



Lidcombe News



May 2013

Edition 46

On this 15th birthday edition of Lidcombe News we are delighted to bring you an array of articles. These include a follow up on the translation research from last time as I have been looking into some of the reasons why therapists in the UK have found it difficult to recruit the numbers hoped for in this research. In addition we have an article from Sabine Van Eerdenbrugh about the treatment issues that parents report to their therapists in the clinic. This is the first of two articles from Sabine, the next one will be in the September 2013 issue and will describe, with examples, the study conducted to collect scenarios for the problems identified in this article. These scenarios are based on the expertise of seven clinicians with 15 years plus experience with the Lidcombe Program and it is, as Sabine herself says, unique to have this level of experience brought together in one study.

This is all in addition to our popular Dear Sue and Just Explain That Again..., and a list of all the problems that Dear old Sue has covered in the last fifteen years since she began, albeit in a variety of guises! We begin though as ever with the list of Link Days and workshops in the UK.

(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).



DATES FOR YOUR DIARY

Norwich is holding a Link day on **Tuesday, October 22nd 2013** from **9-3**.

Venue: 40, Upton Road, Norwich, NR4 7PA. Bring/buy your own lunch.

Contact: Sally Lelièvre for details, directions etc. on tel. **01603 508959**, or email: Sally.Lelievre@nchc.nhs.uk



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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!

The Northwest will be holding its next Lidcombe Link Day on **Thursday 21st November 2013** with a **1.30** start.

Venue: 3rd Floor, **Townside Primary Care Centre**, 1 Knowsley Place, Knowsley Street, Bury, BL9 0SN. (Kim writes: We are just opposite the Town Hall. Please take the lift/ stairs up to 3rd floor and take a seat in the waiting room as no receptionist is usually present. I will come and let you in).

Parking: There is a pay and display car park next to the Centre which is £5 for the afternoon.

Contact email: **Kim Foster** on kim.foster1@nhs.net or

Telephone: 0161 7621688 Monday - Thursday and Friday pm
0161 7783607 on Friday am.

Central England is holding its next Lidcombe Link day on **Wednesday 4th December from 1.30 – 4.30**. The venue has not as yet been arranged but most likely will be in Coventry. The agenda will be case discussions, troubleshooting/problem solving and resource sharing.

Contact Debbie Middleton on Debbie.Middleton@covwarkpt.nhs.uk or telephone: **024 7696 1453** nearer the time for information on where the meeting will be held.

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 they are qualified SLTs), TIs or members of other professions e.g. psychologists, doctors, teachers.*

There are three courses available in the UK over the next few months

Rosemarie Hayhow and Suzanne Smith are running a course at the **Coatbridge Community Centre, North Lanarkshire, Scotland** on **September 11th & 12th 2013** and there may be places available. If you are interested in this course or future courses in Scotland contact Suzanne (suzanne.smith@lanarkshire.scot.nhs.uk)

Mary Kingston and Sally Wynne are holding a workshop in **Norwich** on **October 7th and 8th 2013** at The King's Centre, Norwich. Contact: **Sally Wynne** on email: lidcombe@live.co.uk or **Mary Kingston** on email: kingstonamee@talk21.com for the flyer and booking form, or any other details required.

Mary Kingston and Sam David are running a course in **Hastings** in **November 2013**. This is a department course with a few places to sell. Dates are not confirmed but contact Sam David on samdavid76@btinternet.com for details as they emerge.

“I want to but I don’t have time to...”

Understanding research in the clinical setting from the clinician’s point of view.

Mary Kingston

In the last edition of Lidcombe News (LN edition 45) Sue O’Brian and Rosemarie Hayhow each wrote about the reasons and needs for translation research for the Lidcombe Program (i.e. the investigation of the challenges and outcomes associated with the transfer of research knowledge into clinical practice). Rosemarie’s article reported on the translation study being carried out in the UK where there have been problems recruiting families, and disappointingly low numbers taking part. Rosemarie wrote at the end of her article: “It is work we can and must do if we are to demonstrate to commissioners that we are worth employing, and every study that is undertaken should inform the next one in order that we may achieve well designed research studies that are workable in clinical contexts.” (LN 45, page 13).

