

BILINGUAL

Edition 11

 *I have a child in my clinic of nearly four who is bilingual English and Arabic. Her Arabic is superior to her English. She is stuttering in Arabic but her English, which is 'delayed' for her age, is stutter-free. Should we wait for her English to catch up with her Arabic so that she is stuttering in both languages, or should I try and treat her in Arabic via her mother? Do you have any experience of this yourself, and what did you do?*

 To begin with, treatment in the Lidcombe Program is delivered by parents, not SLTs. It seems a minor point, but if you're clear about that, then the rest follows easily. The mother treats this girl every day, so they can use the language they prefer - which seems to be Arabic. Your role is to train the mother to take speech measures, and correctly and safely present verbal contingencies following the girl's stutter-free and stuttered speech. I have lots of experience using the Lidcombe Program with families who speak languages other than English, so I am confident that this approach will be successful.

Jackie Brown, Elisabeth Harrison, Angela Nikolas, Stacey Sheedy, & Margaret Webber from the Stuttering Unit, Bankstown Health Service, Sydney.

Edition 12

 *When treating a child who is bilingual, and who stutters in both languages, do you find that treatment in **only one** of the languages causes spontaneous generalisation to the other one? Or does treatment have to be delivered in both languages?*

 I can think of children who fit both of the possibilities that you suggest. That is, sometimes treatment effects generalise from the first to the second language, and sometimes not. When working with bilingual children, I start treatment in the language that the child and parent speak at home, and ask the parent to collect daily SRs for both languages. These SRs become the basis of our discussions and decisions about whether or not to treat in the second language.

Our grateful thanks to Lis Harrison, Vanessa Harris, Margaret Webber, Stacey Sheedy and Verity McMillan from the Bankstown Stuttering Unit for answering these questions.

Edition 33

? *I know that the area where the Lidcombe Program was developed is a multi-cultural area. Do you have parents who do not speak English at all? If so, do you use interpreters? What problems, if any, do you have working through interpreters? How have you overcome these?*

 Yes we do have a number of parents who do not speak English and so we often use the interpreter service. Some of the problems and potential solutions are as follows.

1. Difficulty demonstrating therapy (especially if child doesn't speak English either)



Solution: Allow for increased time spent on description about how to do or change therapy. Allow for increased observation of parent doing therapy (clinician watching with interpreter) followed by discussion. Allow for increased use of videoed therapy sessions, watching these with parent and interpreter, to address specific aspects of therapy.

2. Clarifying identification of subtle stutters for both clinician and parent.



Solution: It may take longer to ensure stutters are identified accurately before therapy can proceed. Plan for taped or videoed footage to play back examples of stuttering behaviours.

3. Appointments often move more slowly (things said twice) and so the amount of information given/received may be reduced & may extend amount of therapy required



Solution: Be prepared for this and just work with it.

4. Increased numbers in the room (3 adults to one child) if child is shy or uncertain, this number of adults may reduce their comfort communicating at all in the clinic



Solution: Use observation room if this is available. Use recorded footage of child for speech samples and for therapy.

CONTINGENCIES/FEEDBACK

 I read in Dear Sue, edition 5 that self-monitoring is not essential in the Lidcombe Programme. Can you explain to me what you mean by this as I'm not quite sure how a child controls his bumps without it, and how self-monitoring is different from self-evaluation?

 Lots of questions here so I'll take them one at a time:

- a. *Neither self-monitoring of stuttered speech nor self-monitoring of stutter-free speech are response classes in the Lidcombe program.*
- b. *Self-evaluation of stutter-free speech is a response class in the Lidcombe program. Here is an example of how it's used:*

Child: My paint's finished
Parent: Was that smooth?
Child: Yes
Parent: I think so too - great talking! Here's more paint for you
- c. *Like you, I'm not sure of the reasons for the Lidcombe program's effectiveness. Research gives us no answers yet to that question, so maybe one day your intuition will be proved correct and self-monitoring will turn out to be the key factor. In the meantime, research has shown that the program is an effective stuttering treatment for preschool-age children.*

Our thanks to Elisabeth Harrison, Jackie Brown, Margaret Webber, Ann Packman and Mark Onslow.

Edition 10

 I have heard the term 'prompting' used by therapists, to help a child in situations they find particularly difficult. Is this a term you use, and how would you define it? How do you set up prompting?

 'Prompting' involves giving the child a cue - usually a verbal cue - for appropriate behaviour. Prompting is often paired with praise when the child accomplishes the behaviour successfully.

In the Lidcombe Program, prompting would most likely be used when a child is nearing the end of Stage 1 and 'difficult situations' are mild, but persistent. The child's SR would consistently be 2 or 3, except for a few predictable situations when it would be higher. An example of how prompting could be used: Shortly before one of these situations occurs, e.g. visit to a friend, the parent reminds the child where they are about to go, and cues the child to use stutter-free speech. The parent praises the child's stutter-free speech, and continues to do this while visiting their friend.

Our thanks go to Elisabeth Harrison, Stacey Sheedy and Jackie Brown

 *Some of us have been taught to give the ratio of contingencies of a stutter-free speech to stuttered speech as 5:1. Is this ratio something that the Lidcombe Program has borrowed from operant conditioning theory generally or is it something that is specific to the Lidcombe Program? Do you ever advise different ratios?*

 The concept of reinforcing the behaviour that you want to increase and applying some contingencies to the behaviour that you want to decrease, is drawn from the field of applied behaviour analysis. When considering the ratio of contingencies it is important to relate this to the individual child. As outlined in the Lidcombe Program text, contingencies need to be delivered safely and should not be intensive or intrusive. The 5:1 ratio is not a prescription but rather a bare minimum safe guard. It is there to prompt clinicians to remember that the contingencies for stutter-free speech must be much more frequent than contingencies for stuttered speech. The clinician and parent need to be continually monitoring how the child is receiving any contingencies and make adjustments accordingly. If a child is sensitive to contingencies on stutters then very few or no contingencies on stutters for a period may be recommended. If there is a temptation to deliver a ratio less than 5:1 in structured treatment it is likely that the treatment is structured at a level that is too hard for the child. Overall I would say that the ratio of contingencies is quite variable as the parent and clinician respond to what is happening with any individual child's speech but it should not go below the minimum of 5:1

Margaret Webber, Stacey Sheedy, Anna Huber, Wendy Lloyd and Vanessa Harris

Edition 41



I know from the workshop I attended that we aren't meant to ask a child to self evaluate 'bumpy talking'. I find that this is something parents often do and I was wondering if you could explain again why we shouldn't be doing this.



Read the Clinician's guide pg 73. There is no empirical data to state why it is not done with the Lidcombe Program. Stutter free speech is the goal of the program not stuttering, so it makes sense to ask children to self evaluate the targeted behaviour. Self evaluation is a desirable but not essential part of the Lidcombe Program. If the child naturally starts to self-evaluate their speech then this could be encouraged.

However, a parent or clinician asking a child to self evaluate a stuttered utterance might be extremely and powerfully negative. It must be remembered that the Lidcombe Program is essentially there to promote stutter free speech and to make a child feel fantastic about their talking.

Verity MacMillan, Wendy Lloyd, Stacey Sheedy and Mary Erian

Edition 44



I understand that in the Lidcombe Program we do not use any contingencies for self-evaluating stutters. Could you explain the rationale for this?



The reason for not using contingencies for self-evaluation of stuttering is that the focus would then be on stuttering rather than stutter-free speech. It may become negative to ask the child to dwell on stuttered speech. If on the other hand we request self-evaluation of stutter-free speech, it is another way of praising and reminding the child that they are doing well. It is not used to encourage them to evaluate their stuttered and stutter-free speech as this is not something we set out to teach in the Lidcombe Program.

If however the child *spontaneously* self-evaluates their stuttered speech then the parent could reinforce the accurate appraisal of their speech. Also, one of the optional verbal contingencies in the Lidcombe Program is praise for *self-correction* of stuttered speech.

Our grateful thanks go to Stacey Sheedy, Mary Erian and Angela Nikolas from the Bankstown team in Sydney, Australia, for answering the 'Just explain that again...' questions.

Edition 48



A little boy of 5 years old that I have been treating has taken against the word 'bumpy' though he seems to be fine if I use other words e.g. 'bouncy'. Is it ok to change the words we use and would you suggest I discuss with him what words he likes?



Yes, it is OK to change the words that you use, and to use something else that is meaningful for the child. It is OK to discuss with him about whether he has a preference for a different word. My only caution would be to find out why he has taken against the word. You would want to be certain that he was not being corrected too often or that he is not sensitive about verbal contingencies for stuttering.

Our grateful thanks to Stacey Sheedy, Mary Erian, Sally Nicoll, and Verity MacMillan from the Bankstown Stuttering Unit, Sydney, Australia.

Edition 29



I have always followed the rule in my treatment that only the parents/carers I personally train should carry out treatment with their child. What however is your view on letting e.g. fathers who have never attended treatment sessions give contingencies towards the end of Stage I, when the child is having unstructured treatment? Is it OK to do this? Do you think it would be beneficial?



Your rule is a good one. The responsibility of the clinician is to ensure that they train the parent/carers to deliver treatment safely and effectively. The question to ask is "What is the problem with the child's progress? Why do I think the father now needs to get involved in the treatment"? Whether it would be beneficial to engage another person in giving verbal contingencies to a child will depend on the answer to the above questions.

Our grateful thanks go as ever to the very busy team at the Stuttering Unit, namely Margaret Webber, Wendy Lloyd, Verity Macmillan, Stacey Sheedy and Mary Erian.

Edition 50



I have been working with a father who thinks it would be a good idea if other people, as well as himself, started to give contingencies. His little boy is now at SR 2s and 3s but he is not with his son all day so he wondered whether his partner, or the teacher, or even his teenage daughter might be able to help out. What is your opinion on this, and how should it be handled?



