M = 11.29$ per participant, $Mdn = 10$, $SD = 3.35$). These raw units were organized into six organizing themes: (1) changed thoughts and feelings about stuttering and themselves, (2) increased verbal participation, (3) communication-related changes, (4) increased socializing and social support, (5) improved academic experience, and (6) improved adaptive coping.

(1) All seven CWS noticed a change in their thoughts and feelings about stuttering and themselves. This included reports of increased confidence ($n = 6$), having more pride in themselves ($n = 3$), and feeling happier ($n = 3$). They also explained that they were feeling less anxious ($n = 2$), including "I'm not nervous like I used to be" and "not getting as worked up as I used to." One CWS reported that he was in a "better space" regarding his stuttering ($n = 1$).

(2) Six CWS reported they had increased their verbal participation, which was broadly related to the notion of talking more and in more contexts than before. For instance, CWS explained that they had been talking more in general ($n = 4$), including "talking more with people I wouldn't usually talk to." They indicated that they had been talking more in school as well ($n = 2$), including sentiments such as "I'm talking at school more" and "asking questions in class." They also stated that they were talking more to adults ($n = 2$), talking more to friends ($n = 1$), and talking more at home ($n = 1$).

(3) Six CWS noticed that they had made communication-related changes. They described their speech as more fluent ($n = 5$). They also indicated that they had been using their speech techniques more frequently ($n = 4$), including "learning different techniques has made it much easier to control it" and "I'm using the technique more with my friends to practice."

Figure 1. Thematic network displaying the themes that emerged from the responses of the children who stutter (CWS) to the prompts, "What small signs of progress have you been pleased to notice?" and "What difference has that made?" 1 year after the start of therapy. The gray-shaded areas represent the overlapping themes with those identified by CWS pretherapy.



(4) Six CWS indicated that they had experienced increased socializing and social support. This included reports of others noticing improvements ($n = 3$), such as "my teachers have commented on how much more confident I am since coming here" and "mum has noticed—a few days ago she said my speech was a lot better." They also expressed more interest in extracurricular activities ($n = 2$). They noted that they were experiencing improved friendships ($n = 2$), stating that "I've made a new friend" and "I'm becoming better friends with people I wouldn't usually talk to." They were also enjoying socializing more ($n = 1$) and reported that participating in a support group was helpful ($n = 1$).

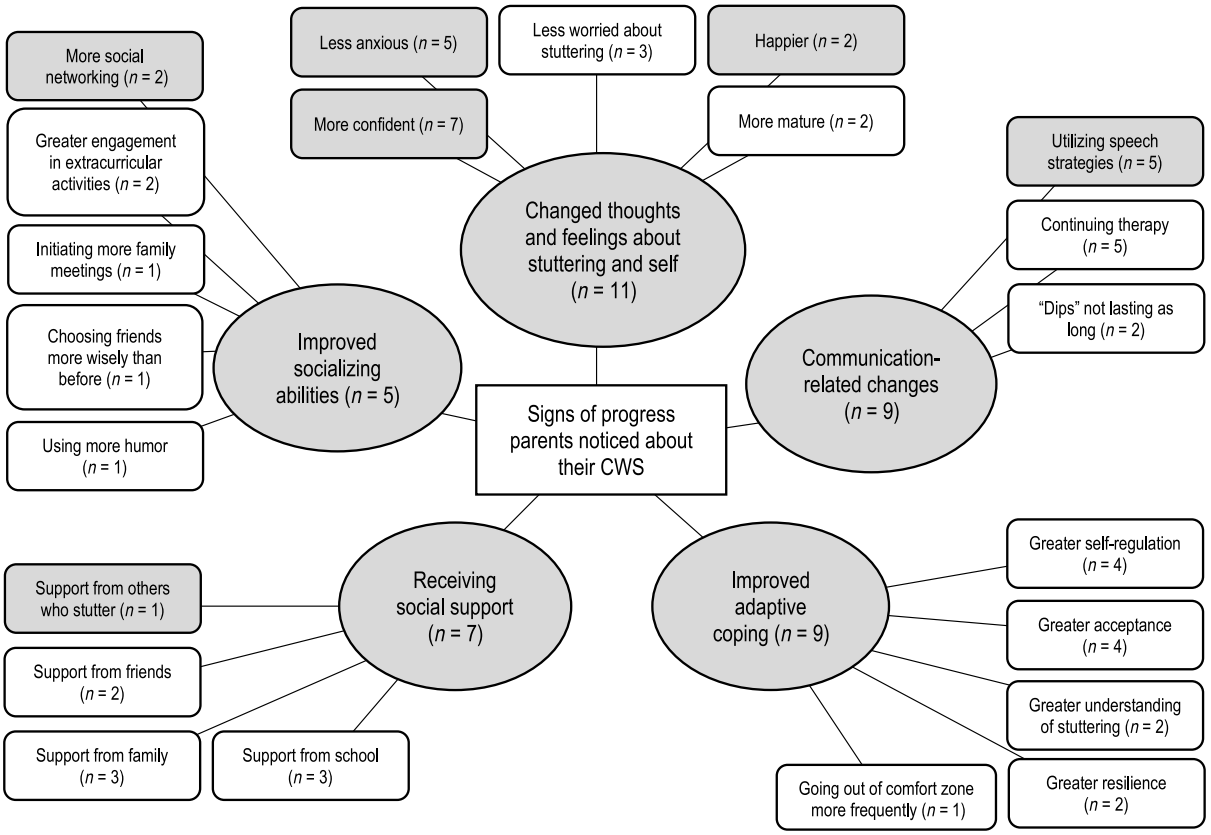
(5) Six CWS noticed that their academic experiences had improved. They reported that they were engaging more in the classroom ($n = 3$), including observations of "I put my hand up a lot more in most of my classes" and "I answer some questions in class," and were in fact enjoying school more ($n = 2$), as evidenced by "I'm having more fun at school" and "I'm happier at school." Additionally, they indicated that their academic performance had improved ($n = 2$) and that scholastic pressure had reduced ($n = 1$).

