Chapter 2

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Becoming an Effective Clinician Specialized in Fluency Disorders

Purpose of the chapter

The purpose of this chapter is to focus on what speech-language pathologists working in the field of fluency disorders can do to become more effective clinicians. There is a need in the field for people specializing in the assessment and treatment of fluency disorders and for specific programs which provide such specialist knowledge and skills.

Although there seems to be an impetus for demonstrating the effectiveness of fluency treatment approaches and for comparing the effectiveness between approaches, the currently available data do not seem to support the idea that any one treatment approach is resulting in better treatment outcomes compared to others. Therefore, a common factors model or *Contextual Model* were employed to hypothesize about possible active components of stuttering treatments.

Strategies to improve the clinician's effectiveness in treating fluency disorders such as increased critical reasoning and improving facilitative interpersonal skills are also discussed.

Finally, a model for the education of fluency specialists is reviewed.

Introduction

Speech and language therapists (SLTs) are specialists in communication disorders. But Bernstein-Ratner and Tetnowski (2006) indicated that because the field of speech-language therapy has broadened considerably, more specialized knowledge is available and necessary. This ever-increasing evolution of the scope of the field led clinicians to develop specialist knowledge and skills for working with particular

client populations, and to develop specific education courses leading to specialization. The call for such specialized education in fluency disorders is longstanding (e.g., Brisk, Healy, & Hux, 1997; Fibiger, Peters, Euler, & Neumann, 2008; Yaruss, 1999). Results of clinician surveys show that clinicians are 'less comfortable' in working with clients who stutter, because 'stuttering is one of the least understood of all communicative disorders' (e.g., Sommers & Caruso, 1995). The perception that stuttering is 'uncommon', and does 'not merit a prominent place in the curriculum and clinical training' was expressed by Yaruss and Quesal (2002). However, a wide-ranging international survey (Leahy, Delaney, & Murphy 2004) showed that a small number of students in each year of education have a specific interest in stuttering and fluency.

Stuttering is a disorder that SLTs commonly treat. From the data collected in the American Speech-Language-Hearing Association (ASHA) (2001) Omnibus Survey (Bernstein-Ratner & Tetnowski, 2006), typical clinician caseloads in the US across all settings show that as many as 65% of them see fluency clients (compared to e.g., 45% clients with voice problems and 25% clients with aphasia). Within school settings, 78% of the clinicians report seeing fluency clients. However, with regard to absolute numbers of individuals seen for a specific disorder, fluency ranks among the lowest of all conditions treated, at 2.4%. This leads the authors to observe that '*effective fluency treatment is not a skill that can be learned on the job*' since the absolute numbers of cases per clinician is the lowest of all disorders, allowing little opportunity to hone skills (Bernstein-Ratner & Tetnowski, 2006). Moreover, it does raise the question of how SLPs can become effective clinicians in the domain of fluency disorders, and which factors play a contributing role in this ongoing development.

One of the aspects that might shed some light on this, is to consider how successful SLPs are in general in helping clients, and how satisfied clients are with the received treatment. Keilmann, Braun, and Napiontek (2004) analyzed questionnaires from parents whose children had received speech-language therapy, and questionnaires from SLPs concerning their satisfaction with the outcome of the intervention. They found that the majority of parents were very satisfied with the outcome of the speech-language therapy, the professional knowledge of the SLPs, and the type of therapy. The individual therapeutic style of SLPs was partially determined by vocational experience. Parents whose children attended therapy more frequently and for longer periods, reported greater satisfaction than those parents whose children attended less frequently. On the other hand, in most cases the SLPs were also pleased with the compliance of the parents. These findings were confirmed by a more recent study on the pediatric service delivery of SLPs, which showed that around 60% of parents were (very) happy with their experiences, while 27% were unhappy (Ruggero, McCabe, Ballard, & Munro, 2012). Among the factors named by parents which contributed to dissatisfaction were insufficiently individualized ser-

vices, not taking parents' perspectives into account in the clinical decision-making process, SLPs not genuinely engaging with families, and a lack of sincerity in the client-clinician interaction or therapeutic alliance.

