



Lidcombe News

January 2014

Edition 48

Lidcombe News prides itself on bringing you reports and information about the programme from around the world. This New Year's edition (and a Happy New Year to you all!) is no exception and we are delighted to have two articles describing how the programme is being implemented in new areas of the world. The first one is from Elaine Yandeau writing from Japan, the second from Valerie Lim, the Lidcombe Program Trainers Consortium member for Singapore.

In addition to this we have our usual Dear Sue, and Just Explain That Again... as well as news about 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).



Contents

Pages 1-2
Link days and courses

Pages 3-8
The Lidcombe Program in Japan by Elaine Yandeau

Page 9
Dear Sue

Pages 10-11
Just Explain That Again...

Pages 12-15
The Lidcombe Program in Singapore by Valerie Lim



DATES FOR YOUR DIARY

Norwich is holding a Link day on **Tuesday, March 18th 2014** 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**

The **Northwest** will be holding its next Link Day on **Thursday 15th May 2014** from **1:30pm – 4pm.**

Venue: Kirkham Health Centre, Moor Street, Kirkham, Preston, PR4 2AU

Contact: Preeya Patel, email: **preeya.patel@bfwhospitals.nhs.uk** or tel. **01253 657960**

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!

Central England will be holding its next Lidcombe Link day on **Wednesday, July 9th 2014** from **13.30 – 16.30**. Debbie Middleton writes: “As well as the ever-valuable case discussions and trouble-shooting, we will be spending some time discussing useful apps within intervention.”

Venue and contact details: Coventry. Please email: debbie.middleton@covwarkpt.nhs.uk for more information.

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.*

Rosemarie Hayhow and Mary Kingston are holding a workshop in the Hull area, at Goole, on February 24th and 25th 2014, hosted by Humber NHS Foundation Trust. Please note this change of venue. Originally taking place in Hull itself (but changed because of flooding) this is now being held at **The Courtyard, Boothferry Road, Goole, East Yorkshire, DN14 6AE.**

Contact: Ruth Edwards, Speech and Language Therapy Department, Victoria House, Park St, Hull, HU2 8TD

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.

The Lidcombe Program in Japan

by Elaine Yandeau



How I became involved with the Lidcombe Program

Being a new graduate of speech language therapy can be daunting; however, opening a private practice in a foreign country is just plain terrifying. Yet this is just exactly what I did when my family and I moved to Tokyo, Japan after completing a Masters of Arts in Communication Sciences and Disorders from the University of Maine. My husband and I lived here before attending graduate school for approximately ten years, so I was very familiar with the culture and country already. Both of my young sons were born here.

There is a small cluster of speech language pathologists (SLPs) in and around Tokyo that makes up our Association of Foreign Speech and Language Pathologists from countries such as New Zealand, South Africa, the United States and Canada. There are approximately 10 speech language therapists serving a large international community. This group is led by Marsha Rosenberg, M.A. CCC-SLP, a speech language therapist from the U.S., who has been in Japan for almost thirty years and was also my ASHA clinical fellowship mentor. There are also SLPs serving for the U.S. Department of Defence throughout Japan, though they remain a separate entity and serve the American children on the bases.

After a short time, my client list from the international community grew quickly and I learned through baptism by fire! These weren't the typical clients of Maine, but children from many cultures speaking at least two languages. My first client was a Filipino/Japanese boy who spoke four languages with severe cluttering!

My education in stuttering was limited to one graduate class in fluency and unfortunately I did not have experience with a person who stutters in graduate school clinic. I was comfortable assessing and diagnosing stuttering, knew some about traditional methods such as fluency shaping and stuttering modification, but little or next to nothing about the Lidcombe Program.

Upon referral of a 5 year-old bilingual boy, whose mother is Japanese and father is Australian, I sought the support of another speech language pathologist here from New Zealand who introduced me to the Lidcombe Program. She had learned about the program through her university (but not at a Lidcombe workshop) and offered to co-treat. After some time in treatment, the boy had made only marginal improvement so I decided to do more research and realized that the therapy was inconsistent with the Lidcombe Manual. I immediately contacted the Australian Stuttering Research Centre for further advice. The client was referred to Dr. Carey, a stuttering specialist in Australia, and member of the Lidcombe Program Trainers

Consortium. From then on Dr. Carey provided therapy via telehealth delivery to the boy in my office, whilst I observed and learned. My client reached Stage Two of the program within 12 weeks. Shortly thereafter I flew to Australia to attend a Lidcombe Workshop and since then have been implementing the program successfully with the mentorship of Dr. Carey.

