

Empathy: Perhaps the Most Important *E* in EBP

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ABSTRACT

Treatment of stuttering has recently been influenced by calls for evidence-based practice. Unfortunately, most of the existing treatment “evidence” in stuttering focuses on the surface behaviors of the disorder. Although these behaviors are an important part of the problem of stuttering, they may not be the most critical factor to the person who stutters. This article discusses *loss of control* as the critical factor in stuttering and examines historical and practical reasons why this part of the disorder has been largely ignored in research about stuttering and stuttering treatment. Suggestions for viewing stuttering from the perspective of the client and the importance of taking this perspective are provided.

KEYWORDS: Empathy, evidence-based practice, stuttering treatment, loss of control

Learning Outcomes: As a result of this activity, the reader will be able to (1) discuss historical reasons why the speaker’s experience of stuttering has not been a focus of stuttering research; (2) evaluate ways in which disfluency, as experienced by the person who does not stutter, differs from stuttering, as experienced by the person who stutters; (3) summarize the three factors that lead to the development of stuttering and that make stuttering so problematic for the person who stutters; (4) evaluate ways in which goals for therapy change when the speech-language pathologist takes an empathetic view of the stuttering disorder.

In recent years, discussion of treatment of communication disorders has included considerable focus on evidence-based treatment or evidence-based practice (EBP).^{1–3} Most readers are familiar with somewhat abbreviated

definitions of EBP such as that from the American Speech-Language-Hearing Association: “The goal of EBP is the integration of: (a) clinical expertise, (b) best current evidence, and (c) client/patient values to provide high-quality

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Stuttering Treatment: Becoming an Effective Clinician;

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services reflecting the interests, values, needs, and choices of the individuals we serve"⁴ (<http://www.asha.org/members/ebp>).

Speech-language pathologists (SLPs) may be less familiar with the more detailed description provided by Sackett and colleagues,⁵ from which many of the abbreviated definitions are derived:

Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer.

Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough. Without clinical expertise, practice risks becoming tyrannised by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Without current best evidence, practice risks becoming rapidly out of date, to the detriment of patients (p. 71).

In attempting to apply the "individual clinical expertise" and "the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences" aspect of this definition in earlier writings,⁶ at times, I have been accused of being antievidence.⁷ In this article, I attempt a more structured discussion of what, in recent years, I have referred to as "empathy-based" treatment for stuttering and I explain why empathy may be the most critical factor in delivering successful therapy to our clients who stutter. At the outset, I admit that this is not necessarily a new discussion. Many authors have attempted to emphasize the importance of the perspective of the person who stutters in our understanding of the disorder of stuttering,⁸⁻¹¹ and those attempts have met with varying degrees of resistance. I also admit that much of this discussion is not based on peer-reviewed evidence. Very few (if any) empirical studies of empathy *in stuttering treatment* have been conducted. I offer some thoughts as to why those studies have not been performed. Most of this discussion is based upon things I have learned from having spent my life as a person who stutters and, more importantly, as someone who has studied the disorder of stuttering and worked with people who stutter for over 30 years. There is no question that my thinking about stuttering has evolved considerably over the years, from the time I attempted to understand it as a boy who stuttered to the present day, as an aging college professor who continues to stutter. My personal experience, of course, has never been sufficient. I was fortunate to have entered the profession of speech-language pathology as a relatively young man because, as a result of that, I read more and more about stuttering, and then met more and more people who stutter. It is probably safe to say that I have thought about stuttering, to varying degrees, every day of my life for the nearly 40 years that I have been involved in the profession of speech-language pathology. As I learned more about stuttering, some common themes emerged. Among these are that some children recover from stuttering and others do not, that not all treatments work for all people who stutter, that many areas of research that initially appear quite promising often seem to be dropped after a few

years of inconsistent findings, and many others. However, the one that has continued to draw my attention is that it seems to be very difficult for many people to understand stuttering. It was almost as though people who stutter and (many of) those who do not are, at least at times, talking about two different things. In recent years, I have come attribute this to the challenge of empathizing with the person who stutters.