This set me thinking about what exactly the problems with recruitment were from the therapists’ point of view, and what researchers can do about this in order that - if possible- further studies may not suffer the same difficulties. In her article Rosemarie included some feedback from a few of the clinicians who had taken part, who cited “work pressure” and “parents came with their own anxieties, and their agenda did not usually include joining a research study”. I was however curious to look at these issues more deeply and see whether there might be any way around them. I have to say at this point that my enquiries are more journalism than exact science and what I discovered has not offered a solution to the problems! However the following pages may help to unpack what therapists meant by the two main barriers to family recruitment mentioned above, and help future researchers to put in place some balances which could in some way help the situation.

The way I set about finding out in more depth what was going on in the clinics was to send Rosemarie a list of questions which she then distributed to the therapists taking part. They were then asked to return their answers to her which were then emailed to me. In this way confidentiality would be preserved. Some therapists gave their responses over the phone or spoke to me personally, and from others I received written information. The project only covered UK therapists and I had in the end 7 people taking part. I also only gave them a month to get back to me.

These were the questions I asked:

1. What are the barriers you have experienced in recruiting families to the study?
2. Is there anything that researchers could do that would help with recruitment of families?
3. Do you feel you need extra skills /training in order to engage with clinical research?
4. Do you have any ideas about how it could be made easier for working speech and language therapists to be able to contribute to research?

Many of the therapists answered in a general way rather than specifically to the questions that I asked but their responses do fit into the questions I raised with them and were interesting in what they tell us about how they see their professional responsibilities both to employers and clients.

They were most eloquent with regard to the first question around barriers to research and the difficulties they raised appeared to be both external (work related/health Trust issues) and internal (personal to their professional integrity). Two of them said that families had refused to take part, one writing “parents did not want data on their child to be shared and they did not want to answer the additional questionnaires that went with the research.” One also said her clients left the country for the duration of the study (but I didn’t think she was making any connection there!).

External barriers included the pressures the health Trusts put on them:

- Seeing new cases within a certain time frame
- Therapist being asked to account for all their time. “If there were codes on Careplus that detailed research activities, at least we could account for the time. It’s all about stats these days”
- Trust administration, record keeping etc. – “it takes a third of my working day” There wasn’t time for anything extra. When having to make a choice between activities one therapist said “short term needs overcame my understanding of the long term need for research. I’m just overwhelmed by the job needs, every day is a pressure. There’s SO much trust stuff, and no room for anything else.”
- The study coincided with a time of political change in the National Health Service (NHS), staff levels were at their worst, case-loads increased, there were anxieties about down-gradings and many changes to working practice, all of which increased work load and time pressures.

Internal barriers were around the feelings therapists had towards their client families, their relationships with them and their communication needs. The research couldn't compete with this. They believed:

- The clients were more important than the research, as one put it "the time should be theirs".
- One said she felt she was "asking them for a favour" (by participating in the research) "before I'd even got to know them" and she thought she should be talking about what she could do to help **them**, not what **they** could give to the service.
- On similar lines another therapist felt that it was also an issue of trust. She wrote: "They are more likely to trust you when asking them to participate, once some trust has been built".

But for some it was also:

- A feeling that research "didn't have much to do with...current working lives." Just forgetting to even ask.
- No sense that the research was high profile or particularly 'special' to make it worthwhile, or even remembering, to ask a family to participate.

Turning to question 2 about what researchers could do to help with family recruitment there were a variety of answers:

- One felt more clarity about what was required, and better organisation of materials would have been helpful - one therapist had not understood that she was meant to be recruiting as many families as possible as she had only received 3 sets of forms. Once she understood what was required she added that a letter had been prepared for her by the lead researcher which could be sent out to the family in advance. She felt this was very useful and saved time as the family then came in prepared.
- Another therapist felt the wording of the information in the research documents "scared the family". She wrote that recruitment would be helped by "less formal/more easily-accessible information documents" though she went on to say "...I realise that there are legal requirements around what has to be included on the information sheets".
- A different timescale/organisational process around **when** to recruit the family would have been helpful. As stated in the response to the barriers question there was too much time pressure on session 1 to do this, but by the 3rd session it would have been much easier. A speech sample could have been taken in the first session and then used if the family joined the project. One therapist also said that she felt the families she **had** managed to recruit on session 1 were by their nature

“super confident” and she wondered whether this actually “skewed” the sample.