Clinical reasoning particularly focused on the child's progress should be used when deciding whether or not to train another person to deliver treatment to the child. In this instance, if the lack of time that the father spends with the child is seen as a barrier for treatment and is potentially inhibiting progress, it may be beneficial to involve another person in the treatment. It is essential that all people who deliver treatment to the child are trained to do treatment safely and correctly, and that the speech pathologist can monitor the treatment that is delivered by all parties.

It is not recommended that more than one other person is trained as this could result in an over-emphasis on the child's speech. Monitoring the safety of treatment delivered by more than two people could also become very complex.

If a decision is reached to train another person to deliver treatment to a child, a family member who spends a lot of time with the child and who is able to attend clinic visits would be an ideal choice. While teachers tend to spend a lot of time with students during the day, it is generally quite difficult to train them accurately, for them to find the time to do treatment with children in a one to one environment and for the speech pathologist to be able to watch and give feedback on how treatment is conducted. In this particular situation, the partner of the father if they are an adult caring for the child may be the first choice. If the teenage sister is an older adolescent who has taken on a care-giving role for the child within the family context, it may be appropriate to choose her. However such a decision should not be made lightly and should be done in careful consultation with both the father and the sister, and the situation must be carefully monitored to ensure that treatment is optimal and to protect the relationship between the siblings.

Our grateful thanks go to Verity MacMillan, Mary Erian, Stacey Sheedy and Sally Nicoll.

Edition 39

 *I am about to start the LP with a child of 4 but he seems completely unaware of his stutter. Is this likely to be a problem with treatment?*



It is not a requirement of the Lidcombe Program that children are aware of their stutter. However, some children learn to differentiate between stutter-free and stuttered speech throughout the course of treatment. Some may ask for evaluation of their fluent speech (e.g. "Was that smooth?") or evaluate their own speech (e.g. "I'm a smooth talker" or "Oops, I did a bump!"). Although these are desirable responses, they are not essential.

The purpose of verbal contingencies for stuttered speech is to occasionally help the child achieve fluency. It is not to make them aware of moments of stuttering. Therefore, when implementing contingencies for stuttered speech, it is important that they are delivered in a supportive manner that is sensitive to the child's temperament.

Our very grateful thanks to the Bankstown team: Verity MacMillan, Stacey Sheedy, Mary Erian, Wendy Lloyd and Sally Nicoll

Edition 46

 *I have read recently that it might be possible to think about the parental verbal contingencies in the Lidcombe Program in the form of a dose, like a medicine. Using this framework, do you have any recommendations about what 'dose' we should be giving or is this individualised as with other aspects of the program? Is asking about 'dose' or number of contingencies given something you would regularly do when discussing treatment with parents?*



I find that some parents and clinicians find it helpful to think in terms of dosage of treatment. I do not use it for all clients but as I would with other analogies, it may be used to explain expectations to some parents.

As for recommendations, I would usually start with daily structured treatment for 15 minutes as per the Lidcombe Program Guide and introduce verbal contingencies throughout the day when there is some fluent speech. I would monitor severity ratings from beyond the clinic and in the clinic to determine whether more or less treatment is required. Sometimes I change the timing of the verbal contingencies as well as the amount and the style of delivery.

However, the amount/dose of treatment really does vary for each child and will depend on the stage of treatment that they are in. The "dosage" is determined by the child's response to treatment reflected in severity ratings and the child's reactions to contingencies. For this reason, you should ask parents how many verbal contingencies they are providing, in what treatment situations, and whether they are delivering them in patches or intermittently throughout the day. That information forms the basis for any changes in the "dosage" of treatment that you recommend.

Times when you might deliver more frequent verbal contingencies include at the start of treatment, especially if the stutter is severe; when the child is starting to experience periods of stutter free speech throughout the day; if you suspect that the child needs more contingencies throughout the day to make further progress. Times that verbal contingencies will be reduced include if the child is achieving mostly stutter free speech and appears to be stable, if the child does not like attention, if you suspect that verbal contingencies are too intensive and therefore invasive for the child (clues are if the child reacts, e.g. "stop saying that", or if you can see the parent providing a contingency on every utterance). It should be noted that verbal contingencies for stutter free speech should always be rewarding, unpredictable, and not constant or invasive.



I have been told recently that in some countries in Europe where 'commenting' on stuttering feels more problematic some clinicians have been moving towards only offering verbal contingencies for stutter-free speech, thereby omitting those for stuttered speech. Do you think there might be problems with this, what might they be and is there any evidence for what might happen if only contingencies for stutter-free speech are given?



It is still unclear which components of the Lidcombe Program make it effective. Is it the structured treatment times? Is it the verbal contingencies, and if so which ones? Or is it the combination of structured treatment and verbal contingencies? These questions still need to be answered, but what we do know from some preliminary research (Harrison et al, 2004) is that verbal contingencies for stuttered speech appear to be a functional component of the Lidcombe Program.

If there are no verbal contingencies for stuttered speech then not all components of Lidcombe Program are being implemented. There are cases

though, such as with sensitive clients, where it might be appropriate only to provide verbal contingencies for stutter-free speech.

References : Harrison, E, Onslow, M & Menzies, R (2004) 'Dismantling the Lidcombe Program of early stuttering intervention: verbal contingencies for stuttering and clinical measurement' *International Journal of Communication Disorders*, vol. 39, no. 2, pp. 257-267

Stacey Sheedy, Wendy Lloyd, Mary Erian, and Angela Nikolas.

Edition 49

 *I have a question about how to use contingencies for moments of stuttering during unstructured conversations. I have a child who seems to have more frequent repetitions at the beginning of a new topic of conversation (SR3), but once he has settled down in the conversation the bumps ease off (SR2). How should I advise the parents to handle this? Ask for self-correction, just acknowledge them, or leave them alone entirely?*

 I would suggest that since severity decreases during the unstructured conversation you advise the parent to try waiting for the drop to SR2 and then praise the fluent speech. If the parent has been praising across the day already then they might be able to try a request for self-correction or an acknowledgment of stuttered speech in that moment and observe whether it is effective or not. In general, the type of verbal contingencies for stuttering will depend on the child and how he has responded to them in the past.

When deciding whether it is appropriate to provide a verbal contingency for stuttering, consider whether it is acceptable to interrupt the child at that moment. There may be times where it is more appropriate to simply let the child speak without applying a verbal contingency.

Another suggestion would be to target similar situations during structured treatment conversations. The parent could start with a simple structured treatment activity and then they may be able to allow this child an opportunity to practise talking about new topics in a structured conversation. This way the parent can support the child during the conversation to enable more fluency. The parent can then provide verbal contingencies on fluency and some on stuttering.

 *Can you just explain again whether I am meant to be using the complete set of contingencies for stutter-free and stuttered speech with all the children on my Lidcombe case-load? If this is not how it works how do I decide which contingencies to use with each child?*

 For most children you need to try the contingencies before knowing which ones are suitable. You may consider how the child responds to feedback generally. You could ask the parent how their child responds when they praise or correct them for various behaviours as this can give insight for how you proceed with verbal contingencies for stutter-free and stuttered speech.

It is beneficial to be able to provide a mix of verbal contingencies wherever possible as this will help them to remain powerful. However, it is usual to start with verbal contingencies for stutter-free speech and to observe how they are received and whether they are effective. If they are accepted then you could introduce the verbal contingencies for stuttered speech. However, if the child seems sensitive then you could proceed with only verbal contingencies for stutter-free speech. Always remember that Lidcombe Program therapy should be fun for the child.

 *After completion of Stage 2 is it always the case that all contingencies should have been systematically withdrawn? Or do you ever recommend that parents carry on with them, even though they are no longer attending the clinic (if so, for how long?)?*

 A recent article* indicated that due to the chance of relapse following treatment with the Lidcombe Program, it is beneficial to provide occasional verbal contingencies for stutter-free speech for an extended period following discharge. It is possible that stuttering is under the control of the verbal contingencies. Hence providing the occasional verbal contingency can assist in maintaining fluent speech.

It is usually recommended at discharge that parents continue to give occasional verbal contingencies for stutter-free speech. The time frame for doing this is flexible and depends on the child's stability. We do not have evidence in the literature about the amount of verbal contingencies that are needed, so I usually tell parents what we do know and then encourage them to monitor the child's speech fluency in relation to how much they are doing.

It is also recommended for parents to reintroduce more regular verbal contingencies if they notice stuttering increase at any time following discharge. Parents may do this for a period of time until the child returns

to criteria and then reduce the frequency of verbal contingencies again. If parents cannot manage any increase in stuttering they should be advised to contact a speech pathologist as soon as possible.

*Jones, M., Onslow, M., Packman, A., O'Brian, S., Hearne, A., Williams, S., Ormond, T., & Schwarz, I. (2008). Extended follow-up of a randomized controlled trial of the Lidcombe Program of Early Stuttering Intervention. *International Journal of Language and Communication Disorders*, 43, 649-661

Our grateful thanks to Stacey Sheedy, Wendy Lloyd and Mary Erian.

CONTEXT OF TREATMENT:

(STRUCTURED/UNSTRUCTURED/STAGE2)

Edition 45



I have just qualified as a speech and language therapist, and attended the Lidcombe training workshop which I found really interesting. While I understand the principles behind structuring the child's first sessions, why we do it and so forth, I am a little unconfident about exactly how to do this in the clinic. I wondered whether you could give me some tips about what to do? I know for example that 'sentence completion' is a good way to elicit shorter utterances, but could you give me some guidance about other ways of structuring a child's sessions, and some equipment suggestions? I am hoping to start the Lidcombe Program with my first client in a couple of weeks and he seems to be quite severe, so any suggestions would be really helpful!



There are a number of ways to structure a conversation for the Lidcombe Program. Some of these are:

- The type of activity being used during a conversation. Some activities naturally elicit shorter utterances and these are more likely to be stutter-free. For example, playing a memory game or talking about a book with simple pictures.
- The linguistic elements of a conversation. The language used can be manipulated to elicit utterances which are of a length that is likely to be fluent. Some examples of how this might be manipulated are:
 - Modelling, sentence completion, binary choices, phonemic cues, commenting, pointing at a picture/something (and saying "Look..." and waiting for the child to make a comment).