The construct of empathy has been widely researched and discussed in the social psychology, counseling, and other “helping professions” literature, and a detailed discussion of that construct is well beyond the purposes of this article. Empathy can be defined as “the intellectual identification with or vicarious experiencing of the feelings, thoughts, or attitudes of another,”¹² or “The ability to be able to feel what another person feels, whether you’ve been in their position or not.”¹³ A more colloquial definition, the one I focus on in this article, is simply putting oneself in another’s shoes. I am not suggesting that SLPs—or researchers, for that matter—do not *attempt* to put themselves in the shoes of the person who stutters when trying to either understand or study the disorder of stuttering. I am suggesting, however, that there are certain things about stuttering that makes understanding the speaker’s experience of stuttering quite difficult for many of those who do not stutter. I also believe that this difficulty in understanding the disorder from the speaker’s perspective—what I refer to in this article as *empathy*—has contributed to a lack of progress in fully understanding the disorder. Beyond that, I also believe it has been a factor in the often bitter disagreements among many of us who study and treat the disorder, the distrust of the profession of speech-language pathology among many people who stutter, and will, in the future, likely be a roadblock to real progress in EBP in stuttering.

There are several examples in the speech pathology literature where researchers have apparently found it difficult to demonstrate empathy. To some degree, this is not surprising, because scientists are expected to be dispassionate, objective observers of whatever they are studying. In fact, one could suggest that at

times scientists may confuse their lack of empathy with scientific objectivity. Two historical (and in my opinion, important) examples of this are articles that attempted to define the disorder of stuttering, and the responses to those articles. The articles are Wingate’s¹⁴ classic “A Standard Definition of Stuttering” and Perkins’¹⁰ “What Is Stuttering?”

Wingate’s¹⁴ standard definition influenced how stuttering was viewed and measured for many years. However, the definition addressed primarily the surface features of stuttering (e.g., repetitions, hesitations, prolongations), with less emphasis on what Wingate referred to as “accessory features” (what most people would likely call “secondary behaviors”). Interestingly (and importantly), Wingate only gave brief mention to what he referred to as “associated features.” The latter were described by Wingate thusly:

In a proportion of cases of stuttering one may be aware of certain accompanying features of a more or less general or vague nature which include such things as indications or report of excitement, tension, personal reactions, feelings, or attitudes. The nature and extent of such features show considerable variation and their relationship to stuttering is not very well known (that is, causal, reactive, interactive, or concurrent). Thus, while mention of them in a definition of stuttering seems warranted, they should be assigned a subsidiary status (p. 488).

Shortly after Wingate’s article was published, Woolf¹⁵ wrote a letter to the editor in which he took issue with Wingate’s definition. Woolf expressed several concerns, primarily that the definition did not sufficiently address the role that struggle, avoidance, and expectancy behavior play in the disorder, particularly in its more advanced forms. Woolf also pointed out that the reason that Wingate felt that these components were less important was because, according to Wingate, they were not always considered to be stuttering by listeners (or by the person who stuttered). However, Woolf also pointed out that “stutterers [sic] are often grossly unaware of much of their stuttering—including the overt struggle aspects” (p. 199).

Wingate,¹⁶ of course, responded, writing:

Woolf comments on evidence suggesting “that stuttering, at least in its more advanced forms, includes the dimensions of struggle, avoidance, and expectancy.” But a standard definition of stuttering cannot be concerned only with stuttering in its more advanced forms; and, further, it should not be determined by “suggestive” evidence. Woolf states that “Bloodstein reports that expectancy and struggle are present in the earliest phase of stuttering,” but it must be recognized that this is simply Bloodstein’s report and not an established fact. This is an interpretation offered by Bloodstein (and one which, in my view, reduces the concept of expectancy from the area of possibility to the level of absurdity) (p. 201).

