Lidcombe News

May 2014

Edition 49

In this penultimate edition of Lidcombe News (see page 3 for more information) and on our sixteenth birthday, we bring you two articles from opposite ends of the world. The first one is about a problem solving checklist for home treatment developed by Michelle Swift from Australia, and the other is by Suzanne Smith from Scotland, containing some reflections on Severity Rating training in our Lidcombe Program workshops.

We also bring you our regular features, Dear Sue and Just Explain That Again, as well as dates for Link days and advertisements for courses running in the United Kingdom.

(Workshops taking place in North America may be found on the Montreal Fluency website, and the Australian Stuttering Research Centre also has its own CPES section).

DATES FOR YOUR DIARY

Central England will be its 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.

Contents

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 Link Day on **Tuesday 16th September 2014** from **1:30pm – 4pm** (but room available for 1.00 if you want to bring lunch).

Venue: **1st floor Beckwith House, 1 Wellington Road North**, **Stockport SK4 1AF**. (Car parking at Heaton Lane car park (SK4 1BS) £1.50 up to 2 hours, £2.20 up to 3 hours and £3.40 up to 4 hours).
Contact: To confirm attendance or any questions contact **Catrina Dawson** on tel. 0161 4264200 or email: **catrinadawson@nhs.net**

Norwich is holding its Link day on **Tuesday, October 21st 2014** from **9-3.** As well as the usual case discussion and problem solving, the new LPTC trainer**, Corinne Moffatt,** will be giving **a** presentation on **'Using the Lidcombe Program with Bilingual Children and Families'**- not to be missed!

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**

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.*

Corinne Moffatt and Sally Wynne are holding a workshop in **London** on Tuesday and Wednesday, **October 14th and 15th 2014** at the Royal College of Speech and Language Therapists.

Contact **Sally Wynne** on email: **lidcombe@live.co.uk or Corinne Moffatt** on email: **corinne@cantalkltd.co.uk** for a flyer and booking form for this course, or for any other enquiries.

The new website dedicated to the Lidcombe Program

Jane Kelly, of the Australian Stammering Research Centre, who has been working tirelessly on the website detail has informed me that she had hoped to have launched the website by now but that there are still some details to be sorted out before this can happen. I mentioned in an earlier newsletter that we had also hoped to have a 'password protected post-workshop section' with for, example, videos of children stuttering for severity rating practice, but this is still under discussion as there are major consent issues to contend with. However, this apart, the website will certainly contain all the back copies of Lidcombe News, with a separate Dear Sue section for easy access. I will give you any up to date news on the website launch in the next edition of this newsletter.

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The future of workshops and the Lidcombe News.

I mentioned in Edition 47 of this newsletter that Rosemarie Hayhow and I, currently members of the Lidcombe Program Trainers Consortium in the UK, will be leaving this year. Corinne Moffatt has been elected to the Consortium and will continue to run the workshops with the many co-trainers who have been so reliable over the past 16 years. UK courses will be posted on the new website so you should have access to the latest courses in this way. Otherwise Corinne will be able to help you out. Her email is: **corinne@cantalkltd.co.uk**

As I am retiring from the profession I no longer feel able to continue producing the Lidcombe News. I have therefore decided to take the number of editions up to 50 (a good round number!) which means that the September 2014 Lidcombe News will be the last one I do. There have been some suggestions regarding its future which include moving the editorship around different centres of Lidcombe excellence but I understand this may be discussed at the next Consortium symposium in Orlando at the end of the year. Whatever the outcome the Lidcombe News will no longer be coming to you from me after September.

I have planned that my final newsletter will essentially be a 'sign post' edition where I will, amongst other things, reference the different topics we have covered over the years. As all the editions will be available on the new website you will hopefully be able to find everything you need from past editions without too much difficulty. In this way it can continue to be a useful resource, and any **new** ideas and issues, as well as the latest research, should be accessible from the website once it is up and running.

Use of the Lidcombe Program treatment checklist to review home treatment delivery

Michelle Swift

In the 47th edition of *The Lidcombe News* the "Dear Sue" question concerned a little girl named Stacey who was not allowing her mother to demonstrate treatment conversations with her in clinic. One of the suggestions was to have the mother bring in a video recording of the treatment conversations which she was conducting with Stacey at home. Another situation in which it is helpful to have parents bring in videos of their treatment conversations at home is when stuttering reduction is not progressing as expected, particularly if the treatment demonstrated by the parent within-clinic is good. It is possible that the structured nature of the clinic environment is masking treatment delivery issues which appear in the rough and tumble of everyday life.

