



Lidcombe News



May 2009



Edition 34

We have a huge edition of Lidcombe News for you this May! Our look at research into the Lidcombe Program from countries other than Australia continues with a Canadian article from Sarita Koushik and Rosalee Shenker who evaluate the success of working with school aged children there. We will be concluding this theme in the September 2009 edition when we will be publishing the second part of Rosemarie Hayhow's promised article where she shares some of her reading and thoughts around parental verbal contingencies. We also have some preliminary ideas about running the Lidcombe Program in groups from Simone Lees at La Trobe University in Australia where she is undertaking her PhD with the Australian Stuttering Research Centre. Then as ever there are the regular features, Dear Sue and Just Explain That Again, and for the first time for a long while we have a Parents' Perspective. There is also news about how to join an online chatroom for the Lidcombe Program.

But first we start with news of Link days (we have a new one in the Midlands!) and courses in the United Kingdom, as well as the latest workshops being offered in other European countries.



DATES FOR YOUR DIARY

Norwich is holding its next Link day on **Tuesday, 9th June 2009, 9.30- 3.30** at **40, Upton Road**. Bring/buy your own lunch. Contact **Sally Lelievre** for details, directions etc. on tel. **01603 508946**, or email Mary Kingston on: **kingstonamee@talk21.com**

There is new Link day starting in the Midlands, set up by Debbie Middleton. This will run on **Monday 20th July 2009, from 1.30 – 4.00 pm**, at **Coventry and Warwickshire Hospital, Stoney Stanton Road, CV1 4FH**. For further details contact Debbie on tel **024 7684 4187** or email: **Debbie.Middleton@coventrypct.nhs.uk**



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

The Link Day for the **Northwest** is on **Tuesday, October 13th** **1.00pm** for a **1.30** start. It is being held at **Ingol Health Centre, Village Green Lane, Preston PR2 7DS**. Please contact **Sally Wiseman** on **01772 777432** or email: **sally.wiseman@centrallancashire.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) who have graduated. It is not designed for students, TIs or members of other professions e.g. psychologists, doctors, teachers etc.

The Bournemouth and Poole PCT is hosting a workshop at 'The Children's Centre, Damers Road, **Dorchester, in Dorset**, on Thursday and Friday, **July 23rd & 24th 2009**. It will be presented by Rosemarie Hayhow and Mary Kingston. This is a department run course but there will be a few places for sale. For further details contact Eunice Gibson on email: **Eunice.Gibson@dsha.nhs.uk**

Cyprus is holding a workshop in June 2009. This will take place in **Larnaca** on Friday, Saturday and Sunday **June 19th -21st**. The presenters are Rosemarie Hayhow and Mary Kingston and the course will be delivered in English. For more information and application details contact **Niki Mylona** on email: **nikimylona@yahoo.com**

Greece is holding a workshop in **Athens** in the autumn. The course will run from Friday to Sunday, **September 18th - 20th 2009** in English, presented by Rosemarie Hayhow and Mary Kingston. For further details about costs, venue etc contact Panagiotis Kokmotos on email: **pankok78@yahoo.gr**

Denmark is holding its next workshop at **Sønderjylland University** on **September 22nd-24th 2009**. It will be **delivered in Danish** by Helle Brandt (the new Consortium member for Denmark) and Lone Cordes Felby. For further details contact Helle on email: **helle.brandt@hedensted.dk**

Finland is holding a Lidcombe Program workshop in **Helsinki** also in the autumn. The course will run from Wednesday to Friday, **October 7th-9th 2009** and will be delivered in English by Mary Kingston and Rosemarie Hayhow. The contact person for details of costs, venue etc is Mia Ylismaa on email: **mia.ylismaa@puheterapeuttiliitto.fi**

Norwich is holding a workshop on Monday and Tuesday, **October 19th & 20th 2009**, presented by **Mary Kingston and Sally Wynne**. For further details and a flyer contact **Sally Wynne** on **lidcombe@live.co.uk** or **Mary Kingston** on **kingstnamee@talk21.com**