Focusing specifically on interventions in fluency disorders, Salvo (2018) found that the majority (80%) of clients, children and adolescents, as well as their parents rated the different aspects of the fluency treatment as 'very positive' (i.e., four on a five-point Likert scale). Clients who received more than five years of treatment provided a wider range of scores. She concluded that in order to provide effective therapy, SLPs should consider the different treatment expectations of both the clients and their parents, and how these can impact treatment, including education, goal setting, interpretation of progress, and carryover. Yaruss (2004) concurs, and states that tailoring the intervention to the client's needs is one of the greatest challenges facing clinicians working with clients who stutter, but is an important factor for client and parent satisfaction. A one-size treatment does not fit all, and SLPs should therefore continually assess the outcomes of their intervention, to ensure that it is consistent with the principles of effective treatment and is actually helping clients improve their communication abilities. Clinicians should be aware that treatment satisfaction, especially for adult clients who stutter, is also related to the level of shared understanding, joint clinical decision-making, and therapeutic alliance. Croft (2018) showed that while clinicians relate therapeutic alliance to treatment effectiveness and client progress, clients associate therapeutic alliance most with outcome satisfaction.

Treatment and therapist effectiveness

Most people would agree that treatment and therapist effectiveness entail more than, and differ from, (simply) client satisfaction with the treatment, as previously discussed. Already in the eighties and the nineties, various authors discussed the effectiveness of stuttering interventions (e.g., Andrews, Guitar, & Howie, 1980; Bloodstein, 1995; Conture, 1996). Bloodstein (1995) and Bloodstein and Ratner (2008) discussed two seemingly conflicting impressions about the effectiveness of stutter treatments. On one hand, stuttering is a difficult problem to treat, especially in adults, but on the other hand, many different types of treatment are liable to work with people who stutter. Based on his analyses of treatment outcomes in over a hundred studies, one would be inclined to infer that substantial improvement occurs as a result of almost any kind of treatment in about sixty to eighty percent of cases. He concludes by stating that "it would seem that therapy itself, apart from what is done in therapy, has considerable capacity for effecting change" (Bloodstein, 1995,

p. 439). One important caveat is the substantial difference in scientific rigor, methodology and terminology used. Moreover, several studies have failed to document the client's progress outside the clinic, or whether the treatment benefits were maintained long-term. Bloodstein therefore described various criteria which must be met before an intervention can be considered successful. These include the use of objective speech behavior measures, sufficiently large participant groups, repeated evaluations extending to beyond-clinic measures, long-term monitoring, and evaluating the impact on one's worries for the future and self-concept as a person who stutters. Conture (1996) adds that not everyone seems to agree on how to judge the effectiveness or success of treatment. He suggests a consensus definition that involves a mix of both subject-independent measures (e.g., frequency and duration of moments of stuttering) and subject-dependent measures of changes in the client's speech, feelings and attitudes, and confidence and willingness to communicate in different situations. Despite this well-founded rationale, if publications still appear nowadays with limited treatment outcomes (e.g., only considering percentage of stuttered syllables), one must at least critically ask why this is the case and interpret the results with the necessary caution. However, most recent studies about treatment effectiveness do include a wider range of outcome variables, as suggested by many authors (e.g., De Sonneville-Koedoot, Stolk, Rietveld, & Franken, 2015; Euler, Lange, Schroeder, & Neumann, 2014; Nye et al. 2013).

Treatment outcome studies in fluency disorders, both in children and adults, seem to support the claim that stuttering treatment is effective in general, but the data do not support one approach as having a greater effect than another (De Sonneville-Koedoot, Stolk, Rietveld, & Franken, 2015; Herder, Howard, Nye, & Vanryckeghem, 2006). In psychological literature, this phenomenon is described as the dodo effect (e.g., Tallman & Bohart, 2004). It refers to the fact that most research into treatment outcome in social and psychological treatment approaches showed that having treatment was better than not having treatment, but hardly any differences were found between different treatment approaches. This led several authors to conclude that the similarities between the different approaches accounts for the similar treatment outcome, rather than the differences (e.g., Asay & Lambert, 2004; Wampold & Imel, 2015). Similarities across treatments are client and environmental characteristics, client-clinician interaction or therapeutic alliance, and the client and clinician's hopes or expectations for change. These variables, combined with specific therapy techniques, are referred to as the 'common factors' and are responsible for the treatment outcome (Zebrowski, 2007). Zebrowski and Arenas (2011) also documented the emerging evidence that these common factors may also be applicable to speech-language therapy and more specifically to stuttering treatment. Plexico, Manning, and DiLollo (2010) studied the underlying factors contributing to

successful or unsuccessful client-clinician interaction in a group of twenty-eight clients who stutter. Important factors for an effective treatment were understanding the stuttering experience, developing a positive client-clinician alliance, and being knowledgeable about stuttering and its treatment.