So you have a family in front of you who appear to be delivering the Lidcombe Program treatment well but the child's stuttering is not reducing. You've asked them to bring in videos of their treatment conversations at home and they have brought in four recordings over the previous fortnight. What do you do with the videos now?

Of course you could just watch the videos and see if anything stands out to you as a potential issue. The issue with this however is that you run the risk of missing potential problems by focusing only on the most salient ones. For this reason we have developed a checklist to help clinicians to analyse video and audio recordings of Lidcombe Program treatment conversations conducted away from the clinic (Swift, O'Brian, Onslow, Packman & Ryjenko, 2012). This checklist is available for free download from http://sydney.edu.au/health-sciences/asrc/docs/lp_checklist.pdf along with detailed instructions about its use.

The checklist was developed from *The Lidcombe Program of early stuttering intervention: A clinician's guide* (Onslow, Packman & Harrison, 2003) and the

previous iteration of the Lidcombe Program Manual (Packman, Webber, Harrison & Onslow, 2008). Expectations of parent treatment delivery either explicitly or implicitly stated in these two publications were used as the basis for the checklist items. At the same time Olya Ryjenko and I were listening to over 350 audio recordings of beyond-clinic treatment conversations between parents and their children. We modified the checklist wording to make sure that all variations of treatment delivery which we noticed in the recordings could be captured by the checklist. The checklist then went through two rounds of reliability testing with 3 independent speech-language therapists each time. The final checklist had overall agreement in ratings of 84% making it a reliable clinical tool.

An important caveat is that the checklist is designed to be used in cases where treatment is not progressing as expected. It is not designed to be applied to every Lidcombe Program case to check that parents are delivering treatment "correctly" if there is no reason to believe that this is not the case. The Lidcombe Program is designed to be individualised to each family. Parents might not use all the components of treatment listed in the checklist and often this will not result in any negative consequences to treatment progression. Additionally at this point we still do not know exactly what components of the Lidcombe Program result in stuttering reduction in young children. So it is wise to hold true to the maxim "if it ain't broke, don't fix it". In cases where there are concerns about treatment progression though, the checklist can be a useful aid to your clinical reasoning.

To use the checklist you need to have at least three recordings from the family over a period of two weeks. This is necessary because in our research we found that occasionally parents conducted a treatment conversation which was quite different from their usual conversations but that overall clear treatment delivery patterns emerged. If you only use a recording from one treatment conversation you run the risk of potentially missing the actual problem and making inappropriate recommendations.

For each home treatment recording you mark each treatment component (checklist item) as occurring "almost never", "sometimes" or "most of the time". The next step is to combine the ratings from all the recordings to derive an overall rating of "almost never", "sometimes" or "most of the time" for each checklist item. This information can then be used to problem-solve treatment delivery with the parent.

The clinical implications of these designations are described in detail in the checklist documentation (http://sydney.edu.au/health-sciences/asrc/docs/lp_checklist.pdf). In summary, a treatment component which occurs "almost never" should be targeted for immediate remediation. A treatment component which occurs "sometimes" should be revisited as soon as practicable. A treatment component which occurs "most of the time" does not need targeting at this present time and the parent should be informed of their success in this area. Again it is important to remember that the

Lidcombe Program is individualised for each family and as such it might be perfectly appropriate for a certain treatment component to be used "almost never" for a given family. Use your clinical reasoning to make these decisions.

We have published an article in the *Journal of Clinical Practice in Speech-Language Pathology* (Swift, O'Brian, Onslow & Packman, 2012) outlining the development and use of the checklist. This article includes two real-life case study examples detailing how the checklist could be used to problem-solve treatment progression issues. It is available for free download from http://hdl.handle.net/2328/27057. Another case study example is detailed below.

Case information

Caroline and her 4 year old son, Jack, have been coming to see you for 6 weeks. At initial assessment Jack had been stuttering for 7 months and his mother reported that it had started to increase in severity. He presented with a moderate stutter, a severity rating of 4 and 5.7%SS, consisting of part-word and syllable repetitions. No secondary behaviours or avoidances were noted during the session nor reported by Caroline. You commenced the Lidcombe Program and Caroline is demonstrating it well in clinic. She responds appropriately to Jack's stutter-free speech and unambiguous stuttering. Jack appears engaged and enjoys the treatment conversations. The conversation is appropriately structured so that he is achieving a severity rating of 1-2 during treatment. Immediately post-treatment Jack has less stuttering than at the start of the session, indicating a treatment effect. However, there has been no change to Jack's stuttering severity on the daily home rating sheet or at the start of your clinic sessions.