(6) Five CWS reported that they had improved adaptive coping related to their stuttering. They noted that they were now saying what they wanted to say regardless of stuttering ($n = 3$), such as "I'm not focusing on my stammering when I'm talking." They also explained that stuttering and listener reactions mattered less to them ($n = 3$), for example, "I don't care about people's comments. It's nothing to worry about. It's just one comment, not the end of the world." They had developed a greater understanding of their stuttering behavior ($n = 1$) and were focusing on things other than stuttering ($n = 1$), which together may have contributed to not feeling as different from their peers anymore ($n = 1$). One data point ("more relaxed home environment", $n = 1$) was excluded from the thematic network because it did not fit into any of the organizing themes.

Parents' Perspectives of Change for Their CWS

There were 65 raw units gathered from the parent worksheets regarding signs of change for their CWS 1 year after the start of therapy ($M = 5.42$ per participant, $Mdn = 6$, $SD = 3.03$). These raw units were organized into five organizing

Figure 2. Thematic network displaying the themes that emerged from the parents' responses to the prompts, "What small signs of progress for your child have you been pleased to notice?" and "What difference has that made?" 1 year after the start of therapy. The gray-shaded areas represent the overlapping themes with those identified by parents pretherapy.



themes: (1) changed thoughts about stuttering and themselves, (2) communication-related changes, (3) improved adaptive coping related to stuttering, (4) increased social support, and (5) improved overall socializing abilities.

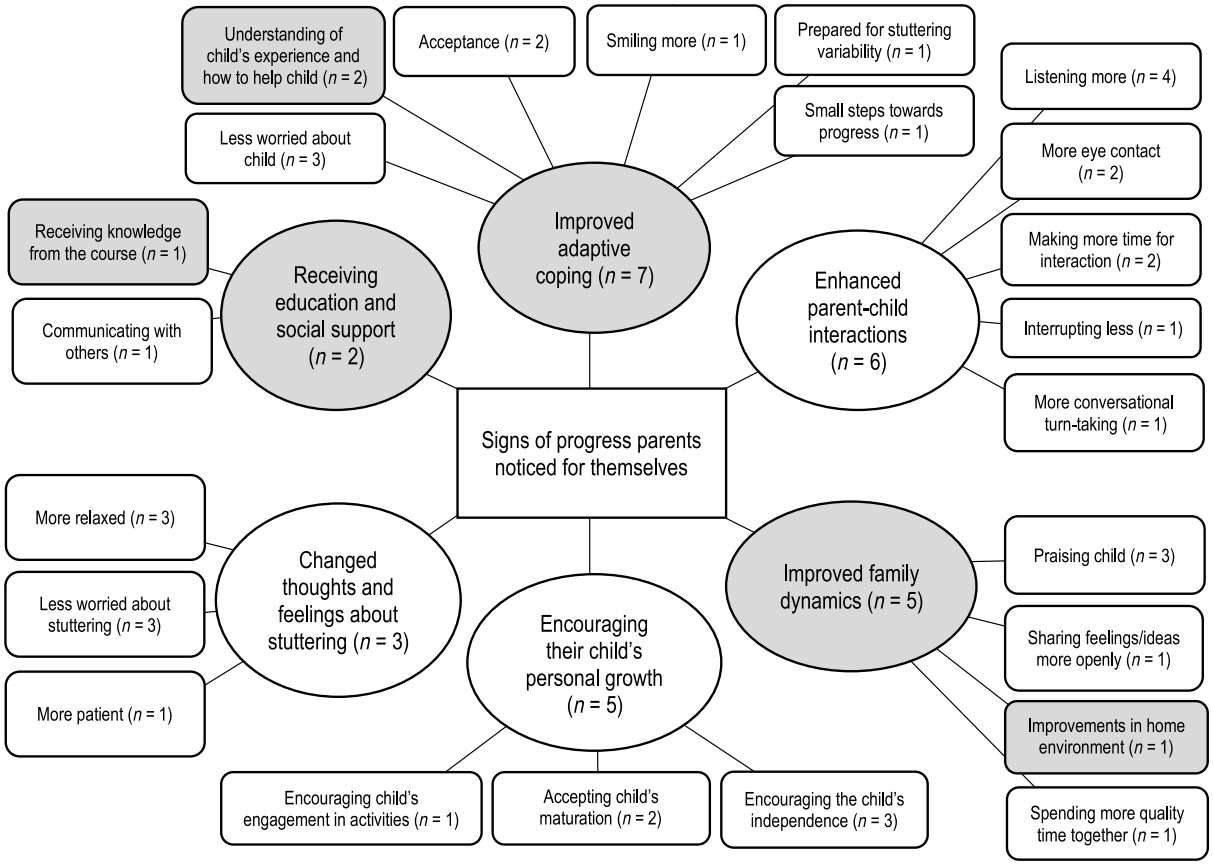
(1) Eleven parents reported that their CWS had changed their thoughts and feelings about stuttering and themselves. Most commonly, parents reported that their CWS was demonstrating increased confidence (n = 7). Parents also indicated that their CWS was less anxious (n = 5), reporting that they were "less worried" and "not showing anxiety" and were happier in general (n = 2). They also noticed that their CWS were demonstrating more maturity (n = 2), such as "maturity and independence both at home and at school (increasingly wants to do more on his own)."