Sweden is holding a workshop in **Stockholm** on Wednesday, Thursday and Friday, **November 4th – 6th 2009**. The course will be presented in English by Mary Kingston, Marita Åvall and Lovisa Femrell. For further details contact

Lovisa on email: lovisa.femrell@ds.se or Marita on email: marita.avall@vgregion.se

Margate is holding a workshop on Tuesday and Wednesday, **November 24th & 25th 2009**. It will be presented by Mary Kingston and Sam David. For further details about costs and venue, contact Sam David on samdavid76@btinternet.com

West Hertfordshire PCT is running a course in **Watford (London)** on Wednesday and Thursday **February 10th & 11th 2010**. Thus will be presented by Mary Kingston and Corinne Moffatt. For further details about venue, costs etc. contact **Lyn Humphreys** on email: Lyn.Humphrey@herts-pcts.nhs.uk

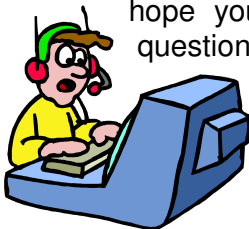
There is a workshop being held in **Northern Ireland** in **Belfast**. This is organised by the **Beeches Management Centre** and will be held on Wednesday and Thursday, **March 10th & 11th 2010**. The presenters are **Rosemarie Hayhow** and **Mary Kingston**. Applications should be made online using the following link: <http://www.beeches.hscni.net/courses.asp> Put **Lidcombe** into the search box, then click on "**Lidcombe Programme of Early Stuttering Intervention**" and then 'apply online' (manual applications will also be taken). You may also contact Fiona Hodkinson on email: fhodkinson@clady.bmc.n-i.nhs.uk with any queries.

THE LIDCOMBE CHATROOM

Kristy Findlay from the Montreal Fluency Centre has sent us this opportunity chatroom. She writes with the following information:

"Judy Kuster, who is responsible for the wonderful Stuttering Homepage Website, has set up a Lidcombe Group Chat. This is available to anyone who has attended a Lidcombe workshop. I

hope you will join this group and begin to participate by asking questions, presenting cases, giving feedback. Looking forward to seeing you 'on-line'!





This is how to join:

1. Go to <http://groups.yahoo.com/group/lidcombe/>
2. Click on Join this Group
3. If you don't have a Yahoo ID you will have to sign up (see bottom of the Yahoo box for how to do this)
4. Once you have your Yahoo ID you can request to join the group. Mention at this point that you were referred by Rosalee Shenker.
5. Once you are approved you will get an email from the moderator which looks like this:

"Hello,
Welcome to the lidcombe group at Yahoo! Groups, a free, easy-to-use email group service. Please take a moment to review this message. To learn more about the lidcombe group, please visit <http://groups.yahoo.com/group/lidcombe>

To start sending messages to members of this group, simply send email to lidcombe@yahoogleroups.com

If you do not wish to belong to lidcombe, you may unsubscribe by sending an email to lidcombe-unsubscribe@yahoogleroups.com

To see and modify all of your groups, go to <http://groups.yahoo.com/mygroups>

Regards,

Moderator, lidcombe

Your use of Yahoo! Groups is subject to <http://docs.yahoo.com/info/terms/>

Our thanks to the Montreal Fluency Centre for allowing us to publish this synopsis of their work into using the Lidcombe Program with a school aged population.

Follow-up of school-age children after Lidcombe Program treatment

*Sarita Koushik and Rosalee C. Shenker

Clinicians frequently ask if the Lidcombe Program could be extended to be used in the manualized format with a school age population. This paper was the result of many such queries.