- Directing the conversation. As the child demonstrates increased fluency the amount of time the parent spends doing that can lessen. The aim of treatment during structured conversation is not to stay at the same level (e.g. all sentence completion responses) but to allow and elicit longer and more spontaneous responses from the child whilst continuing to be at a severity rating of 1 or 2.
- Activities used can be varied. Books, games, felt boards, puzzles, playdoh, drawing/colouring, magnetic boards, etc. are all useful. Some activities elicit fluent utterances for one child and not for others (e.g. some children become too quiet with playdoh).
- Books are often the easiest way to train a parent to implement structured conversations as they can see how to vary the structure within the conversation whilst keeping the child as fluent as possible. While this may be true, it is important not to stay with only one activity for too long as that activity might become discriminative stimuli. Try to vary activities as much as possible.

Stacey Sheedy, Wendy Lloyd, Verity MacMillan, Mary Erian and Sally Nicoll

Edition 48

Could you just explain again about the introduction of unstructured treatment times? I thought I had to wait until the daily SRs were 3s or below but I have recently read in the Lidcombe News that they can be introduced much earlier- could you just clarify when and how I should be doing this?



Unstructured treatment should be used to take advantage of naturally occurring conversations as they happen. Spontaneous fluent speech can be reinforced throughout the day even if it occurs for brief periods. Hence the child's overall severity might be rated as a higher score but if the parent observes conversations or brief interactions that have lower severity then they could do unstructured treatment then. Parents can be instructed to do that once they can competently apply verbal contingencies.

When there are insufficient naturally occurring fluent utterances, it will be difficult to do unstructured treatment. In this case, it is possible to structure brief moments of speech throughout the day so that verbal contingencies can

be applied to speech outside of the formal structured treatment conversations. For example, when the child is asking for a drink, the parent could give a binary choice to elicit a short response and then reinforce the response if it is stutter-free. The parent would be structuring that interaction but this could be an interim step until treatment can be delivered in natural unstructured conversations.

Thanks to Stacey Sheedy, Mary Erian, Sally Nicoll, and Verity MacMillan from the Bankstown Stuttering Unit, Sydney, Australia.

Edition 37

 *Please could you clarify something for us- when a child is in Stage 2 of the programme do you follow the schedule 2, 2, 4, 4, 8, 8, 16 week gaps between visits or are there two 16 week visits at the end? There seems to be some confusion around this point!*

 It is important to remember the purpose of Stage 2 which is to ensure that the treatment effects of the program are maintained over an extended period and that the gradual, systematic withdrawal of verbal contingencies is done in such a way that severity ratings remain the same (1-2 with majority of them being 1). The typical schedule for stage 2 is described in Webber and Onslow, 2003. It is 2, 2, 4, 4, 8, 8, 16 weeks between visits. This schedule is not always followed. As with all of the components of the Lidcombe Program, it needs to be administered in a way that is sensitive to the needs of the individual client. Some clients require two 16 week visits, and some might even benefit from an additional 32 week visit on the end, particularly if they had relapses throughout Stage 2. The role of the clinician is to gather information about the stability of the child's speech including how they progressed through treatment and how they have responded to the reduction of verbal contingencies throughout stage 2 and to use this information to make an informed decision about the Stage 2 visits a child would need.

Webber, M., & Onslow, M. (2003). Maintenance of treatment effects. In M. Onslow, A. Packman, & E. Harrison (Eds.), *The Lidcombe Program of early stuttering intervention: A clinician's guide* (pp. 81-90). Austin, TX: Pro-Ed.

Verity MacMillan, Stacey Sheedy, Mary Erian, Wendy Lloyd and Sally Nicoll

Edition 44

 *Are there any circumstances in which you might elevate the criteria for Stage 2 to say 2s, occasional 3s? If so, what might these be?*

 Typically with children under 6 years of age I would be aiming for Stage 2 criteria of mostly 1s and some 2s. I would be concerned that there would be a risk of relapse if those criteria are not met and I would want to set the child up with the best possible long-term outcome. It is important to ensure that all problem-solving for further progress has happened before making any decision to elevate criteria or discontinue treatment.

Having said that, there might be circumstances where a parent cannot continue treatment as they have "burnt out" or don't have the time to commit to the amount of treatment that is required. It would not be appropriate to continue regular treatment in those circumstances. Also, if the child's severity is not improving, then they may form a negative view of speech therapy. It would be better to avoid that so that when the child is older, they might consider further speech therapy.

If the child has maintained stable severity for a long time then you could consider weighing up the risk of commencing Stage 2 with elevated criteria. In that situation I would explain the risk of relapse to the parents and attempt to determine whether the child's speech was stable enough to maintain. I would also explain to the parent that by doing this they are departing from the Lidcombe Program Guide and cannot expect the same long-term outcomes as in the literature. If you attempt to maintain their severity at this level, you will need to determine how much treatment will be required to maintain that level in the long-term. If it is not stable enough to maintain then there is no point in Stage 2 because relapse is likely and you have already established that the parent is unable to commit to further therapy. This becomes complicated and it might be better to discontinue treatment in that circumstance.

Our grateful thanks go to Stacey Sheedy, Mary Erian and Angela Nikolas from the Bankstown team in Sydney, Australia

 *After completion of Stage 2 is it always the case that all contingencies should have been systematically withdrawn? Or do you ever recommend that parents carry on with them, even though they are no longer attending the clinic (if so, for how long?)?*



A recent article* indicated that due to the chance of relapse following treatment with the Lidcombe Program, it is beneficial to provide occasional verbal contingencies for stutter-free speech for an extended period following discharge. It is possible that stuttering is under the control of the verbal contingencies. Hence providing the occasional verbal contingency can assist in maintaining fluent speech.

It is usually recommended at discharge that parents continue to give occasional verbal contingencies for stutter-free speech. The time frame for doing this is flexible and depends on the child's stability. We do not have evidence in the literature about the amount of verbal contingencies that are needed, so I usually tell parents what we do know and then encourage them to monitor the child's speech fluency in relation to how much they are doing.

It is also recommended for parents to reintroduce more regular verbal contingencies if they notice stuttering increase at any time following discharge. Parents may do this for a period of time until the child returns to criteria and then reduce the frequency of verbal contingencies again. If parents cannot manage any increase in stuttering they should be advised to contact a speech pathologist as soon as possible.

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Our grateful thanks as ever go to the 'Dear Sue team' from Bankstown, Sydney, Australia, for the following answers to your questions about the Lidcombe Program. This time the team included Stacey Sheedy, Wendy Lloyd and Mary Erian.

MEASUREMENT

Edition 8

 *When taking a sample for the %SS do you count 'ums' as a syllable, or ignore them, especially when they are a strong feature of the child's speech? What about if the child stutters on the 'um'?*

 I usually count 'ums', especially when they are a strong feature for a particular child. But I always count them with a child who occasionally stutters on 'ums' or uses 'ums' as fillers/stutters - I count the stuttered 'ums' as stutters, and the stutter-free 'ums' as non-stuttered syllables.

 *When taking the sample, what do you count if the child backtracks? For example if the child says " Yesterday I went to the ..block...I went to the...block...Yesterday I went to the..block... park." How many syllables and how many errors?*

 I think that this is the hardest type of stutter to count online - for obvious reasons. The problem is that you don't know that the child is going to backtrack until after they have done it. But once you have identified that this is the way that a child stutters, then you simply count their syllables with a slightly longer delay than usual between when they say their words and when your finger taps the Truetalk. This gives you the extra second or two to see if they backtrack. In the example above, I would count 8 syllables in total, 1 of them a stutter and 7 are stutter-free. I would also hold down the Truetalk button for the duration of "...block...I went to the...block...Yesterday I went to the..block..." to include the time taken over this stuttered patch of speech.

 *When taking a sample, what do you do when a child self corrects? For example if the child says " My cat i-i-is...is...black. My cat is black!" How many syllables are you counting here?*

 I would count a total of 9 syllables, 1 of them a stuttered syllable, and 8 of them stutter-free.

 *What do you count if a child uses a lot of rote speech in the sample being taken? For example, the child who insists on counting everything, or saying*

nursery rhymes, or, when putting things away, says"and that one in there...and that one in there...and that one in there...and that one in there"....several times.

Do you just count them once or do you count the lot?"



I count the lot.

If a child does this a few times in one conversation, and it is not the habitual way that s/he talks in the clinic, then it's not a problem and I would not do anything about it. On the other hand, if I felt it was happening too often, then in most cases I would intervene. My aim would be to move the child - gently - on to talking about something different. For example, I'd perhaps try to move the "Counting Kid" on to talk about colours or shapes or functions, and the "Nursery Rhyme Kid" on to playing a matching game. The problem here is that a baseline speech measure taken from repetitive phrases or rote speech, is not likely to be valid.

Our thanks go to Lis Harrison and colleagues for answering these questions.

Edition 35



What is the generally accepted number of syllables to count when taking a WC sample of a child's speech for the % SS? Is this based on research or experience?



According to the Lidcombe Program manual (April 2008) the "measure of %SS is based on a conversational sample that typically is a minimum of 300 syllables or 10 minutes duration." However, according to Sawyer & Yairi (2006), it is important to weigh the time factor associated with sample length, against the information to be gained. There may be cases where it is a waste of clinical time to gather a lengthy sample. On the other hand they reported that longer samples may be warranted for some children, particularly those who present with mild or borderline stuttering in order to gather valid information.

To summarise, it is important to consider the purpose of the measure being taken. According to Lincoln & Packman (2003), the role of the %SS measure is to establish the extent of stuttering, to influence decision-making, to determine a response to therapy, to be used to decide on the timing of commencement of treatment, and to determine when Stage 2 entry criteria have been met. There are occasions where the clinician might decide that a

longer sample is warranted if they do not think that they have a valid measure. On the other hand, if it takes too long to gather a 300 syllable sample e.g. for a quiet child, the clinician might choose to rely more on severity ratings or recordings from home.