(2) Nine parents indicated that their CWS had made communication-related changes. Parents reported that their CWS were utilizing their speech techniques (n = 5) and that continued therapy was helping their child maintain progress (n = 5). Parents also noticed that the occasional increases in stuttering frequency were not lasting as long (n = 2), including reports of "child recovers quickly from the dips" and "we have dips but not as big or last as long as beforehand."

(3) Nine parents considered that their CWS had improved their adaptive coping related to stuttering. Parents noticed that their children were demonstrating greater self-regulation abilities (n = 4), such as being "less reactive to dramas" and "gets over tantrums quicker." Parents also indicated that their CWS were demonstrating greater acceptance (n = 4), such as "he is more accepting of his stammer —it's part of him and anyone else can 'like it or leave it'" and "accepting that this is who he is." They reported that their CWS were generally less worried about stuttering (n = 3), reporting that "he is not bothered by his stammer" and that "he carries on regardless." Parents also observed that their CWS had developed a greater understanding of their stuttering (n = 2), had greater resilience (n = 2), and were going out of their comfort zone more frequently (n = 1).

(4) Seven parents expressed that their CWS receiving education and support related to stuttering. This included receiving support from school (n = 3), such as "more understanding and support at school (can do orals at lunch time)" and "her school is very supportive." Parents also provided specific examples of ways their CWS receiving support from family (n = 3), including "he reads every night and I try to

Figure 3. Thematic network displaying the themes that emerged from parents' responses to the prompts, "What small signs of progress for yourself have you been pleased to notice?" and "What difference has that made?" 1 year after the start of therapy. The gray-shaded areas represent the overlapping themes with those identified by parents pretherapy.



make a point to ask about and discuss the contents of the current novel" and "making more quality family time." Importantly, parents noticed that their CWS receiving increased support from friends (n = 2) and from others who stutter (n = 1).

(5) Five parents noticed that their CWS had improved their socializing abilities. Parents thought their CWS were engaging in more social networking (n = 2), such as "meeting friends" more often and "actively expanding her social networks." Parents also reported that their CWS were engaging more in extracurricular activities (n = 2), initiating family meetings more often (n = 1), choosing their friends more wisely (n = 1), and using more humor (n = 1).

Parents' Perspectives of Change for Themselves

There were 47 raw units gathered from the parent worksheets regarding signs of change for themselves 1 year after the start of therapy (M = 3.92 per participant, Mdn = 4, SD = 2.71). These raw units were organized into six organizing themes: (1) improved adaptive coping related to their child's stuttering, (2) enhanced parent–child interactions, (3) improved family dynamics, (4) encouraging their child's personal growth, (5) changed thoughts and feelings about their child's stuttering, and (6) increased education and social support.

(1) Seven parents reported that they had improved their own adaptive coping regarding their CWS' stuttering. Parents described feeling less worried about their CWS in general (n = 3), such as "[I] do not worry as much about him in situations where he is going to be out of his comfort zone" and "less worried because of her positive attitude," and less worried in particular about their CWS' stuttering (n = 3), including such sentiments as "not bothered by his stammer because he is not" and "more relaxed about speech—notice it less." They also discussed the notion of acceptance (n = 2), such as "accepting what is, and living with it," and having a deeper understanding of their CWS' experience of stuttering and how to best help them (n = 2), including reports of "I feel more confident in helping him" and "I have more understanding of what it's like for her and when she has her bumpy days." Parents also indicated that they were more prepared for the variability of stuttering (n = 1) and were taking small steps toward progress (n = 1).

(2) Six parents noticed enhanced parent–child interactions. They indicated that they were listening to their

CWS more (n = 4) and making more eye contact (n = 2). Furthermore, they were making more time for interaction (n = 2), interrupting less (n = 1), and taking more conversational turns with their CWS (n = 1).

(3) Five parents identified improved family dynamics. This sign of progress was corroborated by parents' reports that they were praising their CWS more than before (n = 3), such as "praising her for good behavior or work." They also noted an increase in sharing feelings and ideas more openly (n = 1) and spending more quality family time together (n = 1). These likely contributed to overall improvements in the home environment (n = 1).

(4) Five parents indicated that they were encouraging their child's personal growth. They described facilitating their CWS' independence (n = 3), including such reports as "I leave my child to it more than I used to" and "trying to encourage his newfound wishes for independence." Parents also explained that they were more accepting of their child's maturation (n = 2) by "letting him grow up" and "accepting maturity and growth of my child." Furthermore, they were promoting their CWS' overall engagement in activities (n = 1).

