



September 2013

Edition 47

Now that autumn is arriving in the Northern hemisphere the final edition of 2013 finds its way to you, complete with the promised second part of Sabine Van Eerdenbrugh's article about treatment issues reported by parents using the Lidcombe Program. This second article looks at techniques used by seven experienced Australian clinicians when problem solving these issues. In addition we are delighted to bring you a parent's perspective for our 'Parents' Corner' something we have not had for a while.

This is of course all in addition to our regular Dear Sue and Just Explain That Again..., troubleshooting your problems and answering some of your frequently asked questions. First of all though we begin with a list of Lidcombe Link days and workshops in the United Kingdom, as well as some news items and developments within the Lidcombe Program Trainers Consortium (LPTC).

(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).



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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**

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.*

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. There are still places available.

Mary Kingston and Sally Wynne are holding a workshop in **London** on Tuesday and Wednesday, **March 19th & 20th 2014**, 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 a flyer and booking form for this course, or for any other enquiries.

MISCELLANEOUS



The Lidcombe Program in Poland.

Following her training at a workshop in London, Dr Katarzyna Wesierska has written a chapter about the Lidcombe Program in Polish (it also includes a case study of a Polish speaking child she worked with) called: “W świecie logopedii. Studia Przypadków” which translates as: “In the World of Speech Pathology. Case Studies.” If anyone is interested in reading this chapter in Polish I will be happy to put you in touch with Dr. Wesierska, or you would be welcome to borrow my copy of the book which she kindly sent me. She has also translated the Lidcombe Brochure into Polish and will be doing the same for the Treatment Guide which will be available on the new Lidcombe Website (currently being designed - more on the website in future editions).



New and Retiring

We are delighted to welcome four new trainers to the LPTC. In May, Irma Uijterlinde from the Netherlands joined the team, followed by Carla Di Domenicantonio from Canada, and Véronique Aumont Boucand from France. The fourth new Consortium member is Corinne Moffatt from here in the UK. She currently works in Tower Hamlets in London and is an authority on delivering the Lidcombe Program to the multicultural population in her area. She will be working alongside Rosemarie Hayhow and me until next summer when Rosemarie and I are planning to retire (though we will still be available to help out if ever required), and she will also be presenting the workshops with the many excellent co-trainers we ourselves have always relied on.

Also retiring is the old LPTC logo familiar to most of you from your certificates. The brand new one is featured above. The three elements making up the ‘C’ in ‘Consortium’ are designed to symbolise the parent/carer, child and clinician all working together in partnership. This new design will be used from now on and is the official LPTC logo.

Lidcombe News is delighted to print Sabine Van Eerdenbrugh's second article about parent reported treatment issues (see Edition 46 for the first part). In this edition there are some suggested strategies for their resolution and we hope you will find some useful new ideas for your own practice.

Sabine trained as a speech-language pathologist and a teacher in Belgium and The Netherlands. She is currently a PhD student at the Australian Stuttering Research Centre in Sydney, Australia, and is developing an Internet version of the Lidcombe Program. This article reports one of the studies she conducted for her PhD research. For more than a decade she has worked in various paediatric settings where she has treated many children for communication disorders including stuttering. She is now focusing on completing her PhD. Her email address is sabine.vee@gmail.com.

PROBLEM SOLVING IN THE LIDCOMBE PROGRAM

Sabine Van Eerdenbrugh
Australian Stuttering Research Centre, The University of Sydney

Introduction

I am currently developing an Internet-based version of the Lidcombe Program (Internet LP) with the team at the Australian Stuttering Research Centre. The Internet LP will be interactive and will be designed so that it can suggest various problem-solving options to users.

In a previous Lidcombe News edition, I wrote about identifying the treatment issues that parents discuss with their therapist in the traditional, clinic-based, face-to-face delivery of the program. The 124 treatment issues that were identified fell into four themes: general Lidcombe Program issues, issues related to Lidcombe procedures and components, conditions of parents and/or children and reactions of parents and/or children. This information will

be used for the Internet LP, but could also be used in everyday speech pathology practice.