References: Lincoln, M. & Packman, A. (2003). Measuring Stuttering. In Onslow, M., Packman, A. & Harrison, E. (Eds.), *The Lidcombe Program of Early Stuttering Intervention: A clinician's Guide* (pp. 59-70). Texas: Pro-ed.

Packman, A., Webber, M., Harrison, E. & Onslow, M. (April 2008). Manual for the Lidcombe Program of Early Stuttering Intervention. Downloadable from http://www.fhs.usyd.edu.au/asrc/docs/LP_Manual_English_April_2008.pdf

Sawyer, J. & Yairi, E. (2006). The Effect of Sample Size on the Assessment of Stuttering Severity. *American Journal of Speech-Language Pathology*, 15, 36-44.

Stacey Sheedy, Verity MacMillan, Wendy Lloyd and Mary Erian.

Edition 37

 *I understand that measuring is an integral part of the Lidcombe Program and have seen the research showing that two measures are essential when making clinical decisions. However I am also aware from my own experience that the clinic sample can vary depending on how it is done. For example some children will stutter more when asked about things not in the here and now, or when asked to explain something, rather than just talking about the toys in front of them. Do you, when taking your own samples, ensure that all kinds of conversation are included in the assessment?*

 Yes, I vary the conversational topics. If I can I actually try to bring out the stutter in the baseline so that I know what the more severe stuttering that the child does looks like. I then show the parent how to adjust the therapy accordingly.

Having said that, the beyond-clinic severity ratings are so important because in the clinic you only see a limited interaction with the child. The beyond-clinic ratings can be used to determine the validity of the speech that you observe within the clinic. These beyond-clinic measures are taken in the child's natural environment and so give much more information. It could also be useful to get beyond-clinic recordings if the speech you see within the clinic is not

representative or if you find you are only able to get limited conversational topics.

 *At our Lidcombe Link days in the UK we sometimes practice %SS from passages of text where we know exactly how many syllables there are. We find though that there are often discrepancies in our results! People are pretty good at hearing the stutters but we get differing numbers of syllables. Is this a typical finding and is there any research on this? And in particular are there any 'common' reasons for the discrepancies that we can learn from the research?*

 Your finding is typical. The literature shows that people have good intra-rater reliability (i.e. they rate the same samples similarly when rating multiple times) but have poorer inter-rater reliability (i.e. between raters). See the following reference for further information about this:

Teesson, K., Packman, A., & Onslow, M. (2003). The Lidcombe Behavioural Data Language of Stuttering. *Journal of Speech, Language, and Hearing Research, 46*, 1009-1015.

This paper describes the intra and inter-judge reliability of experienced clinicians and inexperienced clinicians (students). They found that a) intra-judge reliability was satisfactory for both groups b) inter-judge reliability was satisfactory only for experienced clinicians.

Clinically, %SS and severity ratings are both used and each gives different information. %SS gives a measure of the frequency of the stutters and when used from week-to-week with the same child can be used to determine progress since the same clinician is rating the same child and the measure should therefore be reliable and comparable. The severity rating measure gives information that takes into account the frequency and type of stutters. As parents collect that measure beyond-clinic, it can be used to compare the within-clinic severity rating with those taken outside of the clinic.

Stacey Sheedy, Wendy Lloyd and Mary Erian

Edition 40

 *I have been told by a colleague that we no longer need to take the percentage syllables stuttered count in the Lidcombe Program. Can you explain to me how we know when to go to Stage 2 now that one of the measures has gone?*

 Your colleague is correct that the Lidcombe Program manual has been amended and that collecting %SS is optional. Criteria for entry into Stage 2 is three weeks of beyond clinic severity ratings of 1s and 2s with at least four of these being 1s across each week. Within clinic severity rating should be 1 or 2 for the entire interaction with the child for a three week period.

It is important to spend a period of time 'tuning in' to the child's speech within the clinic, like you would do if you were taking a %SS measure. This ensures that you and the parent are not missing any stutters.

If you find that taking a %SS measure assists you in making a decision in regards to entering Stage 2 for a particular client, then you could still use this measure as the manual states that it is optional.

If you are interested in obtaining a copy of the manual it is available at:

http://sydney.edu.au/health_sciences/asrc/docs/lp_manual_2011.pdf

Verity MacMillan, Stacey Sheedy, Wendy Lloyd and Mary Erian from the Bankstown Stuttering Unit, Australia.

Edition 44

 *I read recently in the new Treatment Guide which I downloaded from the Australian Stuttering Research Centre website :www.fhs.usyd.edu.au/asrc that the use of % Syllables Stuttered has changed. I see that while the within clinic Severity Ratings are still taken each week it is no longer considered necessary to measure %SS. I have been used to recording the within clinic %SS on the chart and I wondered whether you now record the within clinic Severity Rating instead?*

 Yes that is correct. It is still considered important to have a severity rating from within the clinic, as you need a way to check that the information that the parent has reported about their child's stuttering severity at home is valid. Also, according to Onslow et al. (2002), there are times when within clinic

%SS meets criteria for Stage 2 while the beyond clinic severity ratings do not, and vice versa. You could make the assumption that this applies to within and beyond clinic severity ratings. Hence there is a need for a within clinic measure to be documented.

One of the reasons that %SS is no longer considered compulsory is due to low inter-judge reliability. However, intra-judge reliability is good so if this measure is used by one clinician for a client from week to week then some useful trends may still be observed. The Lidcombe Program Treatment Guide does have the %SS measure as an optional measure as some clinicians find it useful to help them tune into the child's speech. I still use %SS some of the time as it helps me to tune into the child's speech more closely when I am making observations and decisions. I also use that information to compare one week to the next. If you feel that the %SS is useful, then this measure can still be collected. However, if you choose not to, then you still need to observe and record a within-clinic conversation and rate it using the severity rating scale.

It would be sensible to decide whether you think that for a particular client there may be some benefit in collecting the %SS, for example if the severity is changing very gradually from week to week but not enough to drop the severity rating. On the other hand, if there are reasons to believe that it is not appropriate, such as with severe stuttering, then it might be sensible to omit the %SS measure.

Reference: Onslow, M., Harrison, E., Jones, M., & Packman, A. (2002). Beyond-clinic speech measures during the Lidcombe Program of early stuttering intervention. *Acquiring Knowledge in Speech, Language and Hearing*, 4, 82-85.

Stacey Sheedy, Mary Erian and Angela Nikolas

Edition 47

 *I have read that we are no longer required to do the %SS every clinic visit. Does this mean that we no longer have to have the 10 minutes or so free play activity that we used to have to confirm the Severity Rating?*



This question is very important to clarify. You must always listen to the child. The 10 minutes or so of listening is essential. It gives you immediate

understanding of the child's stutter which in turn will help you to make useful clinical recommendations. It allows you to calibrate Severity Ratings with the parent. As the child's severity reduces, the stutter often changes. Parents need to learn how to distinguish all types of stutters. The parent might be missing stutters or thinking that normal disfluencies are stutters. Unless you listen to the child's speech with the parent you have no way of knowing if this is the case. It allows you to ask the parent whether the sample in the clinic is typical and gives an understanding of the child's stuttering severity at that moment in the clinic. You could also ask the parent what treatment (amount of structure, type of activity etc) they would do based on the current severity of the child's speech and follow on with the parent demonstrating that in the clinic. This gives you insight into the parent's ability to make sensible choices about treatment.

Stacey Sheedy, Wendy Lloyd, Verity MacMillan, Mary Erian and Sally Nicoll from the team at Bankstown Stuttering Unit, Sydney, Australia

Edition 19

 *I have a question about the Severity Ratings. Are we supposed to use them in relation to the child we are seeing i.e. THEIR severity rating, or is there some fixed notion of severity? I appreciate that 1 and 2 on the scale are **no stuttering** and **very mild stuttering** but does it then go in relation to the individual child or to some global concept of severity? Or is this something we can choose for ourselves and in relation to the family we are working with? Some families seem to find it very difficult to see stuttering outside the context of their own child.*

 The severity rating scale is intended to be used as a fixed notion of stuttering. 1 = no stuttering, 2 = extremely mild stuttering, 10 = extremely severe stuttering. This is usually all the information that I give parents initially, but then I shape their use of the scale during the first few sessions. It doesn't seem to take parents long to get the idea. Severity ratings used in this way also gives a common language about severity for speech pathologists.

The problem with using the scale as individualised for each child is that it would be strange to give a mild stutter a severity rating of 10 just because that is the worst that child has been. A global sense of severity can help an anxious parent put their child's stuttering in perspective. Also, stuttering changes over time, so

you might forget what a particular child was like at their worst, or may not have seen it in the clinic. It would then be difficult to be consistent and reliable.

It is important to note that there is an error in the book 'The Lidcombe Program of Early Stuttering Intervention - A Clinician's Guide' edited by Onslow, Packman and Harrison in this regard where it says on p. 64 "10 would apply to the worst stuttering the child has produced".

 *I find the Severity Ratings a most intriguing and useful way of measuring stuttering. However I am not sure how 'creative' I am allowed to be with them! For example is it all right to have more than one rating in a day? Does it matter whether we start with situations and then change to all day scores, or whether we start with all day scores from the beginning? Is it a question of 'what is useful' rather than 'what is right'?*

 Always think about the purpose of the severity ratings. They are used to measure progress and as a communication tool between the parent and the clinician. Generally I would start with asking for a global rating for each day to measure progress. Variations would then arise out of a need for more, or different, information. For example, if the child has changed from stuttering over the whole day, to stuttering mostly occurring in patches, then it might be useful for the parent to give a best and worst score. The important thing to keep checking is that the clinician is clear about how the parent is giving the ratings so you can accurately interpret the information the parent is providing. You are spot on - it *is* a question of using the ratings in a way that is consistent and meaningful to the question you want to answer.