These new insights also prompted a shift from a medical model for change to a common factors model (Wampold, 2010). In the medical model perspective, specific factors (i.e., therapy techniques) are seen as the reason for change. Common factor models emphasize the client-clinician interaction, and focus on the therapist, the client, and the structure of the treatment that is offered, while the specific ingredients of various treatments are relatively unimportant. Recent findings by Donaghy et al. (2020) showing that the verbal contingencies, previously believed to be the active therapeutic agents in the *Lidcombe Program* for preschool children who stutter, are most likely not responsible for the treatment effect, and these findings seem to map onto such a common factor model. More recently, a *Contextual Model* (see Figure 1) has been put forward, where clinical change is attributed to relationship factors which integrate common factors (such as relationship building and creating expectations) with specific factors (i.e., specific treatment goals and therapeutic actions) (Budge & Wampold, 2015; Wampold & Imel, 2015).

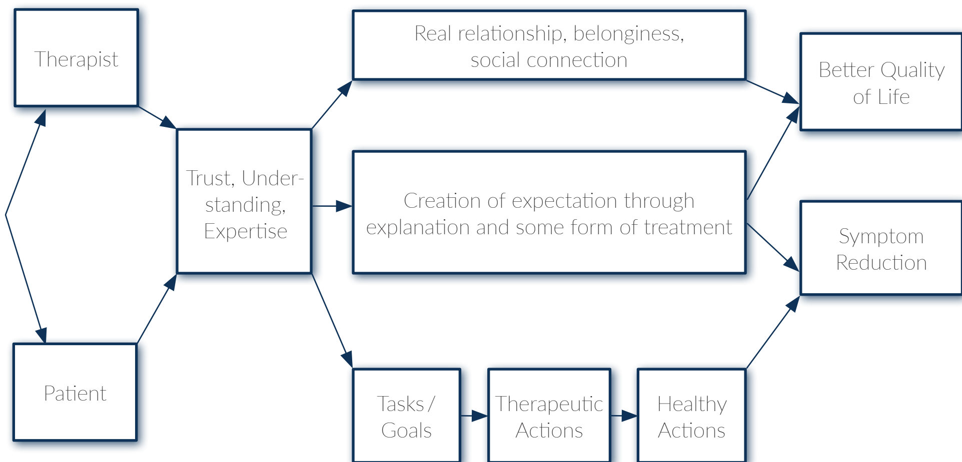

Figure 1: *Contextual Model* of change. Source: Reprinted from Wampold & Imel (2015).

One final important consideration is that there seems currently to be an emphasis on demonstrating the effectiveness of fluency treatment approaches, and on comparing the effectiveness of approaches, but a topic that is much less (or not at all) studied in the domain of speech-language pathology – and more specifically in fluency disorders – is the inter-clinician variability of treatment effectiveness (Eggers,

2018). Different therapists, using the same treatment approach, are not necessarily equally effective in improving client outcomes. Studies in the domain of psychotherapy (e. g., Miller, Hubble, Chow, & Seidel, 2013; Miller, Hubble, & Duncan, 2007) revealed a considerable degree of variability between therapists, with the most effective therapists averaging fifty percent better client outcomes and fewer dropouts than average therapists, and this group is counterbalanced by those therapists who produce, on average, almost no change. It seems logical to assume that developers of treatment programs for fluency disorders are more likely to turn to therapists with the best therapeutic skills to investigate the effectiveness of their program. The question is therefore to what extent these findings can be generalized to different therapists and moreover, how SLPs can become more effective in helping their clients with fluency disorders. While some argue that this can be achieved by simply doing it a lot – similarly to how athletes and musicians improve with time and experience in the right circumstances – others disagree (Rousmaniere, Goodyear, Miller, & Wampold, 2017). Research in the field of psychotherapy has demonstrated that a clinician's proficiency to change client behaviors does not necessarily increase with time and experience (Tracey, Wampold, Goodyear, & Lichtenberg, 2015; Tracey, Wampold, Lichtenberg, & Goodyear, 2014), and the effectivity of some even decreased slightly with more experience (Goldberg et al., 2016). In other words, gaining more experience with a specific treatment approach for stuttering might not automatically lead to becoming a more effective clinician.