(5) Three parents reported changed thoughts and feelings about their CWS' stuttering. Parents reported that they were more relaxed (n = 3), less worried about their child's stuttering (n = 3), and more patient overall (n = 1).

(6) Two parents indicated that they appreciated receiving education and social support. They valued receiving knowledge from the therapy (n = 1) and benefited from communicating with others (n = 1).

How Did Clients' Perspectives of Change Compare to Their Pretherapy Best Hopes?

Qualitative Comparison of Pre- and Posttherapy Perspectives

The results provided in the following section are a comparison of the thematic networks constructed for this follow-up study and those reported in our preliminary study (Berquez et al., 2015).

CWS' perceptions of change about themselves. At the level of organizing theme, all four best hopes that CWS identified pretherapy were realized 1 year later. In the pretherapy worksheets, CWS indicated that they hoped to change their thoughts and feelings about stuttering and themselves, increase their verbal participation, make communication-related changes, and increase their socializing and social support. The small signs of change that CWS identified 1 year later indicated that they indeed noticed changes in all four of these domains. Generally, CWS' reflections on signs of change 1 year post were more nuanced and more specific than their pretherapy best hopes. In the pretherapy worksheets, their responses were organized into 15 basic themes and four organizing themes. One year later, their responses were organized into 26 basic themes and six organizing themes. The two additional signs of change at the level of organizing theme included improved academic performance and improved adaptive coping related to their stuttering. While all CWS' pretherapy best hopes were realized, it is important to note that "more" themes were generated at the end of therapy than were originally hoped for at the outset of therapy.

Parents' perceptions of change about their CWS. At the level of organizing theme, all three best hopes that parents identified in pretherapy were realized 1 year later. In the pretherapy worksheets, parents indicated that they hoped their CWS would change their thoughts and feelings about stuttering and themselves, make communication-related changes, and increase their socializing and social support. The small signs of change that parents identified for their CWS 1 year later indicated that they indeed noticed these changes. Compared to the best hopes they identified in the pretherapy worksheets, parents' perspectives of change for their CWS 1 year later were more nuanced and specific. Pretherapy, parents' responses were arranged into 12 basic themes and three organizing themes. One year later, their responses were arranged into 22 basic themes and five organizing themes, suggesting that their perspectives on change were more elaborate than they had originally hoped for. Similar to CWS perspectives of change, all parent themes identified pretherapy were realized, with a larger number of themes being identified than originally hoped for at the beginning of therapy.

Parents' perceptions of change about themselves. At the level of organizing theme, all three best hopes that were identified in pretherapy interviews were realized 1 year later. In the pretherapy worksheets, parents indicated that they hoped they would improve their own adaptive coping related to their child's stuttering, receive education and support related to their child's stuttering, and change their family dynamics. The small signs of change that parents reported for themselves 1 year later indicated that they indeed noticed these changes. Similar to the elaboration of best hopes that was apparent in the CWS' and their parents' thematic networks reported above (see Figures 1 and 2), parents' perspectives on self-progress 1 year after the start of therapy were also broader. In the pretherapy worksheets, parent responses were arranged into nine basic themes and three organizing themes. One year later, their responses were arranged into 23 basic themes and six organizing themes. These additional organizing themes included enhancing their parent–child interactions, encouraging their CWS' personal growth, and changing their thoughts and feelings about their CWS' stuttering. While all parent themes identified pretherapy were realized, more themes were identified than hoped for in the start of therapy.

Quantitative Comparison of Pre- and Posttherapy Rating Scales

On the SFBT worksheet, clients were asked, "On a scale from 1 to 10, where 10 represents your best hopes from therapy and 1 represents the opposite, where are things now?" They were then prompted to place a hashmark along a 100-mm visual analogue scale. The median ratings on the 1–10 rating scales (millimeter distance from the left

anchor to the client's hashmark) on the first and last day of therapy were compared. For the posttherapy worksheet, it is important to note that the clients did not have access to their ratings that they made at the pretherapy time point. For CWS, their mean posttherapy rating ($M = 75$, $SD = 12.60$) was significantly higher than their mean pretherapy rating ($M = 48$, $SD = 15.05$), $t(6) = -4.32$, $p = .005$. A similar pattern was observed for the parents as their mean posttherapy rating ($M = 80.83$, $SD = 11.17$) was also significantly higher than their mean pretherapy rating ($M = 45.51$, $SD = 26.34$), $t(11) = -4.66$, $p = .001$. In summary, both the CWS' and their parents' perspectives of how close they were to achieving their best hopes had significantly increased from pretherapy interviews to 1 year after the start of therapy (see Figure 4).

Discussion

The purpose of this follow-up study was to examine the use of SFBT principles for helping 11- to 14-year-olds who stutter and their parents explore their perspectives of change after being in a yearlong stuttering therapy program. To do so, we compared clients' responses to SFBT questions regarding what signs of change they had noticed 1 year after the start of therapy to their best hopes that they identified on the first day of therapy. We utilized a mixed-method analysis to analyze their qualitative and quantitative rating scale data. The results suggest that many of their original best hopes identified pretherapy were observed 1 year later, including signs of change in domains of social communication, cognitive-emotional skills, and speech management. Furthermore, CWS and their parents noticed additional gains made over the 1-year period that they had not originally anticipated.