Margaret Webber, Stacey Sheedy, Anna Huber, Wendy Lloyd and Vanessa Harris

Edition 23

 *When you start treatment with a child and explain the Severity Rating charts to the parents do you ask them to score for a whole day, or just for situations in the day? Or does this vary from child to child? If so, could you explain when you would use a whole day score, and when situational scores, and why?*



We routinely train parents to collect a global rating for each day. Sometimes an extra rating might be useful if the parent feels a need to comment on the child's progress in particular situations e.g. if there are peaks of severity for short periods and the parent feels a global rating alone doesn't reflect the variability. Occasionally we use ratings for a short period each day when varied situations might be useful e.g. parent who reports difficulty in tuning in to their child's speech across the whole day.

Ratings need to be able to accurately reflect child's progress so that would be the benchmark in deciding how ratings should be collected.

Our thanks go to Margaret Webber and her team at the Bankstown Stuttering Unit

Edition 35



If a child has a very variable SR throughout the day I have learned that one way round this is to give a situational score- for a different situation each day- and follow a weekly pattern for these situations. Is this the only way to show variability each day, or are there other ways this can be done? As we need all day scores to help determine when the child is ready for Stage II, at what point should we start asking the parent to use these?



The severity ratings need to reflect what is happening with the child's severity in order to determine recommendations for treatment and to monitor treatment progress. Therefore this should be considered in order to decide what information is needed when collecting severity ratings.

One way that I measure variability if parents report that severity is too varied to give one score is to ask parents to give best/worst or average/worst scores each day. As time and treatment progresses, there should be less variability of severity ratings across the day/week. Therefore, severity ratings will be more stable and situational scores will become redundant and eventually 1 daily severity rating will be sufficient.

There are other measurement methods (eg stutter counts, SMST). These could be used to supplement the information gained via severity ratings if more information is needed.

Stacey Sheedy, Verity MacMillan, Wendy Lloyd and Mary Erian.



When I am teaching Severity Ratings to parents we are occasionally uncertain as to whether or not the child is deliberately not saying words they find difficult i.e. avoiding. How should we include (if at all) this information into our ratings?



Generally only unambiguous stuttering is taken into account when applying a severity rating to a child's speech.

To include avoidance in a severity rating it is necessary to make a decision about the behaviour - is it or is it not stuttering? To make this decision, further investigation will need to occur. You might consider the following:

- Check with the parent if this behaviour is something they see regularly at home
- Are there any other speech or language difficulties that may account for this 'avoiding'?
- Is the child's speech easy and effortless? It would be unlikely that there would be word avoidance if there are only effortless repetitions.
- Listen to other children's speech (of similar age) known to NOT stutter to gauge whether they do similar behaviours. All children's speech includes moments of hesitation, of changing what they are saying or of saying 'um', particularly if they are talking while preoccupied with something else. The behaviours you are unsure about are not stutters if they occur in the speech of children who do not stutter.
- Put the child in a situation where they cannot avoid words (e.g. look at a book and ask lots of questions quickly) - does stuttering increase and if so what kinds? If the stutter severity increases dramatically in these situations then it would be likely that the child does have some word-avoidance stutters.
- Video record and watch back closely. Show colleagues and get a second opinion.

If a decision is made that the child is avoiding as part of the stutter, then include that in the assigned severity ratings. It is likely that the stutter they are trying to avoid is a fixed posture, and the severity rating should take that into account.

From clinical experience, most preschool aged children do not word avoid. While we need to be aware of this possibility, it does not happen frequently. Remember other things that may cause pauses in speech eg. language difficulties. If you are unable to make a decision then the behaviour is ambiguous and should not be included in the severity ratings.

Verity MacMillan, Wendy Lloyd, Stacey Sheedy and Mary Erian

Edition 45

 *I have just been on a Lidcombe Training workshop and been introduced to the idea of Severity Ratings. I can see how very useful they are, and how essential to the running of the programme, but the problem is I am not very good at them! I was always one or two points different from the main body of the other participants. Have you any tips for how I might improve my skills as I realise it is vital I get this right.*



Consider the following to improve your skills in assigning severity ratings:

- If you are one point off then it is still considered reliable, particularly if you are consistent with how you assign your ratings. For example, if you are always 1 higher than others then that is OK.
- Consider the frequency and type of stuttering in the speech sample. If the client is experiencing more significant stuttering (e.g. many blocks) then this will be rated on the scale more highly.
- Remember that a SR 10 is the most severe stuttering anyone can experience (not just the most severe stuttering for the client in front of you).
- Listen to recordings of clients stuttering and practise giving a rating. Watch samples of stuttering with an experienced clinician, identify individual moments of stuttering and assign, compare and discuss severity ratings. More practice and more exposure will make it a bit clearer.
- Get the parents opinion of the child's severity in the clinic first and then make a decision about what severity rating you would give.
-

Stacey Sheedy, Wendy Lloyd, Verity MacMillan, Mary Erian and Sally Nicoll

Edition 46



I am working in a clinic where no-one else is trained in the Lidcombe Program. I have only worked with three clients so far and I am not sure how quickly I should be expecting any change in their stuttering and their Severity Ratings. Is there anything written about this that I could read?



There are many publications that are useful in informing expectations. In summary, they all suggest that you should see a downward trend in severity.

Onslow et al. (2002) found that there was a 30% decrease in average weekly severity ratings from clinic visit 1 to 5.

Jones et al (2000) did a large scale file audit and reported that there was a median of 11 clinic visits to reach Stage 2 and 90% reached Stage 2 in 22 visits. Note that this was prior to the recommendation in the Lidcombe Program Guide that you should have 3 visits meeting Stage 2 criteria, so we could now add 3 visits to this number. Rousseau et al's (2007) prospective study reported a median of 16 visits.

Koushik, et al. (2011) did a replication of Jones et al. (2000) for the North American population. Their file audit results replicated the Jones study with a median of 11 sessions to reach Stage 2, but the more severe the stutter the longer the treatment time.

Progress may be influenced by how successful treatment conversations with the child are and how regularly they are occurring. Sometimes, progress is first noticed in structured treatment conversations in that the child is able to say longer and more complex stutter free utterances. This then begins to generalise to reductions in daily severity ratings. It is worth noting that treatment times can be variable and children may respond after several sessions or it can take many months. In all cases if progress is not being observed then it is important to problem solve.

References

Jones, M., Onslow, M., Harrison, E., & Packman, A. (2000). Treating stuttering in young children: Predicting treatment time in the Lidcombe Program. *Journal of Speech, Language, and Hearing Research, 43*, 1440-1450.

Koushik, S., Hewat, S., Shenker, R., Jones, M., Onslow M. (2011) North-American Lidcombe Program file audit: Replication and meta-analysis. *International Journal of Speech-Language Pathology*, 2011; Early Online, 1-7

Onslow, M, Harrison, E, Jones, M & Packman, A (2002) 'Beyond Clinic Speech Measures During the Lidcombe Program of Early Stuttering Intervention' Acquiring knowledge in *Speech, Language and Hearing*, vol. 2, no. 2, pp. 82-85.

Rousseau, I, Packman, A, Onslow, M, Harrison, E & Jones, M (2007) 'An investigation of language and phonological development and the responsiveness of preschool age children to the Lidcombe program' *Journal of Communication Disorders*, vol. 40, pp. 382-397

Stacey Sheedy, Wendy Lloyd, Mary Erian, and Angela Nikolas.

Edition 50

 *Could you clarify something for me about the parent Severity Ratings. In my workbook it says that when we are teaching the parents to rate the home SRs we can either do all day scores or "a speaking task" each day. Can you explain again how/why we decide which to do? Are the speaking tasks meant to be 5 minutes, half an hour, or what length? Finally, when do we go to a whole day score - which I assume we must do in order to go into Stage 2?*

 The purpose of severity ratings is to get the best possible measurement of the pattern of stuttering that is occurring in the child's speech from day to day. They are used to assess progress and guide treatment decisions. Ideally, a daily severity rating would give you that information. However, there may be circumstances in which you would choose to get a smaller or more detailed 'snapshot'. For example, if a parent is finding it difficult to identify stutters, they may take a severity rating over a period of 10 minutes to listen carefully in order to specifically assess that portion of their child's speech. Once the parent has become more proficient at identifying stutters, they should start taking daily ratings. There may also be times when the parent reports periods in the day or situations when the stutter is either higher or lower than the child's typical severity for the remainder of the day. As this might influence how you tailor treatment, you could get the parent to take a rating of the child's typical speech, as well as during those times or situations

when the severity varies. The length of time you ask a parent to specifically measure may vary from child to child and as each child progresses. A daily severity rating should be used as soon as it accurately represents the child's speech. Towards the end of Stage 1, the child's daily severity should be more stable at 1s and 2s, and therefore, a daily severity rating is often sufficient.

It is always important to reflect on why severity ratings are part of the Lidcombe Program. That is, to measure progress and guide clinical decision making. If you feel that more information is required about a child's stuttering in order to make optimal clinical decisions, then you may need to change how they are collected. Ask a parent to rate specific shorter periods as well as a whole day measure. Other additional measures such as stutter counts can also provide you with useful clinical information.

Our grateful thanks go to Verity MacMillan, Mary Erian, Stacey Sheedy and Sally Nicoll.

Edition 42

 *I have heard that it is possible to do a child's severity ratings on Google docs. As we are about to 'go paperless' in my department this seemed like a good option. Can you explain exactly how I find this system on the internet and how it works?*

 You can access Google Docs via the Google website. Once you have set up a free account you click on "Documents" and start a spreadsheet with dates. You can then give private shared access to particular email addresses, inviting parents to add to the document. A parent could enter their severity ratings straight onto the spreadsheet and then you could view them immediately when you log on.

This might be useful for a parent who is often on the internet (e.g. at work or on an iPhone). Google docs will not be convenient for all parents, but it is an option that may make recording severity ratings more efficient for some families.

Thanks to Stacey Sheedy, Verity MacMillan and Wendy Lloyd

MISCELLANEOUS

Edition 32



I have used the LP for many years and found it to be extremely effective. While I appreciate that the behavioural methods we use are 'atheoretical' and that they say nothing directly about the nature of stuttering, I wondered whether you have any theories about why the Lidcombe Program works and what papers may have been published about this?