This was certainly not the only example of Wingate dismissing the harder to observe/harder to measure aspects of stuttering in his writings (see, for example, Wingate^{17,18}), but it may be one of the earliest. In fact, up until shortly before his death, Wingate¹⁹ continued to essentially blame people who stutter in the profession of speech-language pathology for many of the difficulties we face in trying to understand the disorder. (In reading Wingate, I think most would agree that he was anything but dispassionate about stuttering.) I will return to this issue later in this article.

Another very important article was published in 1990 by Perkins. “What Is Stuttering?”¹⁰ was based on a study conducted with his student, Sulyn Moore.²⁰ Perkins^{21,22} had argued for several years that the essence of stuttering was “temporary overt and covert loss of control of the ability to move forward fluently in the execution of linguistically formulated speech” (Perkins,²² p. 431). The Moore and Perkins study was an empirical demonstration of the importance of that loss of control. Perkins¹⁰ argued that definitions of stuttering that relied primarily or solely on descriptions of overt stuttering behavior were flawed because the essence of stuttering was the feeling of loss of control that could only be experienced by the person who stutters. The participant in the Moore and Perkins study was a woman who

was effective at imitating her stuttering. When recordings of her real and imitated stutters were played for unsophisticated judges, those judges were unable to determine which were real and which were imitated, beyond levels that would be expected by chance alone. As she made the recordings, the participant in the study signaled to indicate whether a moment of stuttering was real or not, so initially she was able to identify all of the real and imitated stutters. As time passed, however, her ability to differentiate the real and imitated stutters declined to the point where, when asked to judge the recordings of her speech 4 days after making the recording, her ability to identify whether a moment of stuttering was real or not was about the same as that of the unsophisticated judges. Once the internal cues were gone, she, in essence, became a listener or observer rather than the person who was experiencing stuttering.

In his 1990 article, Perkins went to great lengths to try to explain why the speaker’s experience of loss of control was so critical to stuttering and why that loss of control should be an element of any definition of the disorder.¹⁰ He provided a rich description of the history of stuttering theory, stuttering therapy, and stuttering measurement, and how and why those intertwined to lead us to definitions that did *not* include the speaker as part of the equation. As I read Perkins, it seemed to me that the point he was trying to make was that surface behavior did not accurately capture the essence of stuttering—stuttering was something experienced by the speaker. It seemed quite logical to me at the time (and still does).

In response to Perkins, Bloodstein,²³ Ingham,²⁴ and Smith²⁵ wrote commentaries. As I read their commentaries, I felt that all seemed to miss the critical point of Perkins’s article—feeling of loss of control as the essence of stuttering—and instead they focused narrowly on the definition issue. Bloodstein, for example, said, “The question of whether stuttering is really what the listener observes, the stutterer senses, or the dictionary states looks suspiciously like a question about the use of words. Stuttering can probably be defined with advantage in appropriate contexts as any or all of these things”²³ (p. 393). Smith said, “Although I agree that any theory or definition

of stuttering derived solely from perception of acoustic events cannot be satisfactory, I do not believe that Perkins's definition is preferable. Perkins seeks a definition that categorizes events either as stuttering or not stuttering. I suggest . . . that any definition or theory of stuttering that depends on categorization of events as stuttering or nonstuttering must fail"²⁵ (p. 398). Smith goes on: "Perkins also indicates that this quality of 'involuntariness,' as it is a private experience, may only be assessed by self-report of the speaker. Rather than opening the door to new inquiries, this retreat to mentalism closes the door to scientific efforts to understand stuttering. How can investigators rely on the reported feelings of subjects without any means of objectifying these reports?" (p. 399). Ingham said, "I will argue that Perkins (1990) and Moore and Perkins (1990) may have only relocated the judgment reliability problem and, in doing so, raised as many validity problems as those generated by a listener-based definition of stuttering"²⁴ (p. 394). Ingham also said, "It is also interesting to consider what force Dr. Perkins's argument might have if a stutterer constantly disagreed with listeners' agreed-upon judgments. I would wager . . . that most theoreticians and researchers would grant validity to the listeners' judgments over the stutterer's" (p. 395).