Use of the checklist

Caroline has provided you with three video recordings of her home treatment conversations with Jack. Your summary using the Lidcombe Program checklist is:

	Almost never	Sometimes	Most of the time	Comments
1. PVCs provided immediately after response			X	
2. PVCs provided with a neutral, natural, non-punitive tone			X	
3. PVCs provided by the trained parent only		X		Comments from older sibling
4. PVCs applied to conversations rather than speech known to induce fluency, such as counting		X		Counting
5. PVCs clearly for stutter-free or stuttered speech and not another child behaviour			X	

#	Item				Comments
6.	PVCs accurate for child response (e.g. parent verbal contingencies for stutter-free speech not given for stuttering)		X		Occasional PVC for stutter-free speech given to stuttering
7.	Variety of PVC phrasing		X		Mostly "good talking"
8.	A range of PVC types used			X	
9.	Only Lidcombe Program guide parent verbal contingencies used		X		"Take a breath"
10.	More PVCs for stutter-free than stuttered speech			X	
11.	Child appears to enjoy PVCs for stutter-free speech			X	
12.	PVCs for stuttered speech are not received negatively by the child			X	
13.	PVCs non-invasive to the conversation		X		Jumping in mid-sentence and disrupting flow
14.	Treatment conversation is a positive experience for child			X	
15.	Primary focus of conversation is stuttering treatment, not correct pronunciation or the rules of the game		X		Focus on turn taking during board games
16.	Parent and child engaged and focussed on treatment, not distracted by others		X		Distracted by older siblings
17.	Therapy given during an everyday activity a child and parent would conduct together			X	
18.	Activity results in an interactive conversation		X		Board games have reduced interactive conversations
19.	Child stutters only occasionally			X	
20.	When the child responses range in length, PVCs are primarily given for longer rather than shorter stutter-free utterances		X		Mostly for 2-3 word utterances even when Jack can produce 4-5 words fluently
21.	Treatment duration 10-15 minutes (or as directed by clinician)	No – longer	No – shorter	**Yes - X**	

Recommendations

Eleven of the 21 treatment components on the checklist are occurring during home treatment "most of the time". It is recommended that you inform Caroline that she is using these components well and encourage her to keep doing so. None of the treatment components are being used "almost never" so there are no glaringly obvious areas which need immediate attention. The remaining 10 treatment components are being used "sometimes" indicating a lack of consistency in their application.

Analysis of the comments recorded as the checklist was completed indicates that there are four broad issues impacting on the 10 treatment components; 1) siblings, 2) level of structure, 3) activity conducted, 4) parent verbal contingency delivery.

Siblings – The presence of older siblings is creating distractions from the treatment and resulting in untrained people providing verbal contingencies to Jack. It would be worthwhile discussing with Caroline why she is including the older siblings as part of the treatment conversation. Brainstorming with Caroline other activities which the siblings could do at that time, other times to conduct the treatment with Jack, or limits to set for the older siblings when they are part of the treatment conversation will help to reduce their potential impact on Jack's stuttering outcomes.

Level of structure – Caroline is over-structuring the treatment conversation and providing verbal contingencies to automatic speech such as counting. Because Jack is demonstrating the ability to produce 4-5 word utterances without stuttering, ideally the treatment conversations will be structured to that level, not more or less. Over-structuring the conversations reduces the amount of practice Jack has producing longer utterances without stuttering, reducing the likelihood of generalisation of stutter-free speech into everyday conversations. It is important to discuss with Caroline the purpose of structuring conversations and the need to vary the amount of structure as Jack's ability to produce stutter-free speech changes over time.

Activity conducted – Caroline is playing board games with Jack. This is a highly structured activity which has limited opportunity for interactive conversation, promotes the use of counting (fluency-inducing automatic speech), and adds a distraction of the correct rules of the game. Because Jack is able to produce 4-5 word utterances without stuttering, the activity does not need to be so structured. It would be helpful to brainstorm with Caroline activities which she could play with Jack which promote interactive conversation but can still be structured to elicit 4-5 word utterances. Building, collecting and cooking activities are some which come to mind but they would of course be personalised to Jack's interests.

Parent verbal contingency delivery – Caroline is sometimes delivering parent verbal contingencies in a fashion which works against the operant conditioning principles underlying their use. She is occasionally praising, and therefore reinforcing,

stuttering. She is using a similar phrase frequently which may reduce the salience of the feedback. Her contingency delivery is impacting upon the naturalness of the conversation and she is occasionally giving prompts to change Jack's speech pattern. Caroline's ability to correctly identify stuttering and stutter-free speech needs to be revisited. Additionally she would benefit from help brainstorming different wording for the contingencies.