We still can't say why the Lidcombe Program works. Onslow, Stocker, Packman & McLeod (2002) explored whether acoustic measures of speech timing evidenced change pre and post therapy in children who were treated using the Lidcombe Program. They concluded that there was no evidence to suggest changes in speech timing. Packman, Code & Onslow (2007) suggest that an "operant treatment for early stuttering is effective because it prompts children to learn to adjust for the underlying neural processing deficit at a critical time of speech development" i.e. at a time of neural plasticity.

References: Onslow, M., Stocker, S., Packman, A., & McLeod, S. (2002). Speech Timing in children after the Lidcombe Program of early stuttering intervention. *Clinical Linguistics & Phonetics*, 16, 21-23.

Packman, A., Code, C., & Onslow, M. (2007). On the cause of stuttering: Integrating theory with brain and behavioural research. *Journal of Neurolinguistics*, 20, 353-362.



While the parents in my clinics are delighted with the results they achieve for their children using the Lidcombe Program many are also concerned about the long term success rate of this method. Have you any comments to make or some references about this that I might pass on to these parents?



Reference:

Jones, M., Hearne, A., Onslow, M., Packman, A., Ormond, T., Williams, S., Schwarz, I., & O'Brian, S. (2008) Extended follow up of a randomised controlled trial of the Lidcombe Program of Early Stuttering Intervention. *International Journal of Language and Communication Disorders*

This recent research into long-term outcomes indicates that most children who successfully complete Stage 2 are maintaining stage 2 criteria from 3 to 7

years after treatment. In this study 16% did experience relapse after 2 or more years maintaining stage 2 criteria. Research at this stage has not been conducted for longer follow up periods. Jones et al also report that currently there are no known predictors in relation to relapse following completion of stage 2. They do recommend that parents remain alert to the possibility of relapse. The Australian Stuttering Research Centre is conducting further research in relation to the risk of relapse post LP.

At the completion of Stage 2 we alert parents to the possibility that for some children, relapse may occur some years ahead. We advise them to contact for advice immediately should relapse be detected, thus allowing for appropriate management to be determined and addressed in a timely manner.

Our grateful thanks go to Margaret Webber and Stacey Sheedy

Edition 40

 *I am a student and have been learning about the Lidcombe Program on my undergraduate course. Is it possible to train in the programme while I am still a student or is it only for qualified speech and language therapists?*

 The Lidcombe Program workshop has been developed for practicing Speech Pathologists. However, Speech Pathology students in their final semester of study can attend the workshop.

Verity MacMillan, Stacey Sheedy, Wendy Lloyd and Mary Erian from the Bankstown Stuttering Unit, Australia.

Edition 36

 *Do you have students in your clinics? If so, do you have tips about how to get them involved in the therapy process? Would you recommend that they attend an LPTC workshop on top of this once they become qualified?*

 Yes we do have students attend our clinic from time to time. The clinic I work for is considered to be a specialist clinic and clients attend with the understanding that they will be seen by a specialist clinician. For this reason we are very cautious about the level of involvement that a student has. Initially the student would share the client with me as the specialist clinician. As their

placement progresses and I feel confident with their level of knowledge and skill, I may let them lead sections of sessions. I would not allow a student to interact with a client without direct supervision. In the state that I work in students are only given preliminary training in stuttering at university. I would therefore strongly recommend that any clinician working with children who stutter attend an LPTC workshop, including those who have had a placement with me. Observation and clinical placements do not take the place of training in the Lidcombe Program.

Stacey Sheedy and Verity MacMillan

Edition 47



I am about to have a final year student on placement in my dysfluency clinic for the next 8 weeks. She will be seeing/trying out treatment with a number of children on the Lidcombe Program. Do you think this is enough time/experience for students once they graduate to practise the programme on their own, or would you recommend they attend a Lidcombe Program Trainers Consortium workshop?



It is ideal for clinicians who treat children with the Lidcombe Program to attend a Lidcombe Program Trainers Consortium (LPTC) workshop. Recent research conducted in community clinics (ie outside the ideal world of research) reported that speech pathologists who had received LPTC training had clients who had better results that were longer lasting than speech pathologists who had not received the training (O'Brian et al 2013).

When I have supervised final year students I have approached their stuttering caseload in a joint manner. I have discussed which parts of the clinic visit I want them to lead, but I make sure that they are aware I might intervene at any time. While I have a responsibility to the student, my first responsibility is to my client. I now have evidence that suggests a student or a clinician who has not attended LPTC training may not provide optimal care, and so I am very careful to share responsibility for clinic appointments with students. I would also strongly recommend to any students who visit the Stuttering Unit that they attend a LPTC workshop if stuttering becomes a part of their caseload

when they graduate. The workshop trains the basic components of the Lidcombe Program and also allows a clinician to understand the research, the details of the Lidcombe Program and how the components of the Lidcombe Program work together. The students' experience on placement will be valuable for them to draw from when attending the workshop.

Reference

O'Brian, S., Iverach, L., Jones, M., Onslow, M., Packman, A. & Menzies, R. (in press). Effectiveness of the Lidcombe Program for early stuttering in Australian community clinics. *International Journal of Speech Language Pathology*. Manuscript accepted for publication 4 March 2013.

Our grateful thanks go to Stacey Sheedy, Wendy Lloyd, Verity MacMillan, Mary Erian and Sally Nicoll from the team at Bankstown Stuttering Unit, Sydney, Australia

PROGRAM DELIVERY

Edition 22

-  *I have a family who is very keen to start the Lidcombe Program with their daughter Jade, 5years 1 month, who is stuttering at around 8%SS, SR 5. Both parents are working all the day, and their child has after school care until around 5.30 when they get home. They are happy to do the treatment in the evening but I have some questions about procedures.*
- a) How do we get a representative SR, if all the parents can measure of their child's speech is a short time in the morning and evening? How will we know whether or not she is stuttering at school when we get towards Stage II? Teachers are not always able to give time to such details.*
 - b) Will it be all right just to do the structured treatment in the evenings (though at weekends there is more opportunity for other treatment times), and when she (and her parents) are tired?*
 - c) When we move towards more unstructured treatment, do you think that there will be enough contingencies in just the short time Jade and her parents are together?*

I am concerned not to start the programme if parents who are working long hours may be a contraindication for treatment. I would value your opinion on this issue.

 The viability of treatment for any child will depend on whether enough effective treatment can happen to make satisfactory progress. The issues that you have flagged for this family do offer some challenges.

a) Parents will have the before and after school times as well as the weekends. This should be sufficient exposure to track changes. This of course is the routine situation for school-age children and those children in full time childcare. It can be helpful to chat with the child's teacher prior to stage 2 to check in with any concerns the teacher still has. Teachers are often quite happy to make some taped conversations at school if that is helpful in confirming the child's progress. Parents can observe their child in a number of different situations on weekends which will give that confirmation that the child's progress is not just limited to home and the clinic.

b) How much treatment will be needed can only be determined by progress. However from my experience with children in this situation it is important that parents utilise the weekends to provide greater variety with treatment times. If some days have been missed through the week due to tiredness etc. some extra treatment times on the weekend may help to compensate. As stated above the key will be whether they can get enough effective treatment happening.

c) Again how much unstructured treatment is needed will become clear through measuring progress. Unstructured treatment is often easier for busy parents as they can take advantage of short periods of time and therefore can utilise perhaps some of their morning time as well as evenings and weekends.

Whether treatment is viable? It will be important to clarify with the family the variables that will impact progress. From my experience some families, once they realise what's needed to make progress find ways to do satisfactory treatment and for others their circumstances are too inflexible. Which category any family falls into quickly becomes clear early in treatment. Families usually want to try to see if they can organise their circumstances to enable their child to be successfully treated.

Margaret Webber, Verity MacMillan & Wendy Lloyd from the Stuttering Unit, Bankstown Health Service, Sydney, Australia

Edition 29

 *I have always followed the rule in my treatment that only the parents/carers I personally train should carry out treatment with their child. What however is your view on letting e.g. fathers who have never attended treatment sessions give contingencies towards the end of Stage I, when the child is having unstructured treatment? Is it OK to do this? Do you think it would be beneficial?*

 Your rule is a good one. The responsibility of the clinician is to ensure that they train the parent/carers to deliver treatment safely and effectively. The question to ask is "What is the problem with the child's progress? Why do I think the father now needs to get involved in the treatment?" Whether it would be beneficial to engage another person in giving verbal contingencies to a child will depend on the answer to the above questions.

Margaret Webber, Wendy Lloyd, Verity Macmillan, Stacey Sheedy and Mary Erian.

Edition 30

 *I have read in several places that the average time to Stage II is 11 sessions. I have never achieved this result myself though I have had good success using the programme, and wonder whether this is because I am doing something wrong. Is there anything that can help us work out how long treatment might take, for example what makes it quicker, what makes it slower? How soon should I start to see the Severity Ratings fall?*

 It is important to note that the 11 sessions refers to the **median** time to reach Stage 2. This means that half the cohort of children reached Stage 2 in 11 visits however half took longer than the 11 weeks. If you have had good success in getting children into Stage 2 it sounds like you are doing a pretty good job. Whether progress could have happened more quickly probably needs to be determined case by case. There are a few things to take into consideration. We know that a high level of severity at the start of treatment is a predictor that treatment is likely to take longer. Ref: Jones et al. (2000). JSLHR, 43, 1440-1450.; Kingston et al. (2003) Int. J. Lang. Comm. Dis., 38, 165-177. Research also indicates that we can expect about a 30% drop in severity ratings over the first 4 weeks of treatment. Ref: Harrison et al. (2004) int. J. Lang. Comm. Dis, 39, 257-267. Generally ongoing progress is expected with the Lidcombe program. If progress is not occurring then it is important to consider all aspects of the treatment process to determine why progress might not be happening. Early consultation with colleagues or clinicians experienced in

the Lidcombe program can assist the treating clinician to ensure optimal progress.

Margaret Webber, Stacey Sheedy, Mary Erian, Wendy Lloyd.