It appears that stuttering is most tractable during the preschool years and that responsiveness to treatment decreases with age. It is commonly felt that stuttering becomes less responsive to treatment after the preschool years, and may become intractable some time during early adolescence (see Bothe 2004; Bothe, Davidow et al. 2006; Ingham 1984; Ingham and Cordes 1999; Onslow 1996; Onslow and Packman 1997; Onslow and Packman 1999; Prins & Ingham 1983). The Lidcombe Program was developed for a preschool population and has subsequently had limited use with school-age children. In the Lidcombe Program verbal response contingent stimulation is non-programmed and does not involve control of stuttering using a speech pattern that may be inconsistent with stuttering; i.e., slow rate control. Although the Lidcombe Program has not been used traditionally to treat older children, it is potentially suitable for this age group. Lincoln, Onslow, Lewis & Wilson (1996) reported outcomes of 11 children, aged 7-11 who were treated with the Lidcombe Program. All responded to the treatment but the outcomes for Stage 2 were not as stable as the preschool outcomes. The present study contributes to the development of that treatment by presenting outcomes for another group of school-age children who were treated with the Lidcombe Program.

Method

This study took place at the Montreal Fluency Centre, a specialist clinic in Montreal, Canada. A retrospective method was used with a group of children who had been treated with the Lidcombe Program and for whom routine clinic recordings were available. Twelve children were initially enrolled in the study though one child who had required speech restructuring in addition to the Lidcombe Program during Stage 1 of treatment was excluded from the study. Eleven stuttering school-age children (6 years 8 months - 10 years 8 months) all treated only with the Lidcombe Program comprised the follow up group. For a post treatment follow up, the children were telephoned and audio tape recorded three times, approximately every second day, at random times during the day by a person unknown to them. The main outcome measure was percent syllables stuttered (%SS) from independent, blinded observations of audio-taped recordings. The secondary outcome measure was number of sessions to reach Stage 2 of the program. The mean period post Stage 1 that the 11 children were followed up was 70 weeks with a range of 9 - 187 weeks.

Results

For the 11 school-age children who received the Lidcombe Program, the blinded observer's mean %SS scores pre-treatment was 9.2 (SD = 7.8) and 1.9 (SD = 1.3) at post treatment follow-up. These results were obtained in a median of eight clinic visits (Range [*R*] 6 - 10 visits). In addition to positive clinical results, correlation analysis of follow-up periods and outcomes showed no tendency for relapse with increasing post-treatment periods (mean = 70 weeks). The 11 children received treatment by a clinician in a different country than that in which the Lidcombe Program was originally developed. Therefore, this report independently substantiates the Lincoln et al. (1996) findings of the benefits of the Lidcombe Program with this age group.

For the child who was excluded from the study, the treating clinician judged that progress was not satisfactory with the Lidcombe Program alone and supplemented it with traditional speech restructuring targets. This decision was made because the treatment was not suitable for the child's parent. The parent found it difficult to give the verbal contingences and tended to give only contingencies for unambiguous stuttering. This child did reach Stage 2 in seven clinic visits. The blinded observer's %SS score pre-treatment was 8.3 and 2.5 at follow-up.

Conclusions

The present results of a verbal response contingent treatment program for stuttering school-age children are encouraging. Although the study is preliminary, the Lidcombe Program appeared to be an efficacious treatment for this group of children. Further, the families reported that they enjoyed participating in this program and valued taking part in the therapy process. The effect of parent participation both in and beyond clinic cannot be minimized in this study since this model is one that is often not used with older children. The results of this simple therapy approach for this age group provides a clear opportunity to add to the literature on this subject. Further, it justifies the conduct of clinical trials to establish treatment effects of the Lidcombe Program for school-age children.

References

Lincoln, M., Onslow, M., Lewis, C., Wilson, L. (1996). A Clinical Trial of an Operant Treatment for School-Age Children Who Stutter. *American Journal of Speech-Language Pathology*, 5, 73-85.

Onslow, M., & Packman, A. (Eds.) (1999). *The handbook of early stuttering intervention*. San Diego, CA: Singular Publishing Group.