- One therapist felt that in order to raise the profile of the research, to make it more “special” and give the therapist a greater incentive to recruit families despite time pressures, it might be helpful to meet others doing the research, and engage more with the lead researcher.
- Another felt some financial remuneration to the therapist might help, so that the extra session needed to do the recruiting could be done e.g. as an extra home visit without therefore taking time out of the clinic.

In response to the third question about whether any extra skills/training was required, only one therapist thought this might be beneficial, suggesting an “introductory session” might be helpful. For others any extra training felt unnecessary and a further burden on their time.

The final question asking the participating therapists for their own ideas about how to make it easier to be a part of the research process very much cues into their responses to the other questions. There were suggestions around easing the time/case load pressure which have been mentioned above (e.g. some funding for the extra time required to recruit a family, making minor changes to the way the study was organised) but two therapists thought that a sea change in the way that research is regarded within their health Trust would be really helpful. They said there was no recognition from managers that this was a valuable process, or that they were under even more pressure because of it. One expressed the opinion that there was no interest in or sense of being valued by managers for what she was doing (though she appreciated managers were feeling overwhelmed in their jobs as well) and that there was “no mechanism, no infrastructure” for recognising clinicians “doing research in the average community clinic.” Another expressed the following: “...there was no communication with or from the Trust. I didn’t feel this was something they were interested in talking through with me so I had no feeling of support from up above. It was all done in isolation, there was no sense that anyone was interested. So I wasn’t motivated to do it much really.” What was needed she believed was to “raise the profile of research, make it feel more special, rather than just a chore. It just felt like a time pressure rather than anything particularly worthwhile.”

Trying to draw some conclusions from these responses- and I am extremely grateful to those seven who did find the time to reflect on their research role- the information I received was in a large part no different from that which Rosemarie recorded in her article in January 2013. The main difficulties encountered were time pressures, a deep sense of needing to put the client first given these time issues, and a few organisational problems such as having too much to do in the first session.

But what it also showed was ***the context*** of these issues, why they are happening, and more interestingly, why they are happening now. I from what I was being told that therapists are increasingly under very real pressure at work, and how the anxieties within the current climate in the NHS come together to make research in the work setting, however well designed, very problematic- something that is in itself a very real worry too.

Trying to draw this together and make sense of it all, it felt to me by the end that I wasn't just reading and hearing about research but about something much more fundamental to our NHS. What came through very clearly was that Speech and Language Therapists in the UK have to fit as much into their working days as they possibly can, but even that isn't enough. And while striving to do all they can, they do feel not valued for it, and adding in anything else -such as research- is virtually impossible without any extra time or recognition being given to it. But what also came through was a real concern for patient care, and a desire to help families in trouble, and that this, very understandably, is more important to them than collecting data for a research project. If anything had to be left undone it was going to be the research.

So while the NHS is putting more and more weight behind the need for a strong evidence base the actual process of collecting that evidence is not perceived by clinicians on the ground as being valued, despite all the extra work they are doing. Until its importance is actually recognised by those who have the power to make changes- by giving extra time, by funding extra sessions, or by raising the profile and importance of clinicians doing research in their clinics- it would seem that the problems associated with this kind of clinical participation will continue.

Dear Sue



I have been seeing Mikel, a child of 4 years 4 months, for the past 13 weeks and he has done well up till now. His SRs have reduced in the systematic and steady way that I expected from my recent training and we had got down to 2s with an occasional 3. His mother and I had Stage 2 in our sights! We had moved entirely to unstructured treatment as structured times no longer seemed necessary. However in the last two weeks his SRs have gone up again, and he is now getting 3s and occasional 4s. Could you help me problem solve this as I'm not sure what has gone wrong and what I should be doing about it?

It sounds as though Mikel was actually responding very well to the Lidcombe Program treatment. However, when severity reduced, the shift from treatment during structured conversations to treatment during unstructured conversations probably happened too abruptly. There are many ways to shift from structured to unstructured treatment conversations and often a gradual shift is best.