As I read these interactions (now 20 years ago), it was hard for me as a person who stutters (but also as a researcher) to understand how the writers could focus so narrowly on the issue of defining stuttering and miss the bigger picture of *the speaker's experience of loss of control* as being the critical element in stuttering. I am not suggesting that these writers—and many others—are incapable of empathy. What I am suggesting is that, because they had never experienced stuttering, they apparently found it difficult to conceive of a definition that would make the speaker's experience such a central element. At that time these authors wrote their commentaries, it appeared that the experience of stuttering to them was as elusive as the experience of childbirth is to me. In fairness, I will point out that, historically, much of Bloodstein's work (e.g., anticipatory struggle) has focused on the speaker's experience of stuttering, and no doubt Smith and Ingham may view

stuttering differently today than they did then. In addition, I want to make it clear that I do not bring up these examples to be critical of Bloodstein, Smith, or Ingham. This example is meant to illustrate how "scientific dispassion" can often lead one to take a stance that may conflict with a full understanding of a *human condition*.

I have spent many years trying to explain the disorder of stuttering to a variety of audiences: students, parents of children who stutter, fellow SLPs, fellow researchers, the general public, and others. I believe that there are three critical elements that must be considered when trying to understand stuttering: (1) During a moment of stuttering, the person who stutters is "stuck." He or she either cannot say anything (i.e., is in a block), or involuntarily repeats (words, parts of words, etc.). This, in essence, is the loss of control described by Perkins.¹⁰ (2) Stuttering is a variable disorder. (3) Stuttering is an unpredictable disorder. These three things combine to contribute to the *problem* of stuttering.

I ask the reader to consider stuttering from the perspective of the person who stutters: As he or she is learning to talk, there are instances where, for some unexplained reason, he or she is unable to move ahead in speech. These might initially be viewed by the child as curious events, not necessarily something to be feared or avoided. However, as time goes on these events continue to occur, at different times, seemingly without rhyme or reason, and they may be accompanied by social penalty (e.g., "Don't you know your own name?"). It is likely that the child tries to understand why these events occur at some times and not others, or why the events are more severe at some times than others. In addition, he or she tries to find ways to keep these unpredictable moments from happening, or to find ways to predict when the events may be likely to occur. This, then, leads to things like superstitious (i.e., secondary or accessory) behavior, avoidance (of words, listeners, situations, etc.), and other (mal-)adaptive behavior (see summary in Yairi and Seery²⁶). I do not believe that these behaviors would evolve in the way they do if stuttering were a consistent behavior. If the behavior occurred regularly or in predictable ways, it is not likely that the same coping

patters would emerge. However, the experience of being “unpleasantly surprised” by the loss of control is critical to the evolution of the disorder. I would also submit that the person who stutters does not react to the *behavior of stuttering* (i.e., repetitions, prolongations, blocks), but to the *loss of control* that underlies those behaviors and the feeling of helplessness and frustration that results. Further, I would submit that the clients we see in therapy are not there because they want to learn ways to be fluent (although that is what they often report). Rather, they are in therapy because they want to learn ways to feel more in control of their speech (see Baer^{27,28} and Yaruss et al²⁹). Some readers may feel there is no distinction between the two; I believe there is, and that the difference is an important one.