Japanese attitudes to stuttering and the prevailing treatment in this country

According to Professor Yuki Hara, Associate Professor at Kitasato University, twenty years ago there was more shame regarding stuttering than there is now. In the age of the internet attitudes are changing, especially in the urban areas where there is more information and access to intervention. As more and more families are no longer living with grandparents, their influence is lessening and parents are tending to seek treatment. However, in less urban areas where people are more traditional, misinformation about stuttering, even from professionals, means attitudes of shame are still thriving.

Professor Hara noted that most parents usually first seek help from a teacher, or at a big hospital in a city, or a city ward office, or at a developmental check-up with the paediatrician, general practitioner or at a children's clinic. She also mentioned that oftentimes the doctor or teacher will advise waiting before starting treatment, saying that stuttering is not so serious. In order to get any treatment, parents have to push and strongly advocate for their child, but even if, by some chance, the person referring does have a connection with a speech therapist (ST), most STs do not have sufficient knowledge about stuttering to be effective.

If a child is in elementary school and is stuttering, they are often referred to a class with general support teachers. These teachers are called "kotoba-no-kyoushitsu" which means "speech class", and have a minimal knowledge of stuttering. Sometimes they observe stuttering sessions at a university but no formal training in speech therapy is required. Professor Hara sees this as a huge problem in Japan.

The head of an international school in Kyoto (the old capital of Japan and still very conservative) reported to me that a parent whose child stuttered was given the strategy to "just sing with their child" by a Japanese doctor. Another one of my young clients in Osaka, a city of over two million, received treatment from a speech therapist (referred to as STs in Japan) for approximately two years. His mother had no idea what type of intervention was given because she wasn't included in his therapy. The treatment failed and his stuttering worsened. Another parent of a child who stutters, and lives in the Numazu (with a population of over 200,000 and considered "the country"), reported seeking help from a Japanese speech therapist when her daughter was five years old. She had been stuttering since the age of three but was turned away as she was considered too young. A paediatrician advised the mother that a good strategy was to interrupt and complete her sentence for her when her daughter was stuttering.

My experience using the Lidcombe Program in the Japanese culture

Once I started to use the LP in Japan I came across several issues which affected the implementation of the program.

- Parents are not used to asking questions of professionals:

Traditionally education places an emphasis on rote learning where the teacher transfers the information to the student with little room for questioning or original thought. A teacher is highly respected and is given the name “sensei” which means the same as a doctor. Therefore, during my sessions, it is really important to check for understanding when the parent demonstrates the treatment as often few clarification questions are asked. I also always follow up with detailed notes to ensure a clear common understanding, something which is beneficial to clients of any culture.

- Understanding and appreciating the feelings of shame experienced by parents of stuttering children:

The value of being part of a group and being the same as others is instilled very early on in a child's life in Japanese culture. There is a well-known Japanese phrase: “The nail that sticks out gets hammered back down”. The Japanese mother of my first client who had stuttering disorder, came into my office and closed my blinds, saying that she was worried that others would see me with her and thus view her child differently. In the playground this mother would give me a wide berth when she saw me, as there was a sense of shame that her son needed special help, was different from the group, and might be treated negatively for it. Associate professor Yuki Hara, who specializes in stuttering at Kitasato University, believes that this type of attitude is changing. However, she added that grandparents, who are a strong influence within the family, often view stuttering as a form of shameful “handicap” and will discourage the family from seeking outside help.