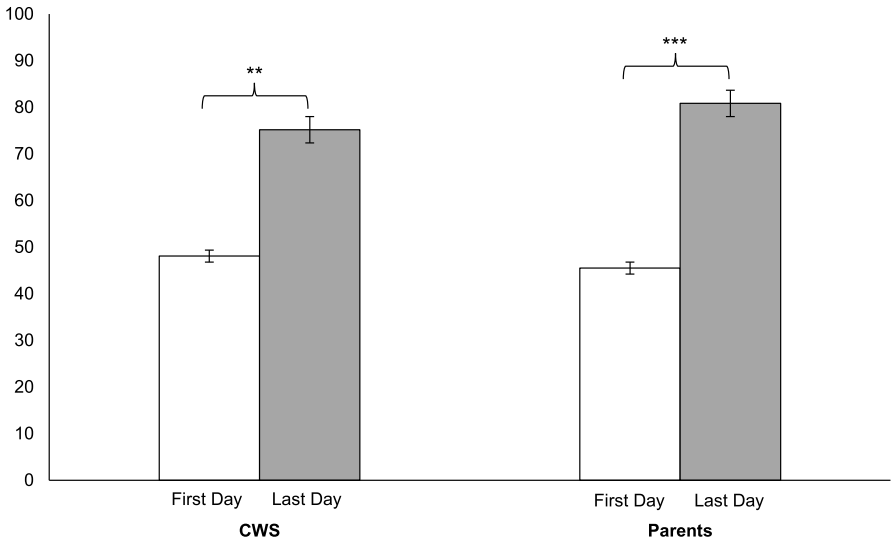
Perspectives of Change

A core principle of SFBT is that the clinician "leads from behind" to promote the client's self-directed change. To do so, clients are urged to move toward rather than away from the problem, assume responsibility for taking action, restructure the cognitive view of self and the problem, and recruit support from others (Manning, 2010). The thematic networks we presented in Figures 1–3 suggest that the CWS and their parents identified all four of these principles as areas of change after being in stuttering therapy for 1 year. Both CWS and their parents reported that they hoped the CWS would increase their verbal participation, which reflects moving toward, rather than away from, the problem (e.g., feared speaking situations). Furthermore, both CWS and their parents reported that they hoped the CWS would improve their adaptive coping, which reflects assuming the responsibility for taking actions, while changing thoughts and feelings about stuttering and themselves reflects restructuring the cognitive view of the self and the problem. Lastly, all three thematic networks revealed that receiving increased support was an important goal for CWS and their parents, which reflects recruiting support from others.

Additional Gains

It should be noted that, regarding parents' observations about signs of change for their CWS (see Figure 2), four organizing themes 1 year after the start of therapy are shaded, although only three organizing themes were identified on Day 1 (presented in Berquez et al., 2015). This is because two notable elaborations in parents' responses yielded an expansion of the organizing themes. First, in

Figure 4. Mean ratings on the visual analogue scale collected from children who stutter (CWS) and their parents at the beginning and end of therapy. Bars depict standard errors. $^{**}p \leq .005$. $^{***}p \leq .001$.



the pretherapy worksheets, parents reported a general hope that their CWS would "improve their coping skills" with little detail about what that would look like. One year later, this concept of improved coping expanded and became its own organizing theme. Posttherapy, parents reported that their CWS improved their coping by demonstrating greater self-regulation, greater acceptance, less worry about stuttering, greater understanding of stuttering, greater resilience, and going out of their comfort zone more frequently. Therefore, the unidimensional basic theme of improved coping in pretherapy interviews evolved into a multidimensional organizing theme 1 year later. Second, in the pretherapy worksheets, parents hoped that their CWS would increase their social support and socialization. This pretherapy organizing theme included four basic themes: that their child would feel less isolated, that their child would meet other CWS, that socializing would be easier for their child, and that their child would be better able to deal with teasing. One year later, this general hope for increased social support and socialization (one organizing theme) expanded into two organizing themes, including receiving social support and improved socializing abilities, containing five and four basic themes, respectively. Therefore, parents described a more nuanced understanding of how their CWS had made progress in the area of social support and socializing abilities.

In general, as can be seen by the amount of nonshaded boxes in the thematic networks in Figures 1–3, both CWS and their parents reported many additional gains that they had not anticipated in the pretherapy worksheets. Based on our findings and those of related literature, it is possible that the very nature of SFBT contributed to the more elaborated picture seen posttherapy. The style of questioning deliberately helped clients to focus on what was working well and what difference that made (George, Iveson, & Ratner, 1999). As CWS and their parents became more attuned to the specifics of what was working well, they could have begun to notice additional small signs of change, much like a domino effect, in that they expected more change to follow. SFBT principles are thought to enable clients to notice concrete examples of small signs of change even when they are not sure if change is possible; even when problems are deeply entrenched, there will be exceptions to the problem (de Shazer, 1985). These exceptions are instances when the problem might have been expected to occur but did not. By helping clients become "good observers of change" within therapy sessions and beyond, they often experience increased hopefulness (Zebrowski, 2007, p. 34).