Are these simply idle speculations, or is there any way to validate my assertions? I propose that the evidence is fairly clear. Before I continue, however, I want to make it clear that I am not framing this in the context of “us versus them.” I believe that many people who do not stutter *do* understand the disorder of stuttering, and show considerable empathy for people who stutter. As Manning⁹ pointed out, it is not impossible for people who do not stutter to understand stuttering; it just takes some effort. I do, however, disagree with Wingate’s¹⁹ contention (perhaps also thought, but unspoken, by others) that professionals who stutter have, in some way, interfered with our progress in understanding the disorder of stuttering. Those professionals, having experienced stuttering themselves, bring a unique perspective to the study of the disorder. If we examine treatments developed by these professionals who stutter, we see that they tend to focus on things that can be related to loss of control or under the surface features of stuttering. For example, we can speculate on why Van Riper³⁰ decided that desensitization was an important component for stuttering treatment, why Sheehan³¹ felt that stuttering was like an iceberg and why avoidance reduction should be an important part of stuttering therapy, why Dean Williams³² wrote that stuttering should be examined in the context of “talking” as opposed to an “it” that was inside the person who stuttered, and why Johnson³³ said that

stuttering “is what the stutterer does trying not to stutter” (p. 68). More recently, individuals such as St. Louis³⁴ and Manning³⁵ have used techniques such as narrative psychology and phenomenological research to develop a fuller understanding of stuttering from the perspective of the person who stutters. What these individuals all have in common, of course, is that they are people who stutter. Although I suspect all of these authors would agree that the surface behaviors of stuttering are at least one aspect of what we are trying to change, they likely would also agree that it is the reactivity to loss of control that leads to the need for desensitization and avoidance reduction, and what leads the person who stutters to “try not to stutter.”

When we consider professionals who are proponents of treatments that focus on surface fluency, virtually all of these individuals do not stutter. Their understanding of stuttering is limited to what they can observe—disfluent speech. Because they never have experienced loss of control of speech, the concept appears to be unimportant or irrelevant to them. In some ways this is not surprising. Normally disfluent individuals usually experience fluency breakdown when they are excited, cannot think of what they want to say, or are talking too fast.³⁶ When most people try to understand stuttering from this perspective, it is logical for them to suggest that person who stutters should calm down, think of what he or she wants to say, or slow down to regain fluency. We could say that these individuals are attempting to empathize with the person who stutters, but their experience of disfluency is not the same as the experience of stuttering. Yes, both stuttering and normal disfluency are involuntary; one might even argue that the normally disfluent speaker experiences a certain loss of control. However, the nonstuttering individual is able to regain that control much more easily and much more quickly than can the person who stutters. (I submit that the two experiences are categorically different, because I have experienced both.) People who do not stutter will sometimes try to use nonspeech experiences to show that, although they do not stutter, they can understand stuttering. I had a colleague many years ago, for

example, who said he had a “shy bladder” and found it difficult to urinate in public restrooms. Based on that, he told me that he could understand what it was like to stutter. My response was that if he had to urinate in front of many people each day and if urination were a social activity, the analogy would have more power. There may be some experiences that allow a person who does not stutter to come close to understanding the disorder; shy bladder is not one of them.

As noted earlier, however, this does not suggest that people who do not stutter are incapable of understanding the loss of control that is so critical to stuttering and its development. Manning⁹ provides an exceptional explanation of the predicament that most nonstuttering SLPs (and their clients) find themselves in:

[Although] as a student I never took a course devoted solely to the topic of stuttering . . . what I did have was my lived experience and my understanding as I learned to survive on a daily basis as a person who stuttered. I knew about the culture of stuttering, and it helped me understand others who were more or less on the same journey. I knew, for example, the power of denial. I understood all too well the things I would do to hide, avoid, or disguise my stuttering so that it would fail to reach the surface and no one would know. I could be completely fluent for my listeners if I did these things well. I also knew that even the possibility of stuttering influenced my decisions about choosing sounds and words, participating in the classroom, using the telephone, and talking with friends and acquaintances. I had some “street smarts” about my problem. From what I could tell, only other PWS [people who stutter] knew such things.