Ingham, R. J., & A. K. Cordes (1999). On watching a discipline shoot itself in the foot: Some Observations on current trends in stuttering treatment research. In N.B. Ratner, & C. E. Healey, (Eds.), *Stuttering research and practice: Bridging the gap* (pp. 211-230). Mahwah, NJ: Lawrence Erlbaum Associates.

**This report has been submitted for publication as Koushik, S., Shenker, R.C. & Onslow, M., Follow up of School- age children after Lidcombe Program treatment.*



Dear Sue,

I am working with a little boy called Vikram aged 4 years 3 months and he is doing very well. When we began 4 months ago he was getting SRs of between 8s and 9s, and a %SS that often went into the 30s. His mother has been excellent, tailoring the therapy to his severity, and we are now down to an average SR of 3s. On our way down to this level he has been very variable, though the trend has always been downwards. The question I have about Vikram's therapy is to do with the proportion of contingencies his mother should be giving in what is now the unstructured phase of the therapy. She is giving them throughout the day in a fairly consistent fashion, with occasional times when they are given more intensely which she calls a session. She probably gives a contingency about every other utterance during these sessions. When we discussed whether this might be too many contingencies (though he was not in any way reacting against them) she tried doing them less frequently. The following week she reported that the SRs went up slightly, and then, when she reintroduced the higher proportion of contingencies, the SRs came down to their former level. While this would seem to be evidence that Vikram needs this higher intensity of contingencies (mainly acknowledgement, some praise for smooth talking; occasional request for self-correction) his mother and I are concerned that he is getting 'hooked' on contingencies, that he will become dependent on her giving them and that he will not maintain fluency without her being present. There is some evidence for this as when he is with his father he reports that the SRs are higher, and this had been noticed by his mother when she rejoins them. Once she starts the contingencies again, down comes the SR.

My question therefore is a) can too many contingencies be given (even if Vikram is responding well to them) and b) could he become dependent and not become 'self sufficient' with his fluency? How would you suggest we proceed?

Vikram has certainly made excellent progress so far. It would seem that his response to therapy to-date has been achieved with a consistent approach, with you and his mother manipulating the amount of verbal contingencies that have been needed given his severity. You have observed the impact of any changes that you have made to the frequency of the verbal contingencies and have then altered therapy accordingly. It is also important to note that Vikram still has some situations where his severity ratings would seem to be higher than a 3 e.g. in some conversations with his father. Vikram has shown that his decrease in

stuttering is not stable and he is not yet ready for the amount of treatment (verbal contingencies) to be reduced. This is not surprising as he has not yet achieved Stage 2 criteria.

In reference to your questions a) & b), contingencies need to be delivered in a way (type & frequency) that results in Vikram continuing to make appropriate progress. However it would be expected that the frequency of contingencies necessary would lessen as he achieves lengthier periods of stutter-free speech and that contingencies are finally faded out during Stage 2. It does sound like the frequency of contingencies during the "sessions" may be a bit high. It may be that when the Mum recently attempted to reduce these she did it too dramatically across the week thus reducing his overall "dose" of treatment by too much, too quickly.

With regards to proceeding, Vikram's mother is concerned about his talking when she is not around. It would be good to clarify the severity in conversations with the father and any other situations a higher severity is noted. This would indicate whether some structured treatment times may still be needed. His therapy may just need a bit of adjustment to ensure he continues to generalise his improvement. Some suggestions follow.

- Vikram's mother could focus on looking for opportunities to give him occasional contingencies when he is talking to someone else, ensuring contingencies happen appropriately in a wide variety of conversations.
- Contingencies could be given by the mother in a "session" where the father is also present.
- If she walks past him while he is explaining something to his father without stuttering, she could give him a verbal contingency at that time. Or she could ask him for self evaluation of stutter-free speech once the conversation is finished.

As Vikram continues to improve a gradual reduction of the frequency and/or time of "sessions" can happen initially, followed by reduction of the intermittent verbal contingencies. The overall "dose" of treatment would need to be considered. Once entering Stage 2 (i.e. severity ratings average <2 and <1%SS in the clinic over 3 visits), it would be expected that contingencies would need to be gradually and carefully withdrawn across Stage 2.