The SLP's hope for change is also important as she demonstrates confidence in the treatment approach, mastery over techniques, and the expectation that the client will make improvements (Zebrowski, 2007). One major tenet of SFBT is that, "once a small change has been made, it will lead to a series of further changes, which in turn lead to others, gradually resulting in a larger systemic change without major disruption" (de Shazer & Dolan, 2012, p. 2). From this perspective, SFBT may engender an attentional shift in clients and SLPs as they both become better able to attend to the changes the client is making and what is going well, as opposed to a narrow focus on the problem, thus increasing hope and optimism (Harley, 2018).

Overall, it appears that therapy has the potential to yield change that is not predicted or expected at the outset of therapy but has value for clients. This is important when developing outcome measures or evaluations as the more nuanced change reported here could be underreported.

Limitations and Future Directions

During the process of analyzing the results, a new question that was missing became apparent: What are CWS' best hopes for their parents? Given the premise that systemic change is a valuable part of the change process and is likely bidirectional in nature, it is of equal value to understand what CWS hope their parents might gain from therapy as it is to understand what parents hope their CWS might gain. As a result, this question is now included in the SFBT conversations in this therapy program.

Another potential limitation is the inherently optimistic style of SFBT. It is, by nature, solution focused. Therefore, it is possible that this framework might discourage clients from discussing the problem for which they seek therapy. However, solution-focused conversations make room for acknowledging the difficulties while prioritizing possibilities (O'Hanlon & Beadle, 1997). When CWS or their parents reported that things have been challenging, the SLP acknowledged their experience, encouraged the client to talk about it, and explored how they had managed in spite of things being so difficult; this helped the client refocus on how they were coping. SLPs created an environment in which CWS and their parents could discuss what was important to them: "let clients know that you have heard and understood their suffering, their concerns, their felt-experience and their points of view, without closing down the possibilities for change" (O'Hanlon & Beadle, 1997, p. 17).

While the clients did express notable improvements over the course of the yearlong program, it is imperative to highlight this was not a treatment efficacy study. There were no control participants, and the sample was small. Furthermore, the positive outcomes may have resulted from an unavoidable maturation effect where the CWS were in a better place with stuttering simply because they were a year older and therefore more mature and independent. Additionally, the therapy program does seek to address social communication abilities, cognitive-emotional responses to stuttering, and speech management strategies (Cook & Botterill, 2005; Millard, 2011). Clients are not aware of these goals at the outset of therapy, but these goals do inform the nature of the therapy program. As such, it is possible that clients focus on changes in these domains because they are primed to do so. Keeping these potential threats to internal validity in mind, the positive changes that we documented in this study show the diverse, holistic changes that were important and meaningful to CWS and their parents from their perspective. In the future, it would be important to further investigate the specific processes of change that takes place over the year.

For instance, what are the mechanisms of change in this intensive therapy program? It would be worthwhile to tease apart the active ingredients that allow clients to move in the direction they are hoping for.

Conclusions

This follow-up study examined how SFBT principles were used to explore perspectives of change among older CWS and their parents after a yearlong therapy program. SLPs posed SFBT-style questions to the clients to promote self-reflection on small signs of change they had noticed 1 year after therapy began. These were compared to their pretherapy best hopes to illuminate what they considered to be important. Many of the client's best hopes from therapy at the level of organizing theme were indeed realized, as demonstrated by the gray-shaded boxes in the thematic networks (see Figures 1–3). Arguably more importantly, the breadth and depth of improvements that clients shared at the end of therapy were maximized when compared to their pretherapy best hopes. These findings support the use of SFBT dialogic principles to compare clients' therapeutic best hopes in pretherapy interviews to the signs of change they notice along the way in order to define the therapeutic change that is personally relevant and meaningful.

Acknowledgments

This study was supported by Whittington Health and Action for Stammering Children. Many thanks to the clients and clinicians who took part and to Sharon Millard for her feedback on this clinical focus article.

References

Andrews, M. A., & Andrews, J. R. (1993). Family-centered techniques: Integrating enablement into the IFSP process. *Journal of Childhood Communication Disorders, 15*(1), 41–46. http://journals.sagepub.com.proxy.lib.uiowa.edu/doi/pdf/10.1177/152574019301500107 https://doi.org/10.1177/152574019301500107

Attride-Stirling, J. (2001). Thematic networks: An analystic tool for qualitative research. *Qualitative Research, 1*(3), 385–405. https://doi.org/10.1177/146879410100100307

Beilby, J. M., Byrnes, M. L., & Yaruss, J. S. (2012). Acceptance and Commitment Therapy for adults who stutter: Psychosocial adjustment and speech fluency. *Journal of Fluency Disorders, 37*(4), 289–299. https://doi.org/10.1159/000501078

Bailey, K., Harris, S. J., & Simpson, S. (2015). Stammering and the social model of disability: Challenge and opportunity. *Procedia—Social and Behavioral Sciences, 193,* 13–24. https://doi.org/10.1016/j.sbspro.2015.03.240

Baxter, S., Johnson, M., Blank, L., Cantrell, A., Brumfitt, S., Enderby, P., & Goyder, E. (2015). The state of the art in non-pharmacological interventions for developmental stuttering. Part 1: A systematic review of effectiveness. *International Journal of Language & Communication Disorders, 50*(5), 676–718. https://doi.org/10.1111/1460-6984.12171

Berg, I. K., & Dolan, Y. (2001). *Tales of solutions: A collection of hope-inspiring stories*. W W Norton.

