Lidcombe News

September 2011

Edition 41

While the United Kingdom basks in the highest September temperatures for decades and the flowers think it's Spring again, here at Lidcombe News we are not so confused! We are delighted to bring you the Autumn Edition with a case study from Brenda Carey describing how she uses Skype to deliver the Lidcombe Program internationally, as well as an article by Sabine Van Eerdenbrugh about the development of a training module for internet delivery of the Lidcombe Program. This is of course all in addition to the ever popular Dear Sue and Just Explain That Again, as well as news of the latest training courses in the United Kingdom. Workshops taking place in North America may be found on the Montreal Fluency website, and the Australian Stuttering Research Centre also has its own CPES section.

Lidcombe Link days in the UK – listed below in the Dates for your Diary section- have been running for the last 13 years and have a very dedicated following. The days are free and anyone trained on the Lidcombe Program (and invited guests) is very welcome to come along and join in the discussions about problem solving individual cases as well as all the other topics the groups choose for themselves.

DATES FOR YOUR DIARY
Central England is holding its next Lidcombe Link day on **Wednesday 7th December** from **13.30 – 16.30**.The venue is Coventry and Warwickshire Hospital, Stoney Stanton Road, Coventry CV1 2FH. **Contact**: **Debbie Middleton** on tel **024 7684 4187** or **email: Debbie.Middleton@coventrypct.nhs.uk** for further details if required.
The focus will be on using the LP with children with other difficulties or diagnoses, including any related papers from the ODC. Bring along any relevant information, books, journals and papers, and there will be group discussions and problem solving particularly around the areas of ASD, Downs Syndrome, ADHD, voice and hypotonia.

Contributions to Mary Kingston. Send your ideas and questions to:
Email: **kingstonamee@talk21.com**   I can't promise to include everything and have to reserve the right to edit contributions as necessary. But I'll do my best!

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Venue: **40, Upton Road, Norwich, NR4 7PA.** Bring/buy your own lunch. **Contact: Sally Lelièvre** for details, directions etc. on tel. **01603 508946,** or email: **Sally.Lelievre@nchc.nhs.uk** If you have not been before please let Sally Lelievre know in advance as there is a possibility the venue may have to change.

The North West's Link day is on **Tuesday 27th March 2012** from **1-4pm. Venue: Darwen Health Centre, Darwen, BB3 1PY**. If you require further details contact **Victoria Mangera (Blackburn with Darwen PCT) on email: victoria.mangera@nhs.net**

COURSES AND EVENTS

It has been agreed by the Lidcombe Program Trainers Consortium that the two day workshop (three days in countries where English is not the first language) is only for Speech and Language Therapists (Speech Pathologists etc) and students in their final semester. It is not designed for parents (unless thay are qualified SLTs), TIs or members of other professions e.g. psychologists, doctors, teachers.

The October 2011 workshops are now full.

A **London** based course is being held on Wednesday and Thursday **March 28th & 29th 2012** at the **Royal College of Speech and Language Therapists.** Contact **Sally Wynne** on email: **lidcombe@live.co.uk** or **Mary Kingston** on email: **kingstonamee@talk21.com** for the flyer and booking form.

MISCELLANEOUS NEWS

The first student based workshop was run by Mary Kingston and Sally Wynne at the University of East Anglia in June 2011 for SLT students in their final semester. It was a great success and if asked we are happy to run it again in 2012.

The first LP workshop in France was held in Paris in September 2011. This was run by Veronique Boucand and Rosalee Shenker, with Ann Packman also in attendance. 25 participants attended.

In case you missed this last time...
*Important announcement! It was reported in a recent edition of Lidcombe News (edition 39 p.3) that a website dedicated to the Lidcombe Program is being set up. There will be a section on the website which is password protected and only accessible to officially trained LP users. If you want to use this you will have to **send your name and email address to the person who trained you**.Your name will be checked against the records and when verified sent to Jane Kelly of the Australian Stuttering Research Centre.**If you receive the Lidcombe News there is no need to do this** as I have your records- but please do tell any other trained colleagues who might wish to benefit from this opportunity.Lidcombe News will report when the site is ready.*