Becoming a critical therapist

One of the current main strategies to improve therapist effectiveness in treating fluency disorders seems to be the dissemination of, and training in, *Evidence-based treatment* approaches. *Evidence-based treatment* is not similar to *Evidence-based practice*. *Evidence-based practice* (EBP) evolved from evidence-based medicine (Sackett et al., 1996), and integrates the best available research evidence with clinical expertise and patient values, in order to make well-informed decisions about clinical cases. Satterfield et al.'s (2009) revised EBP model emphasizes shared decision-making, and puts the model in an environmental and organizational context (see Figure 2). The environment is also an important factor to consider, since it can moderate the acceptability and feasibility of interventions. *Evidence-based treatments* (EBT) are those that have been published and evaluated for efficacy and effectiveness based on a (possibly limited) set of criteria. *Evidence-based treatments* in stuttering interventions include the *Demands and Capacities* based treatment and *Lidcombe* treatment (e.g., De Sonneville-Koedoot et al., 2015). These

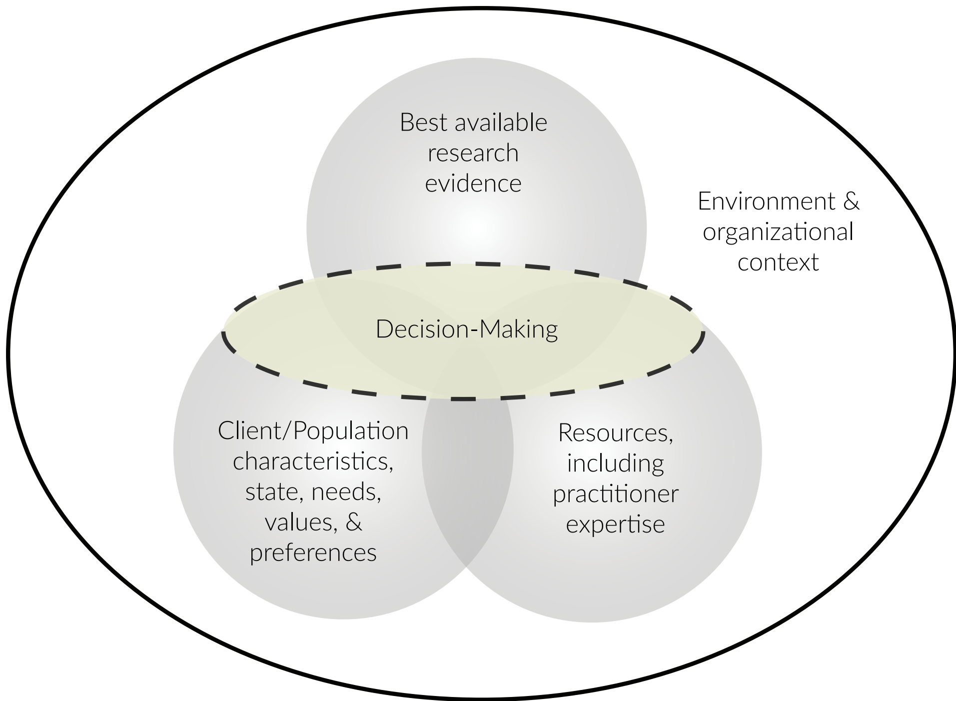

Figure 2: Revised *Evidence-based practice* model. Revised from Satterfield et al. (2009).

relate to 'best available research evidence' in Figure 2 but do not necessarily include the other two components. EBP emphasizes the different processes which clinicians can use to integrate evidence with clinical expertise and client preferences, whereas EBT identifies treatments that are effective for specific conditions. Litell (2014) therefore stresses the importance of critical reasoning, since lists of EBTs do not provide sufficient evidence for an all-encompassing clinical intervention. She states that "clinicians must determine how credible evidence relates to particular needs, values, preferences, circumstances, and ultimately, the responses of their clients".