Summary

I hope that this example has given you a taste of how the checklist can be used and the sort of information it will give to you as a clinician working with parents using the Lidcombe Program. The checklist was designed as a useful tool to help with problem-solving difficult cases. I would love to hear how you find using it in your clinical practice.

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

Dear Sue

I have started seeing a boy aged 4 years, 4 months, for the Lidcombe Program but his attention and listening, and ability to follow an adult led task are extremely poor. Even on tasks of his own choice his attention flits after a couple of minutes. His parents and I have identified that they can keep his attention while sharing a short book together so for this week I have sent them off using this in their therapy times. I am however concerned for the progress of the therapy and wondered whether you have any experience of using the programme with children who have listening and attention difficulties. Should I continue with this little boy, or wait until his attention and listening improve before attempting the Lidcombe Program? Any advice would be gratefully received!

Some children are definitely more compliant than others and one of the challenges of the Lidcombe Program is ensuring that there is enough therapy that is effective in order to see progress, whilst still ensuring that it is fun. I would suggest looking at his overall severity ratings to help you determine whether he is progressing or not. If he is not progressing then it is important to problem-solve and try to find ways to get the therapy done. He is at the critical age where the Lidcombe Program is most effective. Making the decision to have a break from treatment needs to be taken seriously given that school age children may not respond to treatment as well as younger children. If there is a way to get the treatment happening then that would be my first suggestion. Some ideas that may be worth trying are:

- Try multiple (e.g. 2-3 times per day) short therapy times if one 10-15 minute time is not suitable. This may or may not help his overall progress because some children seem to need to practise fluency for a longer period of time in order to progress. Hence you would need to trial multiple shorter sessions to see if they work for this child.
- Consider using a simple, non-distracting tangible reward in the structured treatment conversation time. That might help to keep him on task.
- Have a couple of books ready to use in case you can extend the structured treatment conversation time.
- Try alternate activities such as turn taking games, lotto/bingo games, "hands on" activities (e.g. play dough). Are there any routine activities that may be suitable for the level of structured conversation this child needs? If so, they might be able to be used for structured treatment.

If there is no progress after trying various strategies, then it may be best to discontinue treatment for the time being.

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

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

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

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

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

For most children you need to try the contingencies before knowing which ones are suitable. You may consider how the child responds to feedback generally. You could ask the parent how their child responds when they

praise or correct them for various behaviours as this can give insight for how you proceed with verbal contingencies for stutter-free and stuttered speech.

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

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

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

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

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

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

Lidcombe News is delighted to welcome Suzanne Smith from Scotland to its pages and wishes her well in her bid to become a Consortium member.

Suzanne has worked as a specialist in fluency disorders in Lanarkshire, Scotland, for over 10 years. She undertook Lidcombe Program training in 2005 and is now working towards becoming a Lidcombe Program Trainers Consortium (LPTC) member for Scotland.

Stuttering severity ratings in the Lidcombe Program

As part of my preparation for joining the LPTC I am required to deliver training with an existing LPTC member, and one area I have found of particular interest is the wide discrepancy in the stuttering severity ratings assigned by participants to the video clips used in the training. I have written the following article in response to this and hope to discuss some issues and ideas regarding the measurement of stuttering when using the Lidcombe Program. I hope this may be helpful for Speech and Language Therapists (SLTs) who are perhaps fairly new to doing this and thought provoking for specialists and/or for those delivering training. We perhaps sometimes forget how it was to undertake tasks in the first instances prior to building up our experience. Furthermore, where we have completed fluency assessments and analyses based on a range of approaches these may influence how we approach our measurement of stuttering.

In watching and discussing the video clips in preparation for the training I found that some of the severity ratings I assigned to the clips varied slightly from those suggested by the LPTC. I realised then that my severity ratings tended to be based more on the quantity of stuttering evident without taking enough account of the impact or reactions to stuttering within my severity rating scores. I realised that my past experience of detailed fluency analyses for research purposes had influenced my judgements and I tended to consider the frequency of stuttering too much rather than making the judgement based on overall severity. The rating of the severity of stuttering by a listener produces a subjective measurement, influenced by the definition or examples of stuttering given and the listener's perceptions of the stuttering. Nevertheless, Bloodstein (1995) highlights that this measure has the highest face validity out of all measures used.