Berquez, A., Hertsberg Rodgers, N., Hollister, J., & Millard, S. (2015). What do children who stutter and their parents expect from therapy and are their hopes aligned? *Procedia—Social and Behavioral Sciences, 193,* 25–36.

Berquez, A., & Kelman, E. (2018). Methods in stuttering therapy for desensitizing parents of children who stutter. *American Journal of Speech-Language Pathology, 27*(3S), 1124–1138. https://doi.org/10.1044/2018_AJSLP-ODC11-17-0183

Biggart, A., Cook, F. M., & Fry, J. (2006). The role of parents in stuttering treatment from a cognitive behavioural therapy perspective. In J. Au-Yeung & M. M. Leahy (Eds.), *Research, treatment and self-help in fluency disorders: New horizons: Proceedings fo the Fifth World Congress on Fluency Disorders, 25–28 July, 2006, Dublin, Ireland* (pp. 368–375). International Fluency Association.

Botterill, W. (2011). Developing the therapeutic relationship: From "expert" professional to "expert" person who stutters. *Journal of Fluency Disorders, 36*(3), 158–173. https://doi.org/10.1016/j.jfludis.2011.02.002

Boyle, M. P. (2011). Mindfulness training in stuttering therapy: A tutorial for speech-language pathologists. *Journal of Fluency Disorders, 36*(2), 122–129. https://doi.org/10.1016/j.jfludis.2011.04.005

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*. https://doi.org/10.1080/14780887.2020.1769238

Briggs, M. H. (1998). Families talk: Buildling partnerships for communicative change. *Topics in Language Disorders, 18*(3), 71–84. https://doi.org/10.1097/00011363-199805000-00009

Caughter, S., & Crofts, V. (2018). Nurturing a resilient mindset in school-aged children who stutter. *American Journal of Speech-Language Pathology, 27*(3S), 1111–1123. https://doi.org/10.1044/2018_AJSLP-ODC11-17-0189

Caughter, S., & Dunsmuir, S. (2017). An exploration of the mechanisms of change following an integrated group intervention for stuttering, as perceived by school-aged children who stutter (CWS). *Journal of Fluency Disorders, 51,* 8–23. https://doi.org/10.1016/j.jfludis.2016.10.003

Cook, F. M., & Botterill, W. (2005). Family-based approach to therapy with primary school children: "Throwing the ball, back". In R. Lees & C. Stark (Eds.), *The treatment of stuttering in the young school-aged child* (pp. 81–107). Whurr.

Cooke, K., & Millard, S. K. (2018). The most important therapy outcomes for school-aged children who stutter: An exploratory study. *American Journal of Speech-Language Pathology, 27*(3S), 1152–1163. https://doi.org/10.1044/2018_AJSLP-ODC11-17-0195

Dalton, P., & Dunnett, G. (1995). *A psychology for living: Personal construct theory for professionals and clients*. Wiley.

de Shazer, S. (1985). *Keys to solution in brief therapy*. W.W. Norton.

de Shazer, S., & Dolan, Y. (2012). *More than miracles: The state of the art of solution-focused brief therapy*. Routledge. https://doi.org/10.4324/9780203836484

DiLollo, A., & Manning, W. H. (2007). Counseling children who stutter and their parents. In E. G. Conture & R. F. Curlee (Eds.), *Stuttering and related disorders of fluency* (3rd ed., pp. 115–130). Thieme.

Emge, G., & Pellowski, M. W. (2019). Incorporating a mindfulness meditation exercise into a stuttering treatment program. *Communication Disorders Quarterly, 40*(2), 125–128. https://doi.org/10.1177/1525740118783516

Floyd, J., Zebrowski, P. M., & Flamme, G. A. (2007). Stages of change and stuttering: A preliminary view. *Journal of Fluency Disorders, 32*(2), 95–120. https://doi.org/10.1016/j.jfludis.2007.03.001

Franklin, C., Zhang, A., Froerer, A., & Johnson, S. (2017). Solution focused brief therapy: A systematic review and meta-summary of process research. *Journal of Marital and Family Therapy, 43*(1), 16–30. https://doi.org/10.1111/jmft.12193

Freud, D., Levy-Kardash, O., & Ezrati-Vinacour, R. (2019). Pilot program combining Acceptance and Commitment Therapy with stuttering modification therapy for adults who stutter: A case report. *Folia Phoniatrica et Logopaedica, 72,* 290–301. https://doi.org/10.1159/000501078

Fry, J. (2013). Therapy within a CBT framework. In C. Cheasman, R. Everard, & S. Simpson (Eds.), *Stammering therapy from the inside: New perspectives on working with young people and adults* (pp. 303–338). J&R Press.

George, E., Iveson, C., & Ratner, H. (1999). *Problem to solution: Brief therapy with individuals and families* (2nd ed.). BT Press.

George, E., Iveson, C., & Ratner, H. (2015). Solution-focused brief therapy. In E. S. Neukrug (Ed.), *SAGE Encyclopedia of theory in counseling and psychotherapy* (pp. 1–7). Sage. https://doi.org/10.4135/9781483346502.n338

Guest, G., MacQueen, K. M., & Namey, E. E. (2012). *Applied thematic analysis*. Sage.

Harley, J. (2015). Bridging the gap between cognitive therapy and Acceptance and Commitment Therapy (ACT). *Procedia – Social and Behavioral Sciences, 193,* 131–140.