Stimulated by the EBP movement, different guidelines for the assessment and treatment of stuttering have been developed worldwide (e.g., Neumann et al., 2016; Pertijs et al., 2014). These guidelines cluster together all useful information for therapists, who would otherwise find it hard to process all this scattered information. These preset algorithms and practice guidelines are valuable tools that can help to improve the quality of care for people who stutter, but one has to be careful that they do not discourage therapists from thinking independently and creatively (Groopman, 2007). They should ideally be used as external clinical evidence that

can inform, but not replace, the individual clinician's expertise (Masic, Miokovic, & Muhamedagic, 2008).

Training therapists to become critical thinkers is an essential component of becoming an effective clinician, and is crucial for an optimal clinical decision-making process that incorporates best evidence, clinician expertise, and client preferences. Finn, Brundage, and DiLollo (2016) describe the three main components for critical thinking: a) interpretation, evaluation, and metacognition skills; b) thinking dispositions (or in other words the tendency of a person to think/act in a specific way); and c) awareness of cognitive biases or thinking errors. The authors describe different instructional approaches for teaching and developing critical thinking.

Becoming an effective therapist

Manning (2010) starts his first chapter by stating that "the quality of the clinician is a central factor in determining the success of any therapeutic approach" (p. 1), and continues by discussing various personality attributes, attitudes, and skills that are desirable for a clinician to lead a client successfully through the process of change (see also Manning & DiLollo, 2017). Among the skills he discusses are avoiding dogmatic decisions, widening one's treatment focus, connecting with and challenging the client, modeling risk taking, and the use of humor. Effective clinicians are better at supporting and motivating clients and selecting appropriate therapeutic strategies, and are more effective in guiding clients along the path of treatment. Shapiro (2011) concurs by stating that "the clinician and the interpersonal relationship are among the most significant factors that influence, if not foretell, the outcome of treatment…" (p. 450). He focuses on intrapersonal and interpersonal factors of effective clinicians such as empathy, warmth, genuineness, personal magnetism, compatible friction, and realistic, focused optimism.

Different strategies for improving one's effectiveness have been promoted over the years. They range from the previously discussed training in *Evidence-based treatments* to clinical supervision, continuing education, and using feedback systems – where clinicians closely monitor their client's progress based on outcome data. Based on different studies on attaining expertise across a wide range of fields, Miller et al. (2007) identified three interrelated components for optimizing clinicians' performance, creating a 'cycle of excellence' (see Figure 3). Included components are: a) determining a baseline level of effectiveness, including which strengths and skills need improvement; b) obtaining systematic, ongoing, formal feedback; and c) engaging in deliberate practice (Rousmaniere et al., 2017).

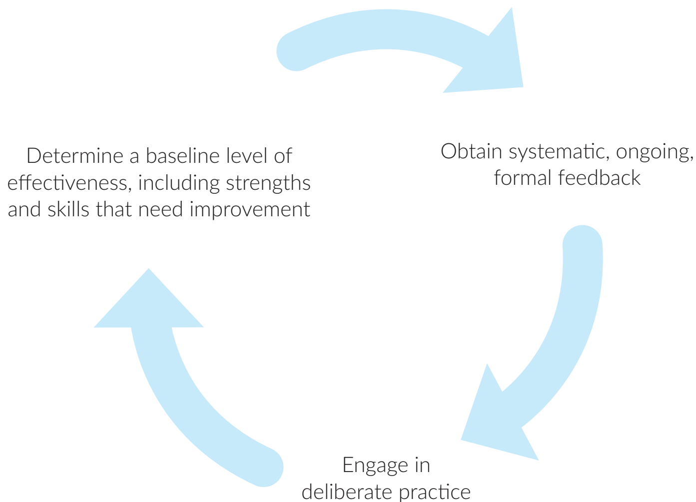

Figure 3: Cycle of excellence. Adapted from Rousmaniere, Goodyear, Miller, and Wampold (2017).