I will now overview Part 2 of this study, in which seven experienced therapists were asked to comment on the treatment issues identified in Part 1. The aim of this was to develop an empirical basis for the problem-solving options offered in the Internet LP. We felt an empirical study was needed because our current understanding of this area is not based on research. Hayhow (2009) reported that while some parents were able to experiment and find solutions for their treatment issues, many others needed support from a therapist to do so. Some potential solutions are described in Chapter 8 and 10 of the book, *The Lidcombe Program of Early Stuttering Intervention* (see Harrison et al., 2003; Hewat et al., 2003), but the information there is limited and is based on the clinical experience of therapists and not on research.

Method

Seven therapists with more than 15 years of experience working with the Lidcombe Program were interviewed to explore how they would solve the treatment issues identified in Part 1. The methodology of this part of the study is qualitative description, which is a research method in which content is analysed in a dynamic process, oriented toward summarising the information (Sandelowski, 2000). The treatment issues identified in Part 1 were managed in a template, which is the basis of template analysis, a procedure in qualitative research that concisely organises information into themes and subthemes (King, 2007). The interviews were transcribed for analysis.

Results

The interviews resulted in a breadth and depth of information, not all of which is related directly to problem solving. The scope of this article does not allow for all of it to be reported in detail; hence, it is summarised briefly here, under the headings, “Problem-Solving Strategies” and “Ideas for Treatment Conversations”.

Problem-solving Strategies

Part 2 revealed—not surprisingly—that therapists have individual preferences for how to address treatment issues. They reported applying the following strategies to various problem situations:

1) *Adding a second (but shorter) structured treatment conversation during the day.* This might be done, for example,

- if children like structured treatment conversations;
- if stuttering increases at a specific time every day;
- if children dislike verbal contingencies given randomly during the day in unstructured treatment conversations;
- if the stuttering does not further decrease.

2) *Introducing ‘10-minute listening zones’, which refers to 10 minutes of intensive listening to the child’s speech.* This might be done, for example,

- as a strategy for relapse prevention;
- to rate stuttering fluctuations more easily;
- if children stutter only occasionally;
- if the stuttering does not further decrease.

3) *Structuring treatment conversations more.* This might be done, for example,

- before going on holidays;
- if there is a lack of improvement;
- if children ignore verbal contingencies;
- if children are not sufficiently stutter-free during structured treatment conversations;

- if the stuttering does not further decrease.
- if the stuttering does not further decrease.

Some therapists use strategies that were not shared—sometimes not even supported—by the other therapists. One example is the suggestion made by one therapist that parents can use barrier games or games with a carrier phrase if children can be stutter-free with short answers but not with longer answers. Some therapists did not support this approach because they felt it does not mirror natural conversation and because short answers should be mixed with longer answers in the same conversation. Some other treatment issues that evoked conflicting responses were having treatment conversations in the car or just before the child goes to bed, replacing reading time.

A strategy that none of the therapists supported, which arose in response to a treatment issue reported by a parent, was setting goals for stutter-free speech with rewards attached to them, e.g. 'If you can stay stutter-free for the next two minutes, you will get a reward'. The therapists did not accept this strategy mainly because they believed it sets children up for potential failure.

While some treatment issues generated differing opinions in terms of problem solving, all therapists said that, in the end, the decision is based on the child and the family.

Ideas for Treatment Conversations

In the course of addressing problem solving, nearly all the therapists reported in detail the strategies that they typically recommend to parents to encourage stutter-free speech during structured treatment conversations and how and why they introduce certain activities. Examples included different types of questions, sentence completion and parallel talking. The level of detail and the amount of time spent by therapists on these topics demonstrate their importance within the program. The importance of this topic has been recognised in the updated Lidcombe Program Treatment Guide (see,

http://sydney.edu.au/health-sciences/asrc/health_professionals/asrc_download.shtml).