Edition 33



Do you think that the Lidcombe Program is suitable for all children who stutter? Are there any client groups who you feel would not benefit from the program e.g. ASD, behaviour problems (e.g. oppositional), children with severe learning difficulties, any others? On what have you based your decisions- is there any research on these areas and the Lidcombe Program?



At this stage there is no Lidcombe Program research that has considered particular sub groups of children. Given this lack of research to assist in this area, currently at the Stuttering Unit, the Lidcombe Program is considered best practice for all preschool-aged children irrespective of any other diagnosis. Our experience, once treatment priorities have been established, is to commence treatment and judge the viability of treatment according to progress as we would with any client.

The following chapter may provide some useful information about using the Lidcombe Program with more complicated children.

Hewat, S., Harris, V., & Harrison, E. (2003). Special Case Studies. In M. Onslow, A. Packman, & E. Harrison (Eds.) *The Lidcombe Program of early stuttering intervention: A clinician's guide* (pp. 119-1380. Austin, TX: Pro-Ed.

Margaret Webber, Verity MacMillan & Kylie Farnsworth

Edition 35



I was taught that it is important in the weekly LP session that the parent demonstrates what they have been doing at home, then we demonstrate any changes that need to be made, and then the parent has a go implementing these changes. Do we always need to follow this routine, even when the parent has become competent at all the procedures and further changes are not needed? How should we proceed if this is the case?



It makes clinical common sense to observe the parent doing treatment so that you can watch their therapy without influencing it by modelling in the clinic first. In that way you have the best chance to see therapy as it has been done at home since the last visit and to see the impact that it has on the child. However, as you mentioned, there may be occasions when you decide that this information is less relevant, such as when you are confident that the parent is

competent in doing the treatment (usually towards the end of Stage 1). At that point in time, it may be more useful to spend the time in the session discussing ongoing management and problem solving how to elicit further progress. Even for diligent parents I suggest that it is useful to continue this process of watching the parent do therapy from time to time, as you may assume that the parent is doing therapy appropriately when they are not.

Stacey Sheedy ,Verity MacMillan, Wendy Lloyd and Mary Erian.

Edition 38



We know from the research that it is possible to treat older school aged children with the LP. How old is the oldest child you have personally treated? Did you have to make any modifications to the manualised version, and what were the particular challenges?



The oldest child that I can recall was 10 years of age. Having said that, I would always trial the Lidcombe Program first, particularly for a child who has not had therapy before or who shows periods of time with mild or no stuttering.

The main things that I did differently to a preschooler were that the parental verbal contingencies were given in an age-appropriate manner, usually with acknowledgement rather than praise. I have found that correction can be quite direct and that the child will often work with me to achieve the overall goal of reducing the severity of their stutter. I can advise the child that I want to help them be fluent for practice times, and ask them to use short sentences and they often comply. They are usually able to self-evaluate and correct their speech more readily and may respond to prompts for smooth talking by controlling their stutter.

The other thing that I have found is that the child can give severity ratings to supplement the parent's ratings. Even if they are inaccurate, I think it is helpful to have the child self-reflect on how they have been going.

The challenges include that the outcome of treatment needs to be kept realistic as the stutter may reduce but the child will probably have some residual stuttering and will need to learn how to manage relapse when it occurs.

The other main challenges relate to motivation of the child and parent for treatment. If the child is motivated but the parent is not, then the Lidcombe

Program is not likely to be a good treatment choice. If the parent is motivated and the child is not, then that can be difficult to manage as the parent wants to help the child improve but will obviously have difficulties in encouraging the child to practice and to respond to prompts about their speech.

In that situation, a decision would need to be made about whether treatment is appropriate or not. Finally, the parent-child relationship is important to consider as Lidcombe Program treatment relies on a positive relationship.

Stacey Sheedy, Mary Erian and Wendy Lloyd from the Bankstown Stuttering Unit in Sydney, Australia.

Edition 39

 *I have been monitoring a little boy for his stutter since onset which was 6 months ago. He is now 3 years and 8 months and the stutter is not reducing. Part of the monitoring process has been collecting Severity Ratings and these remain fairly stable at around a 5, sometimes with periods in the day of 6s or 7s. I am wondering whether you would recommend starting therapy at once, and whether you think he might experience difficulties at nursery with his speech at this level of severity?*



Monitoring is a useful process in helping to determine whether the stutter appears to be resolving without clinical intervention (Harrison, E., Sheedy, S., & Lloyd, W. 2004). You mentioned that this little boy has had stable severity ratings now for 6 months. One reason for commencing treatment after a monitoring period is persistent and stable stuttering (Harrison et. al. 2004).

While monitoring the stuttering of young children close to onset is a useful clinical tool, there is now research about the social and emotional cost of stuttering for young children (Langevin, M., Packman, A. & Onslow, M., 2009). Some of the results of this study were summarised by Ann Packman and Marilyn Langevin in a previous Lidcombe News (May 2007, edition 28 p 3-4). Such findings indicate that it is important to question the length of monitoring and may prompt clinicians to intervene sooner than they may have previously. This little boy is attending nursery and so experiences extended periods of social

interaction with peers in a relatively large group. The Langevin research indicates that it is imperative to question his experiences at nursery. There is a possibility that other children are responding negatively (either directly or in a subtle manner) to this little boy's stuttering, potentially harming his social relationships and his view of himself as a communicator.

Therefore, as this child's stuttering does not demonstrate any signs of decreasing in severity, and since he is at nursery and is possibly experiencing negative reactions from his peers in direct response to moments of stuttering, the decision to intervene sooner rather than later is supported by evidence.

In summary, monitoring is a good option to screen for natural recovery in young children, but even young children can experience negative social and emotional consequences for stuttering. The factors that may impact this decision need to be considered for each individual client in order to make an informed and sensitive decision about when to start treatment with the Lidcombe Program.

Harrison, E., Sheedy, S., & Lloyd, W. (2004). Timing of early intervention for stuttering: New evidence from clinical practice. In B.E. Murdoch, J. Goozee, B. Whelan, & K. Docking (Eds). *Proceedings of the 26th World Congress of the International Association of Logopaedics and Phoniatics, Brisbane. [CD-ROM]*. Melbourne, Speech Pathology Australia.

Langevin, M, Packman, A & Onslow, M (2009) Peer responses to stuttering in the preschool setting. *American Journal of Speech Language Pathology, 18*, 264-276.

Thanks to Verity MacMillan, Stacey Sheedy, Mary Erian, Wendy Lloyd and Sally Nicoll

Edition 42

 *I recently read a paper about Parents' Experiences of the Lidcombe Program. In it some parents expressed the idea that a self-help group for parents would be useful. Have you ever done this (or know anyone who has), and was it in fact considered a good idea by the group?*

 This paper is very interesting and I recommend that all clinicians who use the Lidcombe Program should read it. The paper explores many issues that parents raised during interviews. Indeed one of those issues was parents expressing that self-help groups could be useful. At this clinic we have recently held a

morning tea for Lidcombe Program parents with the goal of promoting discussion and support in an informal setting between parents. While the parents who attended were positive about the opportunity to share together, they needed some help to initiate their conversations, resulting in more guided discussions. We hope that if the group was run regularly and parents became familiar with the process, the conversation might become more open. In response to the success of this first morning tea and the literature supporting the potential worth of such a venture for parents, our clinic plans to host more of these groups and to evaluate their effectiveness.

The reference is: *Goodhue, R., Onslow, M., Quine, S., O'Brian, S., & Hearne, A. (2010). The Lidcombe program of early stuttering Intervention: mothers' experiences. Journal of Fluency Disorders, 35, 70-84.*



I know some people think paper handouts are useful, but others feel they are not a good idea with the Lidcombe Program. What is your view on this? Do you use any yourself in your clinic? If so are they generally accessible to others who like to share information this way?



I have not used generic handouts as I have not felt the need to do so. I am cautious as I want to avoid second and third hand distribution of "how to" information, potentially resulting in attempted treatment without clinician guidance. I prefer to individualise the information that I give to parents so that I have tailored it to their child and their learning style. For parents who indicate that they prefer written information, I suggest that they use a book and make some notes for themselves. Generally if they do this I check what they write to ensure that it is consistent with what was discussed. The types of things that some parents in my clinic have written are reminders about therapy ideas and ways to reinforce stutter-free speech. These are obviously different for each child/parent.

I do have some colleagues at other clinics who use handouts and as I understand it, they have specific handouts for specific topics given to parents according to the appropriate timing for a particular child. Other colleagues report finding it helpful to give parents the Lidcombe Program guide once they have commenced treatment. This is available from the ASRC website (in several different languages) under downloads.

In the future Lidcombe Program trained clinicians will have access to a website that is still in the early planning stages. Shared ideas and resources may be available on this website.

Thanks to Stacey Sheedy, Verity MacMillan and Wendy Lloyd

Edition 47



I run a very busy clinic and find it hard to fit everything into my day that I need to (like most of us I guess..). Do you think therefore that it would ok to do telephone assessments during Stage 2 of the programme rather than have the family actually come and visit me?



There is evidence for Stage 2 delivered in the clinic. Your question translates to whether there is evidence for telehealth delivery of Stage 2 of the Lidcombe Program. There is not specific evidence about Stage 2 but there is for the Lidcombe Program in general. Early trials of telephone delivery of treatment supported it but it took 3 times longer than treatment in the clinic (Harrison, et.al.1999; Wilson, L., et. al., 2004). Since then, the internet has meant that it is much easier to send large files or files can be uploaded to shared access sites for the clinician to watch. It is likely that contact via telephone supplemented with video samples) from home (see Rousseau, et. al., 2008) or contact via Skype could be suitable for some clients when delivering Stage 2 of the Lidcombe Program.

If using the telephone model without clinic visits or video supplements, I would advise where possible to talk to the child on the phone as well as the parent. There is some evidence for use of the speaker phone for obtaining speech samples for preschool children who stutter (O'Brian, et. al., 2010).