Since many clinicians have no clear information about how they are performing (in other words, their success rates), they therefore have no specific reference point for setting out a course of professional development. Duncan (2012) developed the *Partners for Change Outcome Management System* (PCOMS). It consists of brief client questionnaires (scales for outcome and session rating) designed to monitor therapeutic outcome, which are given to clients at the beginning of each treatment session, and also provides information on what happened between sessions. As these questionnaires were designed to be used across professional disciplines, they do not specifically focus on stuttering. However, they can be translated to the domain of fluency disorders or used as a guide to set up one's own client rating scales, including items related to relationship/client-clinician alliance (e.g., "I felt heard, understood, and respected"), goals and topics (e.g., "We worked and talked about what I wanted to work and talk about"), approach and method (e.g., "The therapist's approach is a good fit for me"), and overall (e.g., "Today's session was right for me" versus "There was something missing"). Additional skills and strengths that need improvement should be identified by clinical supervisors or coaches. This should be combined with formative and immediate feedback. This feedback can be provided by the completed questionnaires and senior, experienced coaches/supervisors. This is what SLPs should experience during clinical placements, i.e., clear and ongoing feedback from a local supervisor or mentor on their interaction and clinical conduct. Although feedback is important for improvement, it does not drive the improvement. The important steps are critical reflection on one's weaknesses, getting

advice from a recognized expert and then developing, rehearsing and executing an improvement plan (Rousmaniere et al., 2017). This process aims at making specific skills routine and automatic, and involves reviewing videos of treatment sessions, with expert feedback and repeated role-playing to examine mistakes made.

Wampold (2017) states that the specific skills that are indicated in the *Contextual Model* (see Figure 1) should be the focus of this deliberate practice, since they will lead to better treatment outcomes. So, the focus should be on e.g., a) the ability to build alliances across a range of different clients; b) providing a clear explanation of the treatment rationale and a clear description of treatment goals; c) developing joint clinical decision-making on treatment goals; and d) explaining to the client/client system how specific actions relate to improvement. Effective therapist characteristics that should also be considered and possibly further developed are verbal fluency, warmth and empathy, emotional expression, persuasiveness, hopefulness, alliance-building capacity, problem focus, delivering a cogent treatment, and professional self-doubt.

Training the next generation of fluency specialists

Shapiro (2011) describes how the professional training of therapists working with clients who stutter should ideally consist of integrated academic, clinical, and supervisory processes to impact the affective, behavioral, and cognitive knowledge of future clinicians. The supervisory process includes – but is not limited to – different interaction analysis systems (e.g., client-clinician interaction or supervisee-supervisor interaction), analysis of the therapist's non-verbal interaction, and individually designed procedures. Moreover, professional competence is something that needs to be maintained through a process of lifelong learning.

A specifically designed program to train fluency specialists, adhering to previously discussed principles, is the *European Clinical Specialization on Fluency Disorders* (ECSF; www.ecsf.eu). This is a one-year specialization course in advanced vocational training, accessible to both EU and non-EU participants. Participants are SLPs who have graduated from qualifying programs in speech and language therapy, having covered courses in fluency and fluency disorders.

When this program was developed, the specialization course had to meet the following requirements: (a) create an optimal learning environment for participants to become more effective clinicians; (b) be compatible with the current workload of a practicing SLP; (c) be cost efficient; and (d) be optimal for student recruitment (Eggers & Leahy, 2011). Therefore, it includes lecturing and self-study, supervised clinical internship, and evaluation of acquired competencies. After careful weighing of

different models, the consortium decided on a delivery model (see Figure 4) where modules are provided during 2 intensive weeks (taking place in September and February), scheduled during the academic year. This learning is combined with a minimum of 4 follow-up sessions, provided by ECSF coaches, who are partners in the consortium. For efficient learning, preparatory reading and home assignments form an integral part of the course, including access to an e-learning platform. The specialized clinical training that takes place in the participant's home country under the supervision of an external mentor (who is an ECSF-approved senior fluency specialist) can begin after the first intensive week. Evaluation is based on continuous assessment, the student's development of a portfolio, and specific appraisal points, including case presentations. The portfolio, prepared during the year, incorporates a comprehensive overview of the specialization process, including written reflective papers on the participant's clinical work and the fulfillment of reporting tasks (analytical exercises regarding assessment and therapy). The portfolio is further detailed below.