Crossing Continents: Delivering Telehealth Internationally

By Brenda Carey

Brenda is a private practitioner, specialising in delivering stuttering treatments over Skype both in Australia and internationally. Her doctoral studies at the Australian Stuttering Research Centre concerned telehealth delivery of the Camperdown Program, a stuttering treatment for adults. She is a Lidcombe Program Consortium Member, presents Lidcombe Program workshops and has treated more than 150 children using the Lidcombe Program. Her website is www.stopmystutter.com, and e-mail brendacarey@bigpond.com

Most referrals to my clinic begin with a telephone call, but this one arrived in my Inbox. The e-mail began "I am Sachin and I stay in Bangalore India." Sachin described his son, Ganesh who was 4 years and 11 months old. Ganesh had been stuttering for more than two years. Much to his parents' distress, the repetitions they had long-noted in his speech had during recent months been replaced by prolongations and blocks, associated with grimacing, and eye-blinking. Sachin went on to write that while the family's first language was Hindi, he was fluent in English and had researched stuttering treatments on the Internet. He had come across the Lidcombe Program, though was unable to locate a therapist in India who was familiar with it. Might I, he asked, be willing to provide the program to his child, via him, over Skype?

A clinician providing the Lidcombe Program over Skype faces several challenges. For example, treatment demonstrations by the clinician and parent can be difficult to achieve, when all parties are not located in the same physical space. Treating a child who does not share a common language with the clinician also complicates therapy. And treating a family living in a different time zone presents additional organisational problems. For these reasons, when providing the Lidcombe Program over Skype, it is supremely important to follow the manualised protocol as closely as possible. Conceptually, the program must be identical to that provided to a child in-clinic, because practically, there will inevitably need to be some adaptations. Experience and success with delivering the Lidcombe Program in-clinic is essential. So too is high familiarity with in-clinic benchmarks, and signs that all is not progressing well. And even with these, it is imperative to have a discussion with the parents about the evidence for the Lidcombe Program delivered by telehealth, so that they may make an informed decision.

Thanking Sachin for his query, I confirmed that the Lidcombe Program did indeed have a strong evidence base, but that it's efficacy over Skype was still under investigation. Further I told him that previous research of the Lidcombe Program delivered over the phone showed that it took longer, in fact up to three times longer, than in-clinic delivery. Undaunted, Sachin

responded that he still believed the program to be his son's best chance of stopping stuttering, he felt prepared in the event of it taking a longer time, and that if at any time I felt it necessary, he would be willing to travel to Australia for several weeks to facilitate the process.

So began, in April 2010, the treatment journey with this family.
For all Lidcombe program clients, the first step in treatment is the establishment of a complete picture of the child's stuttering- its composition, variability, frequency and severity. To do this, several steps were taken. First, the family was instructed on how to download and use the electronic recording program, *Audacity*. Second, Sachin was trained in differentiating stuttering behaviours, and assigning a severity score to his child's stuttering, using the severity scale. Third, because as a non-Hindi speaker I was unable to confirm the severity score, Sachin's wife, Vigi, was also included in the assigning of severity scores, so the severity score represented an average of both parents' scores. Finally, to increase the validity of the score, a spontaneous speech sample of no fewer than 10 minutes was e-mailed to me, along with parent stutter counts. This procedure was adhered to the entire duration of Ganesh's progression through Stage 1 of the program.

Once stuttering measurement procedures were put in place, Ganesh's parents were trained to provide Lidcombe Program contingencies. As for in-clinic clients, this was achieved with a combination of explanation and demonstration. However for Ganesh, some alternative methods were used. For example, to allow for a common referent between clinician and client, pictures were e-mailed to be printed and used in sessions, or books requested that could be loaned from a library. During the Skype session Ganesh and I were both then able to engage in conversation about the pictures we had in front of us. In this way, the contingencies were demonstrated at a distance. At other times, training was through explanation and role-play. Measurement assessed the impact of contingencies, and treatment samples were e-mailed regularly so that to the best of my ability, I could establish that contingencies were supportive and encouraging. Above all it was essential to confirm that throughout the treatment process Ganesh appeared to be enjoying his special talking time. The establishment of a supportive, constructive working relationship with child and parent is always important, and never more so than when treatment is delivered at a distance.