Two further interesting suggestions for treatment conversations that arose during the interviews were:

1. *Smooth Talking Kit; Smooth Talking Box; Smooth Talking Seat.*

Parents who need to wait while siblings have sport or other activities, could carry a 'Smooth Talking Kit' or 'Smooth Talking Box' in their car with items such as pictures, small objects or books. The front seat of the car, where the child sits for treatment time, could be transformed into the 'Smooth Talking Seat'.

2. *Smooth Talking shop, Smooth Talking Dollars.*

A 'Smooth Talking Shop' could be introduced as reward system. It could have a range of items, e.g. a trip to the park, a hug, a piggyback to bed, a movie on the weekend or 15 minutes of free time on the computer. The child could earn 'Smooth Talking Dollars' during everyday conversations and could spend it in the shop. The items could cost a different amount depending on how large rewards are. Enthusiastic parents could personalise the dollars by putting their child's picture on the notes.

Conclusion

Therapists problem-solve many treatment issues when delivering the Lidcombe Program in the clinic. Some problems are simple to solve, while others can be more challenging. Part 1 of this study identified many treatment issues and Part 2 gathered potential solutions to them, based on the expertise of seven therapists with more than 15 years of experience with the program. Where appropriate, the identified treatment issues and their potential solutions will be incorporated in the Internet LP. The results of the study also comprise

a rich problem-solving source that can be used by therapists in their everyday speech pathology practice.

References

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Dear Sue



I have been seeing a little girl called Stacey in my clinic for four sessions now. She is coming up to five years old, and has been stuttering since just before her fourth birthday. When this didn't resolve after six months or so her parents brought her to the clinic and we all agreed to start the Lidcombe Program. At the first session I modelled how to structure activities and give the contingencies, and her mother did really well when she took over. Since then however Stacey refuses to do the sessions with her mother in the clinic and insists that it is me who should be doing them with her. At home however she is happy to co-operate and it sounds from her mother's report that it is all going well there.

My question is this. Is it ok to continue like this, with me demonstrating in the clinic, and the mother doing the home activities without my having seen how she is doing? If not, can you think of any ways to help me persuade Stacey to work with her mum in the clinic?

Speech pathologists need to observe parents or carers delivering treatment to the child. You must watch how parents interact with the child, how they deliver the verbal contingencies and how they structure conversations. Telling and showing a parent how to deliver treatment does not mean that they will have the skills to interpret the information you give them. Even if a parent understands what they need to do they may need support and help when actually carrying out the treatment conversations. I cannot think of any occasion when it is acceptable not to observe the parent delivering treatment.

How you observe the parent delivering treatment may vary. It is usually easiest if the parent and child can demonstrate treatment to you directly in the clinic. It is possible that the reason Stacey does not want her mother to do treatment in the clinic is because she really enjoys relating to you. One on one focused attention from an adult not related to her is probably novel and fun for Stacey. Therefore if you explain that it is mum's turn to do smooth talking first and promise that it will be your turn

next you may be able to persuade her to cooperate. Alternatively, you could try for you and mum to do the structured treatment conversation "together". If that is accepted, you may find that over time you can have mum take on more of the lead role so that you can observe treatment in the clinic.

If that is not effective, perhaps you could leave the clinic room and have mum start the treatment conversation with Stacey. You could then re-enter the room and have them continue. Another option would be for all of you to simply move outside the clinic environment, such as walk to a nearby park and have a treatment conversation along the way. Stacey's mother might even be able to demonstrate a treatment conversation in the waiting room with the clinician discreetly watching.

Finally, another solution would be for the parent to video record a treatment conversation at home and bring it into the clinic for you to watch. For a child like Stacey who has simply decided that therapy is not a role her mother should take in the clinic environment, it should not be an issue to watch the video sample with her present. A similar option is the use of video conferencing such as Skype, allowing the clinician to observe treatment conversations in the home in real time.