- Giving praise:

Giving praise in public and private directly to very young children is common and you will often hear the enthusiastic “jo-zu” (Great!) in and around the sand box. However, as they reach elementary school, it is uncommon to hear a parent or family member praise a child in public. In fact it is considered very bad form to boast about yourself in any way in public. As any member of your family is considered an extension of you, it is not acceptable to say positive things about your son, daughter, mother, grandmother - you get the point- unless it is in the privacy of your own home. My older Japanese colleagues mentioned that when they were young, praise was rarely, if ever, given as that would be considered spoiling the child. Criticism was more the norm. However, this is slowly changing and praise is becoming more accepted as important and valued. This factor must be considered when administering the Lidcombe Program as praise isn't given as freely as in other cultures, certainly not in public, and once they are in elementary school. My Japanese colleagues noted that they are taught very early on to not express their feelings very openly,

so when they do so it is more subdued. Therefore, when administering the Lidcombe Program, I noted that mothers who are Japanese are happy to give the praise but overall it is less effusive than that given by their counterparts from western cultures, though just as effective.

- **Parental delivery of the program**
According to the Japan Daily Press, statistics from a 2010 Goldman Sachs reveal that 70% of Japanese woman leave their jobs after having a child, while only 34% who have children under 6 years old are still employed. This seems about right. I was employed as a kindergarten teacher at Katoh Gakkuen, a Japanese English Immersion school about ten years ago. The expectation was that when a Japanese teacher became pregnant, or indeed even when she married, she would leave her job. When I was pregnant and returned to this school after my maternity leave, it was such a surprise to most of the Japanese staff. An even bigger shock was that my husband decided to quit his job to be a full-time house-husband for a time. This is simply not done in Japan as it is still very much a patriarchal society. Also the divorce rate in Japan is still low (but on the rise). Usually therefore the parent who administers the program is the stay-at-home mother and I have had no problems so far with parent compliance with the program. Even if both parents work, I would anticipate that the mother would still be the sole provider of the program, which is the case with two of my clients now. The fathers rarely contribute to the therapy, though of course there is always the exception in every society.

Introducing the Lidcombe Program to Japanese Speech Therapists

There are about 70 training schools for speech therapists in Japan with over 1,500 undergraduates every year. Jun Katsuki-Nakamura, Ph.D. SLHT, the deputy director of International Liaison, Japanese Association of Speech-Language-Hearing Therapists (JAS) believes that there is an emphasis on aphasia, dysarthria, and dysphagia rather than stuttering as 70% - 80% of the STs work is in medical settings with very few employed at schools. Audiology is also a major component of their training. Upon graduation they are able to work as a ST and/or an audiologist after they have passed a stringent national examination, which has a 68% pass rate. There are about 15 Master's degree programs with only two or three students in each class. Even at this level there are not many opportunities to further their knowledge of stuttering. Jun Katsuki-Nakamura noted that there is only one stuttering specialist in every prefecture. There are 47 prefectures and Japan has a population of 127.6 million.

I was asked to come and share my experiences regarding the Lidcombe Program at a prefectural speech association meeting. This quarterly meeting focuses on stuttering and is attended by STs, professors, people who stutter and psychologists. Dr. Carey had previously introduced me to the organizers of this group via email. The participants were so keen with their questions that we were asked to leave the community hall because it was closing. I knew then that there was a strong interest in the program and that it was a

good time to organize a workshop. The Head of School at Yokohama International School (YIS) readily agreed to lend us the facilities, as YIS is committed to early intervention and education not only for international students and professionals, but to our host country as well.

Professor Yuki Hara, from Kitasato University, then contacted me and together we organized the first Lidcombe workshop for Japanese STs for January 11th, 12th and 13th 2014 to be run by Brenda Carey and me. Professor Hara advertised the workshop at the First Congress of Stuttering in September 2013 and the response was very positive. At that time two people, one SLP and one parent whose child had stuttered and received treatment from Dr. Brenda Carey, presented on the Lidcombe Program. The response was quite positive, so when we first opened the workshop to the STs in Japan, we were surprised with the low numbers of applicants. Professor Hara suggested that Japanese people may not be comfortable with applying abroad in English, even though there were translations provided. We then changed the system so that the STs could apply directly in Japan to a Japanese contact. Within a week the workshop was full. (**See editor's note below for how this was received*).

In addition to this, with the support of YIS, and in partnership with the Australian Stuttering Research Centre, we also ran a Lidcombe Workshop in December 2013 for speech language pathologists from the international community, Department of Defense in Japan. STs from other parts of Asia as well as English-speaking Japanese STs also attended the course. From the feedback we have received it was obvious that this was a great success!