The problem-solving that is required will be about the amount of structured and unstructured treatment that is needed in order to see further progress. It seems that there was no longer enough treatment occurring, or that the amount of structured/unstructured treatment was not quite right for Mikel. Although stuttering severity is now quite mild, it is not yet stable. Until it is more stable, Mikel probably needs treatment that is delivered for a defined amount of time during naturally-occurring conversations which take advantage of the fluency that is occurring, or targets for when he has those increases in severity to a 3 or 4.

In Mikel's case you might continue to have a structured treatment conversation but the content can target 'challenging' speaking situations. For example, if Mikel was experiencing patches of 3 or 4 when he was excited, you could target excitement in treatment time, while structuring as needed and increasing the contingencies. There would still be a defined

time to deliver the treatment (15 minutes), and more frequent verbal contingencies than across the remainder of the day, but it may be possible to integrate this into everyday interactions.

When these spikes no longer occur, then the focus can gradually shift to delivering treatment during unstructured conversations. Then verbal contingencies that are applied throughout the day will become more and more important.

Throughout treatment, the important thing is to measure and monitor the impact of any changes in the treatment delivery and adjust the amount/type of treatment according to what Mikel's speech needs.



Just explain that again...



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

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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

Both 'Dear Sue' and 'Just Explain That Again...' were answered by the team at Bankstown Stuttering Unit, Sydney, Australia. These include Stacey Sheedy, Wendy Lloyd, Mary Erian, and Angela Nikolas. Our many thanks to them all for their time and expertise.

Lidcombe Program Treatment Issues

Sabine Van Eerdenbrugh

Australian Stuttering Research Centre

Introduction

I am currently developing an Internet-based version of the Lidcombe Program with the team here at the Australian Stuttering Research Centre. Mark Onslow, Ann Packman and clinical psychologist Ross Menzies have received funding from the National Health and Medical Research Council of Australia to adapt some of our stuttering treatments for the Internet. This program of research is co-ordinated by Sue O'Brian.

The aim of this research is to make our treatments more accessible for the many people who stutter and their families who cannot otherwise receive speech pathology services. This can be a real problem in countries such as Australia and Canada, which have a large land mass and low population; hence the recent interest in developing telehealth delivery of health services in these countries. Other countries, too, can have problems delivering early intervention for stuttering to all who need it, knowing that the cumulative incidence at 3 years of age is now estimated at 8.5% (Reilly et al., 2009).

The Internet Lidcombe Program will be interactive and individualised; hence I needed to gather information about the treatment issues that parents discuss with their therapist in the traditional, clinic-based, face-to-face delivery of the program. I will report our preliminary findings in this paper and some possible problem-solving scenarios in a subsequent paper.

Before I go on, however, I would like to introduce myself. I was born and grew up in Belgium, and I speak Flemish (Dutch), French and English. I obtained a Masters in Speech Therapy & Audiology at the University of Ghent, Belgium, a Masters in Speech and Language Pathology at the University of Nijmegen, The Netherlands, and a Post Graduate Teaching Certificate in Speech Therapy and Audiology at the University of Louvain, Belgium. I worked as a speech pathologist in Belgium before coming to Australia with my husband and family. I have done Consortium training and I delivered the Lidcombe Program for a number of years in my private practice in Sydney, before moving to Perth where we now live.

Five years ago, while in Sydney, I did the Lidcombe Program with my son, under the expert guidance of Cheryl Andrews, and I am pleased to say that he no longer stutters. He had been stuttering for a year before we commenced the program.

Overview of the research study

There are now a number of reports from parents about their experiences of the Lidcombe Program (Goodhue et al., 2010; Hayhow, 2009; Packman et al., 2007; Onslow et al., 2003; Hayhow et al., 2000). However, for the development of the

Internet Lidcombe Program, we needed to identify the treatment issues that parents bring to the clinic and how therapists work with parents to address these issues. Some issues are described in Chapter 8 and 10 of *The Lidcombe Program of Early Stuttering Intervention* (Harrison et al., 2003; Hewat et al., 2003), but investigating the topic empirically was deemed necessary.

Method

Treatment issues that parents report in the clinic were collected from therapists in three ways. The aim was to gather as many issues as possible.

First, we organised a meeting at the Stuttering Unit in Bankstown, Sydney, with five specialist Lidcombe Program therapists, during which they talked freely about the Lidcombe Program treatment issues they perceive parents to have.