ECSF program overview

Phase	Components		Location
Phase 0	Student enrolment; knowledge evaluation through multiple choice questionnaire and individualized suggested reading		Participant's home country
Phase 1	Preparatory reading & assignments for intensive week 1		Participant's home country
Phase 1	Intensive week 1 (Sept): combination of lectures, workshops, role play, case presentation, & discussion		Abroad
Phase 2	Home assignments: theoretical study, reporting, group work	Clinical practice part 1	Participant's home country
Phase 2	Coaching 1 & 2: critical reflection on the required competencies	Clinical practice part 1	Participant's home country
Phase 3	Prep. reading & assignments for intensive week 2	Clinical practice part 1	Participant's home country
Phase 3	Intensive week 2 (Feb): combination of lectures, workshops, role play, case presentation, & discussion		Belgium
Phase 4	Home assignments: theoretical study, reporting, group work	Clinical practice part 2	Participant's home country
Phase 4	Coaching 3 & 4: critical reflection on the required competencies	Clinical practice part 2	Participant's home country
Phase 5	Case presentations & Portfolio evaluation (May/June) Repeats (August/September)		Participant's home country

Figure 4: *European Clinical of Specialization Fluency Disorders* (ECSF) program overview.

The curriculum consists of 2 main components: theoretical knowledge and therapeutic skills, along with specialized clinical training and the evaluation portfolio. The first component consists of 3 modules incorporating: (a) phenomenology (including causal and maintaining variables); (b) assessment, evaluation and diagnosis; and (c) intervention. The Phenomenology Module provides a comprehensive and critical review of the phenomenology of fluency disorders, from which the SLP gains an in-depth understanding of the factors involved in the etiology, development and maintenance of stuttering. Acknowledging that this knowledge is highly dynamic and in need of continuous updating, the module provides the SLP with tools and (research) strategies which are needed for continued professional and scientific development. The Assessment, Evaluation and Diagnosis Module has the goal of SLPs developing a detailed theoretical and clinical knowledge of the various components of the diagnostic process. Finally, the Intervention Module has the goal of SLPs gaining knowledge of, and developing a critical attitude towards, different aspects and elements of fluency treatment from broad perspectives. As a result, students are able to make critical decisions about intervention, and to formulate these into an evidence-based dynamic treatment plan tailored to clients' needs. The emphasis is on participants' continuous reflection to provide the client with best practice.

The second major component, the clinical training, consists of 120 hours of supervised clinical internship, to be completed in the clinic of the student or with the mentor. External mentors, all ECSF-approved senior fluency specialists, and ECSF coaches, who are partners in the consortium, closely guide the students. The role of the external mentors is to provide appropriate support to students so that they can gain personal insights and reflect on the quality of their professional practice. This involves determining the relationship between personal and professional values, standards, and behaviors. The mentor's primary role is to provide appropriate support and guidance to the participant as needed.

Being guided by a mentor is not necessarily applicable in cases where students have experience in treating persons who stutter, and no one with similar experience is available in the student's home country. In such a case, peer mentoring is a viable alternative. The role of the ECSF-coach is to guide the learning process, enhance participants' self-reflection competencies, and evaluate their portfolios and oral case presentations. Where there is no ECSF-coach in the home country of the student, coaching sessions can take another form such as web-based discussions, Zoom conferences etc.

Learning outcomes are defined in terms of both competencies related to prevention, assessment and intervention, as well as knowledge and skills regarding phenomenology, causal and maintaining variables, assessment, evaluation and diagnosis, and intervention. Professional attitudes reflecting ethical considerations

in clinical relationships, and in projecting best practice, are integral to competency development and maintenance.

As described earlier, students prepare a portfolio for final evaluation, to demonstrate their acquired competencies. This portfolio consists of (a) a complete overview of the specialization process; (b) case studies with additional evidence (forms, questionnaires, therapy reports, video reports); (c) written reports of reflective activities; (d) mentor reports; and (e) continuous evaluation reports. As well as being a tool for final evaluation, the goals of the portfolio are for students to take responsibility for their learning process and demonstrate progress, and also to take control of learning through reflection, planning and execution.