What is happening now with stuttering:

Currently, there is positive news on the horizon. Professor Hara and her colleagues, a group of ten, are attempting to train more STs in stuttering and to disseminate correct information on stuttering to a broader audience by writing books on the subject, providing more workshop opportunities, and by translating books from English, such as "Stuttering: An integrated Approach to its Nature and Treatment" by Barry Guitar. Marsha Rosenberg, from the Association of Foreign Speech Language Pathologists, stresses that in order for the Lidcombe Program, or any other stuttering intervention program in Japan, to be successful it is vital that the professionals to whom the parents go first for support – the doctors and the teachers - understand that there is a need to refer the children on.

I am hopeful that the Lidcombe training workshops for speech therapists will have positive intervention implications for many children who stutter and that we will begin to see a ripple effect of change in how stuttering treatment is accessed and delivered in Japan.

Reference

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*Editor's note

This article was submitted before the workshop was held in mid-January 2014 but since then Elaine has contacted me to let me know how it was received by the Japanese therapists. She has received an email from a colleague, Yasuko Netsu, giving some examples of the feedback she was sent from participants about the course.

Yasuko Netsu writes:

"They wrote me the workshop was stimulating, highly suggestive and epoch-making.

One wrote that you and Brenda were 'Kurofune' ('The Black Ship' which was led by commodore Matthew C. Perry), which opened Japan and changed it drastically.

See <http://www.history.navy.mil/branches/teach/pearl/kanagawa/friends4.htm>

Yasuko Netsu adds:

"And I've got two email saying that they newly started Lidcombe Program to families from Tuesday, hurray! YOU CHANGED THE WORLD!!! I myself eager to start but I still need a little time to adjust my schedule.

I'm looking forward to start it.

It's easy to say thank you hundreds of times even though I don't feel it's enough. Still I'd say thank you because I can't find better way to show my feeling".



Dear Sue

I have recently assessed a little girl of four years old, called Leah, who I think will be an excellent candidate for the Lidcombe Program. Her parents are both very keen to attend all the appointments and to do the treatment at home. My question is one of organisation! How is it best to arrange the weekly sessions when both parents want to help? Should I teach them consecutively or both together? If both parents do the treatment in the sessions I am concerned this will be too much for Leah. Should I ask the parents to come on alternate sessions? There seem to be so many options! How do you suggest I should proceed?

It is great that both parents are interested in being involved in the therapy. My advice would be to meet the family first and see how they interact together. When they play together, what happens? If one parent is watching and the other playing, what happens? Some considerations would be that if the child is sensitive then I would advise you to be more cautious about having too many adults in the room working with Leah, whereas if she is happy to play and is more boisterous, then the extra parent might be helpful.

I would then discuss with the parents what is required for effective treatment and plan the approach with them. They know Leah best and so will know what she is able cope with. If both parents insist on being involved, it is better for them to come to the sessions together to ensure that information does not get lost and that there is no miscommunication. Certainly both parents can be involved in discussions about severity of the stutter at home, the amount of therapy, Leah's response to the therapy, etc. Therapy can change weekly so it is important to ensure that accurate information is being relayed both from the therapist to the parents regarding therapy and changes to therapy, and from the parent to the therapist about what therapy was being done, how it worked, severity ratings, etc.

I have had both parents attend and work together and I have also had both parents attend but only one of them does therapy in the clinic. This is based on who is most likely to do the treatment at home. Parents can learn by watching each other although they may have different styles; it will be important that, as the clinician, you train them both appropriately. As you mention there are many options to consider and the most important thing is whether the therapy is working and whether the child is enjoying it. As always, chart progress and if it seems that the child is not progressing, this may be one aspect of therapy that needs to be discussed and possibly changed.



Just explain that again...



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

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

When there are insufficient naturally occurring fluent utterances, it will be difficult to do unstructured treatment. In this case, it is possible to structure brief moments of speech throughout the day so that verbal contingencies can be applied to speech outside of the formal structured treatment conversations. For example, when the child is asking for a drink, the parent could give a binary choice to elicit a short response and then reinforce the response if it is stutter-free. The parent would be structuring that interaction but this could be an interim step until treatment can be delivered in natural unstructured conversations.