During my brief forays into and out of therapy, I found it surprising that few of my clinicians seemed to understand these aspects of the stuttering experience. Or, if they did, they did not communicate that understanding to me. I was impressed that the clinicians who contacted me seemed to be genuinely nice people who wanted to help. They had a lot of information about stuttering, certainly

more than I did. They knew the names of people in the field, the theories, the terminology, and the techniques that were popular at the time. They clearly knew the textbook information that I had not been exposed to. In short, they knew a lot about the surface features of the problem.

The clinicians who tried to help me were able to count the moments of my stuttering and place the surface features into categories of repetitions, prolongations, and blocks. They highlighted my avoidance and escape behaviors. They were able to tell me, even once in a while show me, how to perform certain techniques for improving my fluency. They gave me assignments to practice during the treatment session and at least attempt to do outside the security of the therapy room. On a few occasions, they went with me and modeled these activities. But, most of my clinicians did not seem to understand my experience of stuttering. I felt that I was up against a monumental and intimidating force, and I was not having much success.

Even though the therapeutic techniques that were used with me resulted in speech that sounded and felt even stranger to me than my stuttering, they were sometimes useful. But techniques did not solve my problem. I still felt helpless and alone. I was terribly frustrated because I knew that I had things to say, but I did not know how to communicate those thoughts with any skill or confidence. If others, including my clinicians, had some sense of my predicament, no one was willing or knew how to tell me (pp. 58–59).

But all is not bleak. Manning goes on to provide several examples of ways in which people who do not stutter can (and have) increased their understanding of the disorder, primarily by finding ways to put themselves in the shoes of people who stutter. I strongly encourage anyone reading this article who would like to learn ways to develop empathy for their clients who stutter to read Manning’s⁹ article.

Manning notes, and I agree, that an important area where empathy (or lack of empathy) becomes a problem is in treatment, specifically, the use of “targets” or “tools” in

therapy. There is no question that modifying one's speech pattern can lead to noticeable changes in fluency. However, people who do not stutter often appear to view targets as *the* answer to the problem of stuttering, saying, for example, "When you use your targets, you are so fluent. Why don't you use them all the time?" When viewed in the context of loss of control and variability, however, targets take on a somewhat different appearance. Yes, they can be helpful and they "work" much of the time. Sometimes, despite one's best effort, the involuntary, out-of-control moment of stuttering occurs and, at that time, these "fluency targets" are not helpful. (Stuttering modification techniques, however—those designed to lessen the feeling of loss of control, and which may still result in stuttering, but less severe stuttering—are often more useful at these times. Having said that, however, I will emphasize that, when viewed in the context of loss of control, no "technique" for stuttering is guaranteed to be effective.) In addition, using targets—or adopting any novel way of speaking for a long period of time—is difficult. (For example, I ask my students to practice and demonstrate a variety of fluency-enhancing behaviors in my graduate stuttering class.³⁷ Generally, they prefer to speak with pseudostuttering behaviors rather than to use the fluency-enhancing behaviors, even though they initially find pseudostuttering to be difficult.) Many SLPs—unintentionally, I hope—impart the message to clients that "if you would just use your targets, you could be fluent," or "if you did it all the time, you could be fluent all the time." The implied meaning in both of these cases is, "There is something you can do to not stutter any more, and therefore if you continue to stutter, you are doing something wrong. You are not working hard enough." I have met many clients in my career who have felt enormous guilt and a tremendous sense of failure when they have been unable to maintain fluency after attending a fluency-shaping therapy program. They were told—either directly or indirectly—that they had been provided with the tools to speak fluently, and as long as they used those tools they would not stutter. Later, when the tools lost their effectiveness^{38,39} and the clients began to stutter again (i.e., react to the loss of control at the

core of stuttering), they were convinced that they were doing something wrong.

I have often said, if stopping stuttering were easy to do, wouldn't people just do it? There must be a reason why *some people* continue to stutter after multiple therapies and years of effort. An expressed or implied message that people who continue to stutter suffer from laziness, not working hard enough, not having figured out a simple answer, "choosing" to stutter, or any other thing that ignores that stuttering, at its core, is intermittent, unpredictable, loss of control seems quite cruel to me.