Just explain that again...



? *It states in the updated manual (2008) that the criteria for moving to Stage II are as follows:*

- a) %SS less than 1.0*
- b) SR scores for the previous week of 1 or 2, with at least four of these being 1.*

These criteria need to be achieved for three consecutive clinic visits.

However in the previous manual it did not state "These criteria need to be achieved for three consecutive clinic visits" My question therefore is this: was the number of sessions stated as an average to reach stage II based on three consecutive weeks of the specified criteria or just one? If so, should the 11 sessions to Stage II which are often quoted, be changed to 13? Similarly, should the figure of 90% attaining Stage II by 22 sessions be changed to 24?



The median time of 11 clinic visits should be adjusted as you suggest above, to account for three consecutive weeks at criteria before entering Stage 2. Rousseau, Packman, Onslow et al. (2007) provide some further research that clinician's may like to consider. This prospective study (n=29) was conducted in a generalist clinic and achieved a median treatment time of 16 clinic visits to reach Stage 2. The authors suggest that in light of this study's results and the expectation of 3 consecutive weeks at criteria to enter Stage 2, that the median treatment time to complete Stage 1 be reconsidered. They suggest that a clinician trained in the Lidcombe Program could expect that below 1%SS within the clinic and parent severity ratings of 1-2 would be attained in a median of 11-13 clinic visits, with Stage 1 normally concluding after another 3-5 visits". The authors also suggest that this "benchmark" would need to be confirmed by further prospective research.

Reference: Rousseau, I., Packman, A., Onslow, M., Harrison, E., & Jones, M. (2007). An investigation of language and phonological development and the responsiveness of preschool age children to the Lidcombe Program. *Journal of Communication Disorders*, 40, 382-397.

? *I have heard that there is an alternative model for the delivery of the Lidcombe Program called Telehealth, and that it is designed for families who are not in easy reach of regular clinical help. Could you:*

a) give me some references for the this model so I may read the research



Harrison, E., Wilson, L., & Onslow, M. (1999). Distance intervention for early stuttering with the Lidcombe Programme. *Advances in Speech Language Pathology, 1, 31-36.*

Lewis, C., Packman, A., Onslow, M., Simpson, J. A., & Jones, M. (2008). A Phase II trial of telehealth delivery of the Lidcombe Program of Early Stuttering Intervention. *American Journal of Speech Language Pathology, 17, 139-149.*

Wilson, L., Onslow, M., & Lincoln, M. (2004). Telehealth adaptation of the Lidcombe Program of Early Stuttering Intervention: Preliminary data. *American Journal of Speech-Language Pathology, 13, 81-93.*

? *b) let me know whether it takes longer to reach Stage II using this model and why this might be*
c) if so, how many sessions does it take (based on 3 consecutive weeks of the specified criteria for moving to the maintenance stage).



In answer to both b) & c), Lewis, et al. (2008), used a telehealth model that involved regular telephone conversations, video demonstrations of Speech Pathologists conducting Lidcombe Program therapy, email and telephone correspondence as needed. They also used audio-recorded samples of conversations with the child and parent doing therapy at home. According to these authors, it takes around 3 times more resources than standard presentation for completion of Stage 1, with a mean of 49 telephone consultations over a mean of 62.9 weeks. The mean total time commitment by the Speech Pathologist was 77.3 minutes per consultation.

The authors state that the reasons for the additional time needed for treatment is related to the Speech Pathologist not having face-to-face contact with the child and that time is expended while recordings are mailed to the Speech Pathologist.

Research about the use of more improved telehealth technology, that delivers more immediate contact between the client/parent and Speech Pathologist would be of interest.

Our grateful thanks for both 'Dear Sue' and 'Just Explain That Again', as ever, go the Bankstown Stuttering Unit in Sydney, namely, Stacey Sheedy, Margaret Webber, Verity MacMillan and Kylie Farnsworth.