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

There are many occasions where I never use tangible rewards as I only recommend their use if I think they will be helpful. Tangible rewards may sometimes be used at the start of treatment to get the child and parent used to the idea of the verbal contingencies. Once the parent can

adequately provide verbal contingencies and the child is accustomed to receiving them, they are generally no longer necessary and should be faded out as soon as they are not needed.

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

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

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

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

Our grateful thanks for the answers to Dear Sue and "Just explain that again.." go to Stacey Sheedy, Mary Erian, Sally Nicoll, and Verity MacMillan from the Bankstown Stuttering Unit, Sydney, Australia.

The Lidcombe Program Experience in Singapore

by Valerie Lim



Valerie obtained her Bachelor of Speech Pathology and Master of Science (research) degree at La Trobe University in Melbourne, Australia. After working for a few years, she went on to pursue her PhD at the Australian Stuttering Research Centre in Sydney, Australia. Valerie's PhD research focused on the manifestation and treatment of stuttering in bilinguals. She currently works as a speech-

language therapist at the Singapore General Hospital. Valerie has extensive clinical experience in the area of stuttering, but continues to work in other areas of Speech Therapy including aphasia and swallowing. This article describes the challenges experienced with the Lidcombe Program in Singapore. Valerie's email address is valerie.lim.p.c@sgh.com.sg

Background

I started working as a Speech Language Therapist at the Singapore General Hospital (SGH) in 2001. About a year later, I set up the Fluency Specialist Clinic in our Department to cater to the slowly growing number of referrals for adults who stutter and also to allow our speech therapists to develop more specialised skills in stuttering management. As SGH is by and large an adult acute hospital, the main clientele at the time was mostly teenagers and adults who stutter. However, as time passed, our clinic started to receive more and more referrals for children who stutter. Following the Lidcombe Program Consortium Training we began implementing the Lidcombe Program (LP) for preschool aged children. We now have a team of 6 Speech Therapists who have specialist skills in stuttering management, all of whom have received LP Consortium Training.

In general the LP has been well received by the children and families that we work with, and we have successfully treated many preschool aged children who stutter. The challenges that we encounter with the LP in Singapore and the experiences of our local parents tend to mirror those reported by Hayhow (2009) and Goodhue et al. (2010). The common challenges include scheduling weekly clinic visits for Stage 1 of the LP, parents' difficulty finding time to attend weekly clinic sessions, and difficulty conducting and incorporating therapy into their daily lifestyle. We also have the unique challenge of working with a linguistically diverse and bilingual population. In this article, I discuss some of these challenges, how we have tried to overcome them, and what we hope to achieve with the LP in the near future.

Our Challenges with the LP in Singapore

1. Creating Weekly Clinic Visits

One of our initial challenges with the implementation of the LP was that our outpatient appointment schedule did not allow us to offer weekly Stage 1 visits. Being aware of the benchmark research data for the LP (Jones et al., 2000; Kingston et al., 2003), and following a team visit to the Bankstown Stuttering Unit in Sydney, our team decided to put forward the proposal to change our clinic appointment schedule to allow us to create weekly visits for children undergoing Stage 1 of the LP. Once our treatment schedule was full, all new referrals would be put on a waiting list until such time as a weekly appointment schedule became available. This occurred when the children successfully moved to Stage 2 of the LP. However not all clinicians who treat children who stutter in Singapore are able to provide the weekly Stage 1 visits within their respective institutions. It still is the case that many local clinics are only able to offer Stage 1 visits on a modular basis where children receive a set number of sessions (e.g. up to a maximum of 6 sessions) before being put back onto the waitlist.

2. Difficulty finding time for treatment and incorporating therapy in daily life

As with dual income families all over the world, many parents work long hours and report having limited time with their children. Singaporean children are usually either in full-time day care at a very young age, or are cared for by their grandparents and/or their live-in domestic helpers. Very often the domestic helpers are themselves from other Asian countries such as the Philippines, Indonesia, or Myanmar and do not speak English as their first language. Our first option is usually to try to counsel parents to set aside time to commit to stuttering treatment during the small but important window of opportunity for their child to be successfully remediated. Although not ideal, we occasionally have had to improvise by training the child's other carers (e.g. grandparent) to implement the LP, or to delay treatment until parents can afford the time. We discuss the daily schedules with parents to help them find ways to incorporate treatment into their busy lives, and support parents via reminder emails or telephone calls.