These are just some possibilities and I am certain that there are others. It is an important issue to resolve. Guiding a parent through the Lidcombe Program requires specific understanding of how parents are delivering treatment to their child really only possible through observation and detailed discussion.

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 for this edition's 'Dear Sue' and for the 'Just Explain That Again...' on the following page.



Just explain that again...



 *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.

 *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.

References

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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?



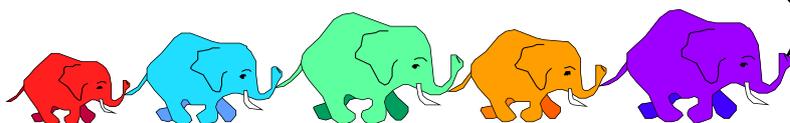
It is ideal for clinicians who treat children with the Lidcombe Program to attend a Lidcombe Program Trainers Consortium (LPTC) workshop. Recent research conducted in community clinics (ie outside the ideal world of research) reported that speech pathologists who had received LPTC training had clients 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.

Parents' Corner



Parents'
Corner

It is some time since we were able to give you a parent's perspective on the Lidcombe Program so it is with especial pleasure that we are printing this contribution from a parent who is currently working with her four year old son. He is now in the last phases of Stage 1 and heading happily towards Stage 2. His mother, S, tells us about 'O' and the treatment he has had to date, and in particular how the Lidcombe Program has changed her feelings from helplessness to empowerment. (In the Lidcombe News we have decided not to print the names of parents or children so they are just known by their first initial. His speech and language therapist, Stephanie Burgess, is happy for her name to be used).

Lidcombe - A Parent's View

Some background about O:

O was an early talker. He has always been very articulate with an excellent vocabulary and keen to participate in any conversation going! His language development has always been ahead of his age.

At around 2 years old he woke up one day with a stutter! It was a shock! But a family friend, who was also a speech therapist, told us this was very common; especially in articulate boys and would probably rectify itself - which it did. This happened a few times over the years.

When O started school (aged 4 years and 3 months) the stutter returned, but much more severely than before. O struggled some days to speak clearly at all and started to make noises and funny faces, to "give up" on what he was trying to say and was obviously angry and frustrated. We sought professional help!

Initially we tried to reduce the "demands" placed on O - we reduced our questions, gave him plenty of time to talk, reassured him it was ok to have "tricky words" (as we call them), stopped and really listened when he spoke, initiated daily one on one play sessions where O was in total control and praised him as much as we could. Although O's frustration levels

reduced and he continued to participate in conversations, both at school and home, his stuttering was still very up and down.

In April he was really struggling again so we had another visit to Steph... who suggested the Lidcombe Program.

Lidcombe:

Starting the Lidcombe Program has been a really positive experience for O and me. As a parent it meant that I was **actively** doing something that would help my child. As a parent of a child with a stutter I had previously felt helpless, now I was empowered!

Initially the tightly structured "smooth talking" sessions felt a bit unnatural and having to "perform" in front of Steph was daunting - although she was always positive and supportive. But after about a fortnight the sessions became part of mine and O's daily routine and I almost didn't have to think about what I was saying; it became much more natural.

The programme certainly requires dedication and commitment from the parent and I do wonder how parents in full-time employment manage. As a part-time teacher I have the advantage of days when I'm not at work as well as being used to sharing play activities and stories with young children. I am also, by nature, a "rule follower" so being asked to deliver the "smooth talking" sessions **exactly** as Steph explained them has not been a problem!

In the time since O has been on the programme the fluency of his speech has definitely improved. Even on his most dis-fluent days O manages **some** fluent speech and we have had some days where **all** his speech has been 100 per cent fluent. Part of the programme involves rating the fluency of O's speech each day and it has been wonderful to see the lines on the graph slowly heading down towards greater and greater fluency; long may it continue!

What O thinks about "smooth talking": (these are his words)

"It's helping me with trying to stop my tricky words".

"I like the comments that mummy says back to me".