There were many aspects of the therapy process that were indistinguishable from in-clinic therapy. Sessions were weekly, for an average of 45 minutes. Sachin was taught to provide contingencies in response to Ganesh's stutter-free speech, and this was initially done in one or two conversations, lasting 10 to 15 minutes, each day. Sachin was taught through live and recorded demonstrations how to structure conversations to elicit speech that was likely to be stutter-free. Through discussion of his son's interests, Sachin was given ideas for games, books and activities that would be engaging, but not excessively distracting or exciting, for his son. And Sachin was supported during the program when time limitations made it more challenging to provide the treatment, when fluctuations in fluency were discouraging, or when Ganesh was unwell or more difficult to engage.

Severity ratings influenced treatment and treatment influenced severity ratings.

The pattern of Ganesh's progress was both predictable and familiar. Pretreatment Ganesh's stuttering was assigned an SR of 5. By week four of the program this had reduced to 4, encouraging both Sachin and me that in-clinic benchmarks were being met. By week 12 of the program, stuttering was at an SR of 3 and all structured conversations had been withdrawn. By session 17 in September 2010, the entry criteria for Stage 2 had been met. Ganesh progressed uneventfully through Stage 2, and contingencies in unstructured conversations were gradually withdrawn, as the number of stutters continued to reduce.

Ganesh's treatment took 17 sessions, and 22 weeks, a very pleasing result for both me and his father. And so it was up to Sachin to remind me of our first discussion and my warnings about problems that might arise, and how none of these had come to fruition. Which I didn't mind a bit, and is the same discussion I continue to have with prospective telehealth clients, again and again. And this is exactly how it should be.

Note: This family kindly provided consent for their story to be told by Brenda in the Lidcombe News. However, to protect the family's privacy, pseudonyms have been used in this report.

References

Harrison, E., Wilson, L., & Onslow, M. (1999). *Distance intervention for early stuttering with the Lidcombe Programme.* Advances in Speech Language Pathology, 1, 31-36.
Lewis, C., Packman, A., Onslow, M., Simpson, J. A., & Jones, M. (2008). *A phase II trial of telehealth delivery of the Lidcombe Program of Early Stuttering Intervention.* American Journal of Speech-Language Pathology, 17, 139-149.
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.

Dear Sue

I have been seeing a little girl called Jade for 5 weeks now and her Severity Ratings are still a fairly consistent 4 or 5 as they have been from the start. I feel we are not making any progress and that the problem is that Jade's mother is struggling to give the contingencies. She is pretty good at structuring the session and making it conversational but seems to forget to say anything about Jade's speech. I have demonstrated the contingencies on many occasions but when it comes to the mother's turn she just doesn't seem aware that she isn't doing the same. Do you think it would be a good idea to video a session to show her what is happening, or do you have any other suggestions to help with Jade's therapy?

The first issue to discuss with Jade's mum would be whether there is a reason that she is not using contingencies. There may be a reason for the low level of praise. If you can determine why not, then it may be easier to discuss the issue and resolve it. Some things to look at would be:

- Check with the parent how she usually praises her child for other behaviours – is there something from this that can be adapted to the way she praises for stutter-free speech?
- Is it that the parent is uncomfortable with the praise? Maybe the clinician has been demonstrating a lot of 'praise' that is too over the top for that parent? It could be that the parent would be more comfortable with 'acknowledgement'.
- Does the parent report that she praises more at home? If so ask the parent to bring in a recording of home therapy to listen to. This may serve as a platform to identify how often praise occurs.
- Check that Jade is accepting praise at home – does the parent praise minimally because Jade has reacted to it at home?

If the issue is simply that the parent forgets to praise:
- Use a tangible reward system during the therapy. This way the parent is reminded to praise by the act of handing the child the token, ticking a box etc.

- Give the parent a goal for VCs e.g. praise 10 times during the therapy time; If using a book have the parent aim to praise 'x' amount of times per page. Sometimes having a number to work towards can help.
- Demonstrate treatment, and then you could indicate to mum during her treatment by nodding or some other gesture when she needs to give a verbal contingency, and when she does one correctly reinforce her for doing it. Follow this by discussing what she did well and why it was effective.
- Try demonstrating the contingencies using a book where the clinician does one page with Jade, then the parent has a turn, and then back to the clinician and so on. This way the parent is getting a regular demonstration of praise and this may serve to remind her to praise more often.