I would suggest that if we examine individuals who have "overcome" stuttering, we would find that the nature of their success lies in how they have dealt with loss of control. That is, they have developed the ability to speak with a greater feeling of control, have learned ways to be less reactive to the unpredictability of that loss of control, have accepted the variable nature of stuttering, have learned to be less reactive to social penalty, and so on. Although some of these successes may be measured in terms of speech fluency, not all can. In fact, when some people give up their attempt to be fluent by hiding their stuttering, the result may be increased overt disfluency, but reduced handicap as a result of stuttering. In other words, many of our therapy "successes" can, and will, still stutter. Better ways to measure changes in the feeling loss of control—as daunting a challenge as that might be—will allow us to measure treatment success and treatment outcomes in different ways and give a much fuller picture of what we are accomplishing in therapy. To reach that end, however, it is imperative that stuttering be viewed not from the outside, but from the inside—the perspective of the person who stutters. I believe that this empathetic view of stuttering, as difficult as it may be to achieve and as unpalatable as it may be to many researchers (if history is any indication), will prove to be a much more fruitful perspective and will ultimately lead to a deeper understanding of stuttering and stuttering treatment. It is a direction in which we have needed to move for many, many years. EBP provides the ideal impetus and framework from which to proceed.

Clinicians, however, already have sufficient clinical evidence to suggest that taking an empathetic view of the stuttering disorder will allow them to broaden their goals for treatment, change their definitions of success, and provide therapy that more fully addresses the problem of stuttering as experienced by their clients who stutter. This, too, can only lead to better treatments for all of our clients who stutter. You may not stutter, but you can put yourself in your clients' shoes. If you can truly do this, stuttering may appear to be quite a different disorder.