However, telephone Stage 2 appointments may not ideal for some children or families. If you are concerned that a parent may find it difficult to stay motivated at this point in the program then clinic appointments may be preferable as they are a larger, more intrusive reminder about the importance of staying within criteria. A child who has a history of subtle stutters may be worth monitoring more closely in the clinic as would a child whose parent has not been reliable at reporting small changes to the stutter throughout treatment. On a case by case basis, use your clinical common sense to determine whether a telephone contact might be a possible option and use measurement to make sure that it is working.

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Rousseau, I., Onslow, M., & Packman, A., & Jones, M. (2008). Comparisons of audio and audiovisual measures of stuttering frequency and severity in preschool- age children. *American Journal of Speech-Language Pathology*, 17, 173-178.

Wilson, L., Onslow, M., & Lincoln, M. (2004). Telehealth adaptation of the Lidcombe Program of Early Stuttering Intervention: five case studies. *American Journal of Speech-Language Pathology*, 13, 81-93.

Our thanks go to Stacey Sheedy, Wendy Lloyd, Verity MacMillan, Mary Erian and Sally Nicoll

Edition 39

 *I am about to start the LP with a child of 4 but he seems completely unaware of his stutter. Is this likely to be a problem with treatment?*

 It is not a requirement of the Lidcombe Program that children are aware of their stutter. However, some children learn to differentiate between stutter-free and stuttered speech throughout the course of treatment. Some may ask for evaluation of their fluent speech (e.g. "Was that smooth?") or evaluate their own speech (e.g. "I'm a smooth talker" or "Oops, I did a bump!"). Although these are desirable responses, they are not essential.

The purpose of verbal contingencies for stuttered speech is to occasionally help the child achieve fluency. It is not to make them aware of moments of stuttering. Therefore, when implementing contingencies for stuttered speech, it is important that they are delivered in a supportive manner that is sensitive to the child's temperament.

Our thanks to the Bankstown team: Verity MacMillan, Stacey Sheedy, Mary Erian, Wendy Lloyd and Sally Nicoll

Edition 49

 *After completion of Stage 2 is it always the case that all contingencies should have been systematically withdrawn? Or do you ever recommend that parents carry on with them, even though they are no longer attending the clinic (if so, for how long?)?*



A recent article* indicated that due to the chance of relapse following treatment with the Lidcombe Program, it is beneficial to provide occasional verbal contingencies for stutter-free speech for an extended period following discharge. It is possible that stuttering is under the control of the verbal contingencies. Hence providing the occasional verbal contingency can assist in maintaining fluent speech.

It is usually recommended at discharge that parents continue to give occasional verbal contingencies for stutter-free speech. The time frame for doing this is flexible and depends on the child's stability. We do not have evidence in the literature about the amount of verbal contingencies that are needed, so I usually tell parents what we do know and then encourage them to monitor the child's speech fluency in relation to how much they are doing.

It is also recommended for parents to reintroduce more regular verbal contingencies if they notice stuttering increase at any time following discharge. Parents may do this for a period of time until the child returns to criteria and then reduce the frequency of verbal contingencies again. If parents cannot manage any increase in stuttering they should be advised to contact a speech pathologist as soon as possible.

*Jones, M., Onslow, M., Packman, A., O'Brian, S., Hearne, A., Williams, S., Ormond, T., & Schwarz, I. (2008). Extended follow-up of a randomized controlled trial of the Lidcombe Program of Early Stuttering Intervention. *International Journal of Language and Communication Disorders*, 43, 649-661

Our grateful thanks to Stacey Sheedy, Wendy Lloyd and Mary Erian.

STUTTERING AND CO-EXISTING CONDITIONS

Edition 38



If a preschool child has phonological difficulties in addition to their stuttering do you always start with the Lidcombe Program first? Are there times when you feel that the phonology should be addressed before the stuttering?



In general I would start with the stuttering therapy because the literature indicates that therapy should take 4 - 6 months in most cases to get to Stage 2. There are cases however where I would address the phonology first. These would be if the child's speech was unintelligible or if it was affecting their interactions with others more than the stutter. I would keep in mind that

the timing of treatment for stuttering should be within the preschool years, as once the child is school age, the evidence for stuttering treatment is not as good.

 *On the same theme, if a child has language difficulties in addition to their stuttering do you always start by addressing the stuttering? Do you think that language difficulties may make the treatment of the stuttering more problematic and sometimes act as a kind of trigger for the stutter?*

 Timing of treatment would be based on several factors. These include the age of the child, when they are starting school, time since onset, reaction to the stutter, severity and how stuttering is impacting on their daily interactions, the severity of the language difficulty and how it is affecting the child's interactions and whether there is enough language to be able to do stuttering therapy effectively.

If the language difficulties are mild and the child is close to school age then I would treat the stutter first. If the language difficulties are severe and the child is quite young with recent onset of stuttering, then I would probably treat the language difficulty first. If the difficulties were somewhere in between, then I think it would be a case-by-case decision with parental input.

I do think that language development can impact on the severity of the stutter. I have seen children who have a sudden increase in vocabulary or length and complexity of utterances have corresponding increase in the severity of the stutter. I assume that the improvement in language skills has been a trigger for an increase in the severity of the stutter and would manage this with an increase in the structure of the therapy as needed in order for therapy to be effective.

Stacey Sheedy, Mary Erian and Wendy Lloyd from the Bankstown Stuttering Unit in Sydney, Australia.

Edition 40

 *Do you use the Lidcombe Program with children with Down Syndrome ? If so, do you take into account the developmental age rather than the chronological age when considering timing of treatment?*

 You can use the LP with children with Down Syndrome. However, it is important to remember that much of the research on the Lidcombe Program has been based on children without concomitant disorders. Hence it is difficult to apply the reported outcomes to this population.

When treating children with Down Syndrome it is therefore important to ensure that you have valid and reliable measurements so that you can determine that progress is occurring.

In terms of deciding on the timing of intervention, if their developmental age is such that they would not be able to participate adequately in the treatment, then you may consider waiting for a time. Otherwise you should consider the same issues that you would for other children. These are overviewed below:

- time since stuttering onset (the chances of natural recovery occurring is reduced over time whether the child is normally developing or has a concomitant disorder)
- pattern of severity of stuttering over time
- when the child will be starting school
- if the child or parent or peers are reacting negatively to the stuttering
- Family history of stuttering

See Onslow, Harrison and Packman (2003). *The Lidcombe Program - A Clinician's Guide: Chapters 4* for more information about the Timing of Intervention.

Thanks to Verity MacMillan, Stacey Sheedy, Wendy Lloyd and Mary Erian from the Bankstown Stuttering Unit, Australia.

Edition 45



I am working with a little boy who I am beginning to realise has a clutter as well as a stutter. In your experience have you found the Lidcombe Program to be as effective when a child has both disorders present, and can I expect him to go down to 1s and 2s in the same way as a child with just a stutter ?



To my knowledge there has been no research about treating children who clutter using the Lidcombe Program. In fact, cluttering is often not diagnosed until a child is beyond the preschool years (St. Louis et al 2007). For these reasons much of what I say here is based on clinical observations rather than on published evidence.

If a child has a clutter as well as a stutter there may be a variety of impacting factors to consider including language or learning disorder, a fast speech rate, compromised intelligibility, and poor self evaluation. I would suggest treating the stuttering first, as you would with the Lidcombe Program, but ensure that verbal contingencies are only applied to effortless, stutter-free and intelligible

speech. If the stutter is successfully treated but the cluttering behaviours remain, they may need to be treated separately.

It is difficult to predict what will happen in the case of this little boy. The most logical course to undertake would be to treat this child as a single case study. Take very careful measurements prior to and during treatment. Base your clinical decisions on these measures. Seek supervision opportunities and problem-solve this unusual case with senior staff or mentors.

Finally, consider writing up this case study for others to learn from your experience of treating a preschool age child who clutters.

Reference: St. Louis, K. O., Myers, F. L., Bakker, K. & Raphael L. J. (2007). Understanding and treating cluttering. In Conture E. G. & Curlee R. F. (Eds.), *Stuttering and related disorders of fluency* (3rd ed.) (pp. 297-322). New York: Thieme.

Thanks to Stacey Sheedy, Wendy Lloyd, Verity MacMillan, Mary Erian and Sally Nicoll

RESOURCES AND TANGIBLE REWARDS

Edition 24

 *Can you tell me what toys, pieces of equipment, you commonly use with the children at the Stuttering Unit in Sydney, and **how** you use them. It would be really useful to share ideas around the world!*



Books, puzzles, memory games, felt/magnetic picture boards and so on can make it easier to structure conversations, so may be especially useful in the beginning stages of therapy. Lego/ duplo, trains, playdough, blocks, cars, dolls etc. can be useful when working towards more unstructured conversations in the clinic.

However, many activities can be manipulated in terms of structure. For example a book or a puzzle can be used for structured or unstructured conversations. The difference is how you guide the conversation (the language you use, types of comments and questions you make) and how much freedom you give the child in the activity.

Margaret Webber, Mary Erian, Wendy Lloyd, Verity MacMillan and Stacey Sheedy.

Edition 48



When I attended a workshop on the Lidcombe Program I saw treatment being carried out using tangible rewards (games like Pop up Pirate, peg boards etc.) Do you use these rewards with all children, and do you continue with them all through Stage 1? Do you ever have problems with the tangible rewards?

There are many occasions where I never use tangible rewards as I only recommend their use if I think they will be helpful. Tangible rewards may sometimes be used at the start of treatment to get the child and parent used to the idea of the verbal contingencies. Once the parent can adequately provide verbal contingencies and the child is accustomed to receiving them, they are generally no longer necessary and should be faded out as soon as they are not needed.

Some situations when tangible reinforcement can be useful are where the parent forgets to use verbal contingencies, so the tangible might be a prompt for them. Tangible reinforcement could also be useful if the child's speech is difficult to structure, if they have difficulty staying on task, if the verbal contingencies have less impact over time or for some extra motivation to keep them engaged later in therapy.

Problems can occur with tangible rewards. The novelty can fade and if that happens then new rewards might be needed. Also some rewards can be too distracting so that they divert from rather than focus the therapy.

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