Another strategy that could be useful would be to discuss the lack of progress using the severity rating chart. Discuss that the reason the ratings are not changing is due to the lack of verbal contingencies in therapy time. If the lack of progress is seen to be a direct result of no verbal contingencies, the mum might try to learn how to do them. It would also be important to reinforce mum's strengths at structuring treatment. As for asking Jade's mum to watch a video and self evaluate there may be some benefit in increasing her awareness of the behaviour that you want to target (i.e. increasing her verbal contingencies) although I have not found this strategy to be needed very often.

I attended a Lidcombe workshop many years ago and I have a question about when to do the Severity Ratings. I was taught that you could either ask the parent to do the scores for 15 minutes a day (different situations each day in a weekly cycle) or daily scores. Once the 15 minutes a day scores got down to 3s you went to all day scores to prepare for Stage 2. I understand that this is different now, and that parents are asked for daily scores from the beginning. Could you clarify for me what is now the accepted thinking about ratings and when you do them?

The important thing to remember is to use the severity ratings in a way that will provide enough information to accurately track progress and make treatment decisions.

The Lidcombe Program guide states that the parent assigns a daily severity rating score for the child's stuttering for the whole day. A clinician may wish the parent to use supplementary SRs for a particular speaking situation that occurs each day, such as dinner time and bath time. These are recorded in addition to the daily severity ratings. Another option is for the parent to record a most severe severity rating for the day in addition to an overall score for each day.

It is usually sufficient to ask the parent to give one average rating per day. If one score per day is not providing accurate information or enough information to enable you to make informed clinical decisions, then you can ask the parent to provide supplementary severity ratings in addition to the average rating.

If the parent is unable to provide a global rating each day for a particular reason (e.g. they struggle to tune in for the whole day) then it may be decided to have the parent rate for 15 minutes/day

in a weekly cycle. However as much as possible you are aiming to return to a global measure when able.

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.

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.

Development of the training module for the Internet Lidcombe Program

by Sabine Van Eerdenbrugh

Sabine trained as a speech pathologist and a teacher in Belgium. She is currently a PhD student at the Australian Stuttering Research Centre in

Sydney, Australia, and this article reports the topic of her PhD research. She has a private practice where she uses the Lidcombe Program and treats children with other communication disorders. She also did the Lidcombe Program with her son (see picture) who used to stutter but does not any more!

Background to the development of the Internet Lidcombe Program

In the early days of The Lidcombe Program (LP), no one thought that this treatment would be delivered in any way other than in the original format: in a clinic with a speech pathologist training parents to treat their (pre)school aged child who stutters. In the late nineties however, a speech pathologist at the Bankstown Stuttering Unit helped out a family of a young child who stuttered, but who was unable to travel to the clinic with his parents. They used the telephone[1]. The telephone sessions were supplemented with training videos, mailed by the speech pathologist to the parent and audio recordings of the child's speech mailed by the parents to the speech pathologist. The success of this intervention led to the trialling of telehealth delivery of the LP on a larger scale. Subsequent studies showed this method of delivery to be successful also[2,3].

The step from the telephone to more advanced telecommunication (Skype) has been taken recently after successful delivery of stuttering treatment for adults via Skype[4]. At the present time, a randomised controlled trial is underway in which the LP using Skype is being evaluated.

Internet LP

The internet is now used widely for treatment delivery in psychology, e.g. for depression and anxiety (e.g. Moodgym, VirtualClinic). The ASRC team has developed and trialled a cognitive behaviour therapy program for adults who stutter and is now trialling an Internet version. Even though moving from delivering the LP through Skype to delivering it as a clinician-free version on the internet is the logical next step, the delivery methods differ significantly. Whereas before a speech pathologist was always involved in the communication with parent(s) and child, the Internet LP is being developed without face to face contact with a speech pathologist.

The Internet LP will consist of two main modules: training and treatment. The Internet LP training focuses on training parents, for example on how to give

severity ratings to their child's speech, whereas the Internet LP treatment consists mainly of problem solving strategies to aid parents conduct the treatment correctly and effectively. The Internet LP training module is being developed at the present time and a description follows. The development of the treatment module will be reported at a later date.