3. Providing Verbal Contingencies in Other Languages (e.g., Mandarin)

In order to ensure that the LP experience is as positive an experience as possible, it is encouraged that verbal contingencies are delivered without any negative connotations (e.g. 'that was bumpy' rather than 'that was not smooth'). However, this may be unavoidable when delivering verbal contingencies in other languages such as Mandarin, the 2nd most common language spoken in Singapore. In Mandarin, there is no exact translation for the word 'bumpy' and so, it is acceptable within the language culture to use the word '丕' (not) to precede a word to indicate the opposite meaning. For example,

不顺 - not smooth

不平 - not smooth

不流利 - not fluent

不顺畅 - not smooth flowing

Other ways in which we provide contingencies for stuttered speech in Mandarin are to use specific words to describe the stutter (e.g., 有点停住 'a bit of a stoppage', or 一点拉长 'a little elongated').

Although the use of the word '不' to express negation is acceptable within the language context, as with all verbal contingencies we try to ensure that parents deliver them with a gentle tone to minimise any negative impact it may have on the child. We are still in the midst of compiling and updating our list of the different verbal contingencies that can be provided in Mandarin (see Lidcombe News edition 44, page 18, for a sample).

4. Bilingual / Multilingual Population

Singapore is a multicultural society where bilingualism is very much the norm rather than the exception. The majority of the population is ethnic Chinese (74.2%), followed by the ethnic Malays (13.3%) and Indians (9.1%). The remaining 3.3% of the population constitutes people of other ethnicities (e.g. Eurasians) (Population Trends, 2013). As a result of this multiracial population, there are 4 official languages spoken in Singapore: English, Mandarin, Malay, and Tamil. All children, irrespective of their home language, are educated in English and, depending on their ethnicity, learn either Mandarin, Malay, or Tamil in school. This bilingual education usually starts when a child is about 3 years of age and continues till they are 18 years. Even though Singaporean children are essentially exposed to 2 languages from childhood, it is common for one language to be dominant. The home language remains important, but English tends to be the lingua franca and the main language for education and subsequent employment.

Although our clientele is bilingual, a large percentage of the children and their parents who come to see us for early childhood stuttering tend to be English-dominant, and so they are assessed and receive treatment in English. It is likely that our clinic attracts the English-dominant because: a) information obtained from the internet about stuttering, and where to receive treatment, is English-biased, b) the outreach programs that we conduct yearly to educate the public about early intervention for stuttering are mostly conducted in English (with only 1 forum conducted in Mandarin thus far), c) our therapists are also mainly English-dominant and thus have a preference for providing treatment in English. For those children whose home language is not English (those who speak Mandarin being the largest group), and who use two languages in their daily repertoire (e.g., English-Mandarin), we have provided bilingual stuttering treatment and have targeted the languages either simultaneously or consecutively, depending on what the family prefers. In my experience, and similar to what has been reported thus far, both options have yielded good treatment outcomes (see Van Borsel, 2011 for an overview).

Moving Forward

There are several challenges in working with early childhood stuttering in Singapore which we hope to address in the not too distant future:

- 1) we hope to reach out to more children and parents whose dominant language is not English, and to educate them about stuttering and the benefits of early intervention
- 2) we want to better understand why our referrals for early childhood stuttering are comparatively lower than in countries such as Australia and the UK. Is there a stigma for the disorder? Are we more accepting of the disorder? Or is it a case of poor public education? Are there any differences in the incidence and prevalence of stuttering in countries that speak Asian languages? Perhaps it is time for us to consider conducting an epidemiological study of the disorder in Singapore.
- 3) we lack local treatment outcome data, and we hope to embark on our own file audit so that we can compare our data with the benchmarks that are already available (Jones et al., 2000; Kingston et al., 2003; Koushik et al., 2011).

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