Quality assurance within the ECSF program occurs through external and internal review processes (Leahy et al., 2014), which were carried out for the first time in 2009 by course participants, the EU commission and a senior ASHA Fluency Specialist. Participants were asked to rate the overall session formats, the practicality and usefulness of the information given, and the lecturer's ability to present information. They were also asked to provide an overall course rating, based on a 5-point scale. All ratings averaged 'very good' (4) to 'excellent' (5). The EU commissioner labeled it as "a very well performed and managed project where all planned outcomes are being fulfilled." and the senior ASHA Fluency Specialist praised the very suitable pedagogical approach, stating: "It is simply a miracle to see the level of organization, content and commitment that has gone into this effort." A recent evaluation in 2018 (Eggers et al., 2018) by one third of its graduates showed that the mentoring, coaching and lectures by the experienced staff members were rated as the best elements of the course. The course had a strong to very strong impact on the advancement of graduates' careers, and they reported that besides more knowledge, they had become more confident and skilled in treating clients with fluency disorders, and improved their critical reasoning.

The ECSF program – currently run by a consortium of 15 universities, colleges, and centers of excellence from 10 EU and non-EU countries – provides specialist knowledge and skills that can be recognized by local professional bodies as important elements which can lead to clinical specialization. The program is a well-designed combination of lectures, clinical practice, and home assignments. The course has been run for 13 consecutive years and has trained over 250 individuals, from 32 countries.

Graduates of this ECSF program can continue their specialization process by registering with the European Fluency Specialists (EFS; www.europeanfluencyspecialists.eu).

The process of becoming a European Fluency Specialist involves documentation of an additional 80 hours of clinical and/or academic activities, 35 hours of continued professional development activities, and 10 hours of participation in discus-

sion groups, within a time frame of three years (Eggers et al., 2019). Certification is renewed every three years in order to maintain the highest standards of care to people with fluency disorders.

Conclusion and future directions

In order to become an effective clinician in the area of fluency disorders, SLPs need to gain more specialized knowledge and skills, in order to feel more comfortable when working with clients with fluency disorders. This could possibly be facilitated through a post-graduate specialization program, as discussed in this chapter, but there are more elements to consider. In addition, clinicians must be trained both in critical reasoning and in improving their facilitative interpersonal skills. This can be achieved using a range of instructional approaches. A specific example of such an approach is deliberate practice, which involves identification of one's performance shortcomings, receiving guidance from experienced specialists, reflecting on feedback received, and developing a plan for improvement.

Moreover, ongoing and future research will provide additional insights into the effectiveness of fluency treatment approaches and, more importantly, into the active ingredients of these interventions.

Multiple Choice Questions

1. Which of the following statements – regarding how satisfied SLPs, clients and parents are with the treatment process – are correct?
   a) The majority of clients' parents were very satisfied with the outcome of the speech-language therapy;
   b) Factors contributing to dissatisfaction were SLPs not engaging with families, and lack of sincerity in the therapeutic alliance;
   c) Only 50% of the clients, children and adolescents, as well as their parents rated the different aspects of the fluency treatment as 'very positive';
   d) Clients relate therapeutic alliance to treatment effectiveness and treatment progress, while clinicians associate therapeutic alliance most with outcome satisfaction.
2. Which of the following statements regarding treatment effectiveness are correct?
   a) More recent studies on the effectiveness of stuttering treatment map onto Bloodstein's finding that around 50% of treatments seem to be effective;

b) The dodo-effect refers to the phenomenon that treatment outcome studies mostly result in considerable differences between treatments;
c) Different therapists, trained in and using the same treatment approach, are not necessarily equally effective in improving client outcomes.
d) A common factor model perspective emphasizes different therapy techniques as the active therapeutic agents.

3. Which of the following statements are correct? Miller's cycle of excellence for increasing a clinician's effectivity:
   a) Is based on training in *Evidence-based treatments*, clinical supervision, and continuing education;
   b) Consists of 3 independent and unrelated factors;
   c) Includes baseline determination, systematic formal feedback, and deliberate practice;
   d) Involves repetitive practicing of specific skills and reviewing videos of treatment sessions.
4. Which of the following statements – regarding the ECSF postgraduate specialization course – are correct?
   a) The curriculum of the postgraduate ECSF specialization includes lecturing and supervised clinical practice;
   b) To graduate from the ECSF specialization course, students have to pass an oral exam at the end of the program;
   c) During their specialization training, students are guided by an ECSF-coach and an external mentor;
   d) Students' evaluations are executed via the use of a self-developed portfolio.

Suggested Reading

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