<u>Training module</u>
The Internet LP training module has a number of different sections. It will contain video examples of different types of stuttering and varying severity and will provide training in the use of the severity ratings. There will be videos of parents and children conducting "smooth talking times" and examples of when adjustments are needed, with demonstrations of changes in activity, changes of place or timing of the activity and changes of the language use of parent and child in conversations. Videos demonstrating correct and incorrect ways to give feedback to a child will show how to give contingencies safely and appropriately. These examples are often exaggerated but have a clear message that is explained by a speech pathologist. The advantage of having videos of parent and child, as compared to a speech pathologist and a child, is that they reflect the parent's and child's situation in their home environment. Preschool aged children who stutter were video recorded to demonstrate the stuttering types and stuttering severities. Their faces were blurred except for their mouths. Preschool aged children who do not stutter were video recorded with their parent to demonstrate treatment activities and procedures. Even though these children do not stutter, they were asked to repeat words to simulate certain treatment situations. In one series of videos, the parents then adjusted treatment appropriately to their child's needs. In another series of videos, they gave exaggerated or inappropriate feedback to their child's stuttering. The parents who participated in these videos are linked to the ASRC (staff, PhD students) and knew exactly what the set up and the purpose of the videos were. Recording children who do not stutter was a conscious decision as it would be unsafe to bring children who stutter in situations where they could experience harmful treatment.

A 'virtual' speech pathologist will take the parent through the entire program. This female person, aged 35, will introduce and explain the videos, discuss the issues and guide the parents through the Internet LP training. This will be done by way of voice-overs, with a picture of her face appearing at the same time. Not only will she bring clarity to the explanations of the program, it will also contribute to the parent's feelings of having a speech pathologist nearby, even though she is not directly involved in the child's treatment process.
The program is individualised for each parent and child, according to the information the parent provides as they progress through the program, for example answering questions, sharing personal experiences, describing opinions and matching examples. Based on these interactions, the parent receives personal advice.

Before starting the training, exclusion requirements are listed, e.g. the child is not older than 6 years of age and has no concomitant speech and/or language difficulties and the parent must have adequate command of English. Later in the training, parents are asked to answer questions about their family.

If the program identifies that the parent and/or child do not have the desired profile, the parent is advised to consult a 'real' speech pathologist and further access is denied. This safety check is made regularly throughout the program. The treatment module will include checks that the severity ratings are improving over a certain period and that the child is enjoying the program. These checks are critical to ensure that the child is responding to the treatment and is not distressed by it in any way.

Time will tell how the Internet LP training will be used, but it has the potential to be used in a number of ways. It could be the first step in the treatment process. A speech pathologist could refer parents to this Internet LP training and could start face-to-face treatment on completion. This would save the speech pathologists clinical hours. It could also be used by speech pathologists who don't treat children who stutter very often, to refresh their knowledge. It may be that some straightforward cases may complete the program completely online. What we do anticipate is that it will be helpful for families who live remotely or who are unable to consult a speech pathology service for other reasons.

Discussion

Clearly, the Internet LP won't suit everyone. Many parents will still prefer face-to-face treatment with their speech pathologist. Some parents may not be in the optimal circumstances to start or continue the Internet LP. Other parents may experience difficulties once they have started the Internet LP.

There is no doubt that the Internet LP is an innovative treatment for stuttering in the speech pathology profession. The program includes studio quality video recordings, optimal sound samples recorded in a sound-proofed room, complex graphical designer involvement and highly experienced IT people to ensure quality. A 'virtual' speech pathologist welcomes parents to the world of stuttering and the LP, and video demonstrations make them ultimately ready to treat their own child. The delivery models of the LP have diversified over the past few decades. It is a luxury that speech pathologists and parents will be able to choose which one suits the family best.

References

[1]Harrison, E., Wilson, L. and Onslow, M. 1999. *Distance Intervention for Early Stuttering with the Lidcombe Program*. Advances in Speech-Language Pathology, vol. 1 pp 31-36.

[2]Lewis C., Packman, A., Onslow, M., Simpson, J.M. and Jones, M. 2008. *A Phase II Trial of Telehealth Delivery of the LP of Early Intervention.* American Journal of Speech-Language Pathology, vol. 17 pp 139-149.

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[4]Carey, B. O'Brian, S., Onslow, M.,Block, S., Jones, M. and Packman A. 2010. *Randomized controlled non-inferiority trial of a telehealth treatment for chronic stuttering: the Camperdown Program.* International Journal of Language and Communication Disorders, vol. 45, pp 108-120.