Second, we asked therapists at four other clinical sites to record treatment issues that parents brought to the clinic over a 7-month period. Two were Lidcombe Program experienced therapists and two had less experience with the Lidcombe Program.

Finally, three Lidcombe Program experienced therapists were interviewed in depth, in order to identify any further issues that parents report when implementing the Lidcombe Program. These therapists were also asked to suggest problem-solving scenarios.

All reported treatment issues were coded into themes and a template of the themes was constructed.

Results

Procedure 1

Discussion with the Stuttering Unit therapists resulted in 15 categories of treatment issues. Most of these have already been reported by parents in the previously mentioned publications. Additional treatment issues brought up during the meeting included:

- Accurate identification of subtle and obvious stutters is often problematic for parents.
- Many parents praise their children for stutter-free speech too often and the potency of the reinforcement is lost.
- Children can respond negatively when someone other than the person who is doing the treatment gives verbal contingencies.

Procedure 2

The majority of the Lidcombe Program treatment issues identified in this study were collected by therapists at the four generalist sites. New treatment issues were reported as questions asked by parents in the clinic. Some of the new issues reported by them include:

- If my child uses a special voice to cover up the stuttering, how should it be treated?
- If I have only limited time to listen to my child's speech each day, can I do the Lidcombe Program?
- Do I need to take extra measures when a holiday is coming up and if so, what are they?
- Can treatment during structured conversations be done in the car?
- Do different types of books used during structured conversations have different language demands?
- How does treatment need to be adjusted when my child does not generalise speech improvements beyond structured conversations?
- If a younger sibling presents with stuttering, when should the Lidcombe Program be initiated for the sibling?

Procedure 3

The three Lidcombe Program experienced therapists reported some treatment issues not already identified. Some examples are:

- Repetitions and fixed postures (prolongations and blocks) are not the only stuttering behaviours. Many parents don't know about verbal or nonverbal superfluous stuttering behaviour.
- Parents may find it difficult to provide verbal contingencies at moments when their child is excited and stutters a lot.
- Withdrawing structured treatment during Stage 2 can be problematic if done incorrectly.

Themes

124 treatment issues were identified and categorised subsequently into four main themes. Some examples are given in the table. Note that not all subthemes are shown.

Themes and sub themes	Example of treatment issue
GENERAL ISSUES	
Children's maturity	Sitting still and taking instructions: prerequisites for doing the Lidcombe Program?
Starting the Lidcombe Program	Should the Lidcombe Program be started if children have a cycle of fluency?
PROCEDURES AND COMPONENTS	
Organising treatment times	Could treatment during structured conversations be done in the car?
Applying conversation strategies during structured conversations	Which conversation strategies could be applied during treatment in structured conversations with children who stutter severely?
Choosing and using activities appropriately during structured conversations	Which types of books could be used during treatment in structured conversation?
Verbal contingencies during structured conversations	What can parents do if their children seem to ignore praise?
Adjusting the program (treatment in structured and unstructured conversations)	How could the program be adjusted if children are only stuttering in certain situations, e.g. when they visit their grandparents?
Stage 2	Are there strategies to withdraw treatment in structured conversations in Stage 2?
CONDITIONS OF PARENTS/CHILDREN	
Child-related conditions	How could a sensitive child be treated?
Parent-related conditions	How can the Lidcombe Program be done when parents are not living together?
REACTION OF PARENTS/CHILDREN	
Reaction to the stuttering	What could parents do if children are distressed about their stuttering?
Reaction to the Lidcombe Program	What to do if parents feel anxious about their responsibility in the Lidcombe Program?

Not surprisingly, perhaps, the majority of the treatment issues found were related to the second theme, 'Procedures and components'.

Conclusion

Therapists face many issues when conducting treatment with the Lidcombe Program and this study has identified some of these. It is essential for the Internet Lidcombe Program to be able to respond to the treatment issues that parents could encounter when they are not visiting a therapist each week. The information in this study,

gained from therapists themselves about the treatment issues that parents report to them, will be incorporated into the Internet Lidcombe Program.

In addition, the dissemination of the results of this study has the potential to assist therapists delivering the program face-to-face. Knowing the treatment issues that can potentially arise may help therapists pro-actively prepare parents for them, when appropriate.