Harley, J. (2018). The role of attention in therapy for children and adolescents who stutter: Cognitive behavioral therapy and mindfulness-based interventions. *American Journal of Speech-Language Pathology, 27*(3S), 1139–1151. https://doi.org/10.1044/2018_AJSLP-ODC11-17-0196

Ingham, R. J., Ingham, J. C., & Bothe, A. K. (2012). Integrating functional measures with treatment: A tactic for enhancing personally significant change in the treatment of adults and adolescents who stutter. *American Journal of Speech-Language Pathology, 21*(3), 264–277. https://doi.org/10.1044/1058-0360(2012/11-0068)

Kelly, E. L. (1955). Consistency of the adult personality. *American Psychologist, 10*(11), 659–681. https://doi.org/10.1037/h0040747

Kelman, E., & Nicholas, A. (2020). *Palin parent–child interaction therapy for early childhood stammering* (2nd ed.). Routledge.

Kelman, E., & Wheeler, S. (2015). Cognitive behaviour therapy with children who stutter. *Proceedia – Social and Behavioral Sciences, 193,* 165–174.

Luterman, D. (2016). *Counseling persons with communication disorders and their families* (6th ed.) Pro-Ed.

Manning, W. (2010). *Clinical decision making in fluency disorders* (3rd ed.). Delmar.

Manning, W. H., & Dilollo, A. (2007). Traditional approaches to treatment of stuttering in adolescents and adults. In E. G. Conture & R. F. Curlee (Eds.), *Stuttering and related disorders of fluency* (3rd ed., pp. 233–255). Thieme.

McNeill, C. (2013). The teens challenge: Stammering therapy, learning and adventure. In C. Cheasman, R. Everard, & S. Simpson (Eds.), *Stammering therapy from the inside: New perspectives on working with young people and adults*. J&R Press.

Menzies, R. G., O'Brian, S., Onslow, M., Packman, A., St Clare, T., & Block, S. (2008). An experimental clinical trial of a cognitive-behavior therapy package for chronic stuttering. *Journal of Speech, Language, and Hearing Research, 51*(6), 1451–1464. https://doi.org/10.1044/1092-4388(2008/07-0070)

Menzies, R. G., Onslow, M., Packman, A., & O'Brian, S. (2009). Cognitive behavior therapy for adults who stutter: A tutorial for speech-language pathologists. *Journal of Fluency Disorders, 34*(3), 187–200. https://doi.org/10.1016/j.jfludis.2009.09.002

Millard, S. K. (2011). Intensive group therapy for children who stutter: Early evidence. *SIG 4 Perspectives on Fluency and Fluency Disorders, 21*(1), 22–32. https://doi.org/10.1044/ffd21.1.22

Milner, J., & O'Byrne, P. (2003). *Assessment in counseling: Theory, process and decision-making*. MacMillan.

Murphy, J. J. (1996). Solution-focused brief therapy in the school. In S. D. Miller, M. A. Hubble, & B. L. Duncan (Eds.), *Handbook of solution-focused brief therapy* (pp. 184–204). Wiley.

Nicholas, A. (2015). Solution focused brief therapy with children who stutter. *Procedia—Social and Behavioral Sciences, 193,* 209–216. https://doi.org/10.1016/j.sbspro.2015.03.261

Northcott, S., Burns, K., Simpson, A., & Hilari, K. (2016). "Living with aphasia the best way I can": A feasibility study exploring solution-focused brief therapy for people with aphasis. *Folia Phoniatrica et Logopaedica, 67*(3), 156–167. https://doi.org/10.1159/000439217

O'Hanlon, W. H., & Beadle, S. (1997). *A field guide to possibility land: Possibility therapy methods*. BT Press.

Plexico, L. W., & Burrus, E. (2012). Coping with a child who stutters: A phenomenological analysis. *Journal of Fluency Disorders, 37*(4), 275–288. https://doi.org/10.1016/j.jfludis.2012.06.002

Ratner, H., George, E., & Iveson, C. (2012). *Solution focused brief therapy: 100 Key points and techniques*. Routledge.

Shirk, S. R., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71*(3), 452–464. https://doi.org/10.1037/0022-006X.71.3.452

Sisskin, V. (2018). Avoidance Reduction Therapy for Stuttering (ARTS). In B. J. Amster & E. R. Klein (Eds.), *More than fluency: The social, emotional, and cognitive dimensions of stuttering* (pp. 157–186). Plural Publishing.

Wambaugh, J. L. (2007). The evidence-based practice and practice-based evidence nexus. *SIG 2 Perspectives on Neurophysiology and Neurogenic Speech and Language Disorders, 17*(1), 14–18. https://doi.org/10.1044/nnsld17.1.14

Yaruss, J. S., Coleman, C. E., & Quesal, R. W. (2012). Stuttering in school-age children: A comprehensive approach to treatment. *Language, Speech, and Hearing Services in Schools, 43*(4), 536–548. https://doi.org/10.1044/0161-1461(2012/11-0044)

Zebrowski, P. M. (2007). Treatment factors that influence therapy outcomes of children who stutter. In E. G. Conture & R. F. Curlee (Eds.), *Stuttering and related disorders of fluency* (3rd ed., pp. 23–38). Thieme.