During Lidcombe Program training, participants have the opportunity to assign severity ratings from observing short video clips of children who stutter. These severity ratings are then discussed and compared with the ratings suggested by the LPTC. The severity ratings given by participants can vary widely, both under- and overestimating stuttering, compared with the LPTC agreed ratings. Unfortunately, lack of time during the presentation makes it difficult to explore this at any length. Perhaps the video clips are unclear for some participants and perhaps the pressure of making first attempts of assigning ratings in a training situation affects confidence and judgements. Nevertheless, I am concerned by this wide discrepancy with its

potential consequences for assessment, diagnosis and treatment. At its extremes, where an SLT assigns lower severity ratings than would be accepted, children who may benefit from the Lidcombe Program may not be offered intervention or the Program may be discontinued when stuttering is still apparent. Conversely, where higher severity ratings are given than would be accepted, the Program may be used when it is not needed or the treatment goals may be unachievable. Importantly, the clinician's judgement is used as the yardstick for the severity ratings (Packman et al., 2014).

As stated in the 'Lidcombe Program of Early Stuttering intervention: A clinician's Guide' (Onslow et al., 2003), "in the clinical setting, severity rating measures are important for:

- Establishing the extent of the problem
- Informing clinical decision making
- Specifying treatment goals
- Quantifying treatment outcomes
- Facilitating communication about stuttering" (Lincoln & Packman, 2003, p66).

Lincoln and Packman (2003) state that measuring stuttering severity involves giving ratings on a scale to indicate overall severity rather than just a percentage measure. They report that severity ratings are "easy to use, requiring little training" and they are "intuitive, in that most people are familiar with the idea of giving something a score out of, say, 10" (Lincoln & Packman, 2003, p60). Moreover, the simplicity of severity ratings makes them "a quick and effective way for clinicians and parents to communicate about children's stuttering severity" (Packman et al., 2014, p2). The 10-point rating scale used in the Lidcombe Program has the descriptors: 1 = no stuttering, 2 = very mild stuttering and 10 = extremely severe stuttering. Severity ratings are given considering both the frequency and type of stuttering and are assigned "in relation to the population of stuttering pre-schoolers who present to clinicians" (Packman et al 2014, p3) such that a severity rating of 10 would be the most severe stuttering imaginable for any child. In my discussions with parents using the severity ratings, I add that a 2 or a 3 are at a level where only the parent or SLT may notice stuttering and that a 4 is perhaps at a level where other people may begin to notice it. I recall these descriptors from my Lidcombe training and have always found them beneficial in discussions with parents/carers.

Perhaps during Lidcombe Program training, where wide discrepancies in the severity ratings are apparent, more opportunity for reviewing the video clips and discussing these would be beneficial. This would ensure greater validity and reliability of the severity ratings assigned by participants and for increasing their confidence in using these in clinic. I wonder too, whether, with the launching of the new dedicated Lidcombe website later this year, there may be an opportunity to view video clips of children stuttering with a severity rating already assigned so we may all ensure we

stay within the agreed range. I understand there is currently some difficulty with this because of consent issues but hopefully this may be overcome in the future as I feel it is an extremely important training issue. Alternatively for example, the increased availability of samples from the World Wide Web (such as on YouTube) may enable discussions and progress in this area.

Where SLTs feel they may benefit from increased experience in identifying stuttering, with this being paramount for assigning severity ratings, the procedures of measuring 'percentage of syllables stuttered' and/or 'measuring stutters per minute of speaking time' would be valuable. Lincoln and Packman (2003) describe the advantages of measuring 'Stutters per Minute of Speaking Time' for increasing parents' accuracy of identifying stuttering, this being important for parents reliably to assign severity ratings and validly deliver verbal contingencies for stuttering and stutter-free speech. Rather than just being useful to parents, SLTs who are new to using the Lidcombe Program and who feel they need to increase their own competence for identifying stuttering, may wish to undertake such practice.

From discussion with some of the course participants a few months after their training, they reported some initial confusion and limited confidence in using severity ratings. Importantly however, with increased experience using these in clinical settings, they report that they are now confident in assigning these and find them easy to use. Nevertheless, the opportunity for participants to have increased skills in assigning severity ratings whilst attending training would enhance their confidence at the outset of delivering the Lidcombe Program. Severity ratings are an essential component of the Lidcombe Program and necessary for informing intervention and measuring outcomes. Some discrepancies may be evident between the severity ratings assigned by SLTs but as the shared language and agreement we achieve in our work with individual children and their families expands, the value of severity ratings as a clinical measure is clear.

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