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Topic list of all the 'Dear Sues' from edition 1 until now.

All the back copies of 'Dear Sue' are available to you- just email me (see email address at bottom of page 1) and I will send you what you want, or the more recent ones are available from the Montreal Fluency website: www.montrealfluency.com. It is also worth noting that the Dear Sues have been written over a 15 year period during which time some terminology has changed and elements of the programme have undergone revision.

Some terminology changes

1. Going 'online' means treatment which is unstructured. What we used to call 'sessional' treatment is now called 'structured' treatment.
2. 'Maintenance' is now called Stage 2
3. We used to talk simply about "praise" and "correction". We now use the terms "parental verbal contingencies for stutter-free speech" or "contingencies for stutter-free speech" and "parental verbal contingencies for stuttering" or "contingencies for stuttering," rather than "praise" and "correction". See Ann Packman's article in LN Edition 11, September 2001, pages 8-11 for more about this.

Please note also that there have been other changes e.g. %SS is now a voluntary measure, so when reading the older Dear Sues do bear all these points in mind.

<u>Edition</u>	<u>Topic</u>
Edition 1	What to do if the child is not in a stuttering phase: when to start treatment?
Edition 2	Stuck on 3s
Edition 3	What to do if the child can't "say it again"
Edition 4	Problems with Stage 2
Edition 5	Child doesn't seem to notice if he's stuttered. Self-evaluation; but is this a focus for treatment?
Edition 6	Situational difficulties. Prompting
Edition 7	Problems with stuttering if talking about 'abstract' things/ not the here and now
Edition 8	Nothing is happening... (Chère Charlotte)

Edition 9	"Starter mechanisms". What to do about these.
Edition 10	What to do while waiting for treatment/ or during the monitoring phase
Edition 11	What to do with a 'blocking' type stammer
Edition 12	Lidcombe and Down's Syndrome
Edition 13	Praise, and parents who have problems giving this
Edition 14	Age limits and Lidcombe
Edition 15	What to do with 'chatty kids'
Edition 16	Problems with feedback in unstructured situations
Edition 17	Problems getting Within Clinic samples. Do we need a %SS? (NB This was written before the %SS was a voluntary measure only)
Edition 18	Stuck on 2s
Edition 19	Involving outside agencies e.g. Learning Support Assistants
Edition 20	What if the child doesn't stutter in clinic?
Edition 21	A child who is sensitive to contingencies
Edition 22	A child who is making good progress but who occasionally has peaks particularly in 'competitive' situations e.g. with siblings
Edition 23	Working with a mother with a severe stutter herself. Some issues to consider
Edition 24	Working in groups. What are the possibilities for this with the Lidcombe Program?
Edition 25	Interjections or fillers e.g. ums. What to do with a) identifying this behaviour b) dealing with this behaviour c) measuring this behaviour
Edition 26	Child finding difficulties with concentration/awareness of the contingencies
Edition 27	Generalisation problems; how conscious does the child have to be?
Edition 28	Child starting to be unhappy about contingencies

Edition 29	Seeing a child every two weeks rather than every week. Feasibility of this?
Edition 30	Generalisation issues; therapy like a game
Edition 31	Treating twins: some options to consider
Edition 32	Child uncomfortable with contingencies- can we leave out the ones for bumpy speech?
Edition 33	Parent uncomfortable with behaviourist principles
Edition 34	How many contingencies should be given in unstructured treatment and could a child get 'hooked' on them?
Edition 35	Variability: generally good progress but very occasional high SRs within each day. What to do about these?
Edition 36	LP with a family where the child does not speak English though the mother does. Feasibility of this.
Edition 37	LP and children with co-morbidities. In this case hearing loss.
Edition 38	A lack of stability with the SRs
Edition 39	Relapse some time after the end of Stage 2. How to proceed
Edition 40	The role of language, and language delay, in timing of treatment and treatment itself
Edition 41	Parent finding it hard to give contingencies. Would the use of videoing be a solution?
Edition 42	Parent needs a break. How to organise this
Edition 43	Parent with a problem using SR charts/ measuring
Edition 44	When/how to move from structured to unstructured treatment
Edition 45	Sorting out those last residual little stutters- often predictable ones
Edition 46	Getting the right mix of structured and unstructured treatment