REFERENCES

- Davidow JH, Bothe AK, Bramlett RE. The Stuttering Treatment Research Evaluation and Assessment Tool (STREAT): evaluating treatment research as part of evidence-based practice. *Am J Speech Lang Pathol* 2006;15(2):126–141
- Prins D, Ingham RJ. Evidence-based treatment and stuttering—historical perspective. *J Speech Lang Hear Res* 2009;52(1):254–263
- Zipoli RP Jr, Kennedy M. Evidence-based practice among speech-language pathologists: attitudes, utilization, and barriers. *Am J Speech Lang Pathol* 2005;14(3):208–220
- American Speech-Language-Hearing Association. Evidence-based practice (EBP). Available at: <http://www.asha.org/members/ebp>. Accessed April 26, 2010
- Sackett DL, Rosenberg WMC, Gray JA, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. *BMJ* 1996;312(7023):71–72
- Yaruss JS, Quesal RW. Research based stuttering therapy revisited. *Perspectives on Fluency and Fluency Disorders* 2002;12:22–24
- Ingham JC. Evidence-based treatment of stuttering: I. Definition and application. *J Fluency Disord* 2003;28:197–206; quiz 206–207
- Cooper EB. Chronic perseverative stuttering syndrome: a harmful or helpful construct? *Am J Speech Lang Pathol* 1993;2:11–15
- Manning W. How can you understand? You don't stutter! *Contemporary Issues in Communication Science and Disorders* 2004;31:58–68
- Perkins WH. What is stuttering? *J Speech Hear Disord* 1990;55(3):370–382; discussion 394–397
- Quesal RW. Stuttering research: have we forgotten the stutterer? *J Fluency Disord* 1989;14: 153–164
- Random House Dictionary of the English Language (RHDEL). 2nd ed. Unabridged. New York, NY: Random House; 1987
- Urban Dictionary. Available at: <http://www.urbandictionary.com>. Accessed April 21, 2010
- Wingate ME. A standard definition of stuttering. *J Speech Hear Disord* 1964;29:484–489
- Woolf G. A definition in search of data and a theory (A comment on Wingate's "Standard Definition of Stuttering"). *J Speech Hear Disord* 1965;30:199–200
- Wingate ME. A reply. *J Speech Hear Disord* 1965;30:200–202
- Wingate ME. A rational management of stuttering. In: Peins M, ed. *Contemporary Approaches to Stuttering Therapy*. Boston, MA: Little, Brown and Company; 1984:271–298
- Wingate ME. Physiological and genetic factors. In: Shames GH, Rubin H, eds. *Stuttering Then and Now*. Columbus, OH: Charles E. Merrill; 1986:49–69
- Wingate ME. *Foundations of Stuttering*. San Diego, CA: Academic Press; 2002
- Moore SE, Perkins WH. Validity and reliability of judgments of authentic and simulated stuttering. *J Speech Hear Disord* 1990;55(3):383–391; discussion 394–397
- Perkins WH. The problem of definition: commentary on stuttering. *J Speech Hear Disord* 1983; 48:226–246
- Perkins WH. Stuttering as a categorical event: barking up the wrong tree—a reply to Wingate. *J Speech Hear Disord* 1984;49:431–433
- Bloodstein O. On pluttering, skivvering, and floggering: a commentary. *J Speech Hear Disord* 1990;55(3):392–393; discussion 402–404
- Ingham RJ. Commentary on Perkins (1990) and Moore and Perkins (1990): On the valid role of reliability in identifying "What is stuttering?" *J Speech Hear Disord* 1990;55:394–397
- Smith A. Toward a comprehensive theory of stuttering: a commentary. *J Speech Hear Disord* 1990;55(3):398–401; discussion 402–404
- Yairi E, Seery CH. *Stuttering: Foundations and Clinical Applications*. Upper Saddle River, NJ: Pearson Higher Education; 2011
- Baer D. If you know why you're changing a behavior, you'll know when you've changed it enough. *Behav Assess* 1988;10:219–223
- Baer D. The critical issue in treatment efficacy is knowing why treatment was applied: a student's response to Roger Ingham. In Olswang LB, Thompson CK, Warren S, Minghetti NJ, eds. *Treatment Efficacy Research in Communication Disorders*. Rockville, MD: American Speech-Language-Hearing Foundation; 1990:31–39
- Yaruss JS, Quesal RW, Reeves L, et al. Speech treatment and support group experiences of people

- who participate in the National Stuttering Association. *J Fluency Disord* 2002;27(2):115-133; quiz 133-134
30. Van Riper C. *The Treatment of Stuttering*. Englewood Cliffs, NJ: Prentice-Hall; 1973
 31. Sheehan J. *Stuttering: Research and Therapy*. New York, NY: Harper & Row; 1970
 32. Williams DE. A point of view about stuttering. *J Speech Hear Disord* 1957;22(3):390-397
 33. Johnson W. *Stuttering and What You Can Do about It*. Minneapolis, MN: University of Minnesota Press; 1961
 34. St. Louis KO. *Living with Stuttering: Stories, Basics, Resources, and Hope*. Morgantown, WV: Populore; 2001
 35. Plexico L, Manning WH, Dilollo A. A phenomenological understanding of successful stuttering management. *J Fluency Disord* 2005;30(1):1-22
 36. Starkweather CW. *Fluency and Stuttering*. Englewood Cliffs, NJ: Prentice-Hall; 1987
 37. Quesal B, Murphy B. The stuttering curriculum in the new millennium: building "skills" into "knowledge" classes. *Perspectives in Fluency and Fluency Disorders* 2008;18:33-36
 38. Craig A. Relapse following treatment for stuttering: a critical review and correlative data. *J Fluency Disord* 1998;23:1-30
 39. Hancock K, Craig A. Predictors of stuttering relapse one year following treatment for children aged 9 to 14 years. *J Fluency Disord* 1998;23:31-48