Simone Lees is a PhD student and speech pathologist from Australia. The following article outlines research into whether the Lidcombe Program is viable in a group format. She isn't able as yet to give us the complete answer but has promised to share her final results when they are ready. So, as she says herself: "Watch this space!" We are very grateful to Simone for her contribution to the Lidcombe News and very much look forward to hearing from her again. She has given us her email address in case you wish to contact her and discuss this further- see end of article.

"To group or not to group" – That is the question.....

Simone Lees, PhD student, Australian Stuttering Research Centre, University of Sydney, Speech Pathologist, La Trobe University, Australia.

The Lidcombe Program is a 1:1 treatment model. We know it works in this format as it has been researched using this model and studies have replicated this model in various countries around the world. However, we are often asked if it is OK to deliver the Program in groups. Clinicians tell us that it "makes sense" to run the Lidcombe Program in groups; caseloads are large, clients are desperate, and after all, while we individualise the program to suit the needs of each client and family, essentially much of the program is routine and could therefore easily be presented in a group setting. We also know that clinicians do conduct group Lidcombe sessions.

So, is it OK? Our premise has always been that we must deliver treatment that is best practice. That is, treatment that we know works, that has benchmarks we can compare our treatment times to, and that has no negative outcomes for the children or the families we work with. We believe it is inappropriate to offer treatment which does not have known outcomes. So, that is where my PhD project started.

In early 2007, I commenced a Randomised Controlled Trial (RCT) of the Lidcombe Program – delivered in a group model. This type of trial is considered to be the 'gold standard' in research trials and offers the highest level of evidence regarding the efficacy of a new treatment. This type of trial requires strict eligibility criteria, a complex assessment phase, formal randomisation procedures and stringent treatment protocols. Randomisation means children are allocated randomly to either the 'treatment arm' (group treatment) or the 'control arm' (regular 1:1 treatment). I have no control over this process, and therefore cannot choose who would be best for either arm. This excludes clinician bias in a trial of this type. Interestingly, the children I thought would be best for the group and individual sessions have not always turned out so!

Currently, I have recruited more than 50 children between the ages of 3 to 6 years to this project. Half have been randomised to group sessions and half to traditional 1:1 treatment. The children and their parents have attended sessions at La Trobe Communication Clinic, which is a speech pathology clinic based at La Trobe University in Melbourne, Australia. I have been the

only treating clinician for all of these children. Some of the children have now completed the program including all of their Stage 2 visits, some are currently in Stage 2, while others are still attending weekly visits in either a group of 3-4 children or individually.

Data are being rigorously collected each week, video and audio recordings are being made at set data points, and questionnaires are being completed at other time points. Each session is also recorded. We are gathering percentage of stuttered syllables before and after treatment and at other set intervals, parent reported severity ratings, satisfaction measures, time to reach Stage 2 in hours, sessions and weeks, and a range of qualitative measures from the parents. All of this will enable my findings to be analysed by others too, which increases the validity of the findings.

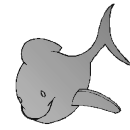
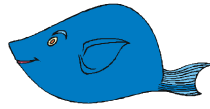
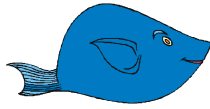
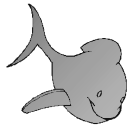
These outcome measures are an integral part of an RCT. It is not enough for the children to just 'become smooth' in a group setting. We need to know if the children are able to maintain their fluency or if they are more prone to relapse than children attending individual sessions. We need to know if the parents find group treatment acceptable. What do they like and dislike about the group format? What would they change if they could? What are the benefits, if any, of group treatment? And importantly, we need to know if the group format actually saves any time, and if so, is the time saving worth the extra effort required by the clinician.

For me, this 'extra effort' has included the time taken to schedule mutually agreeable group session times, learning new skills required to engage more reserved parents during group sharing time, responding appropriately to parent difficulties in a group forum and dealing with the disruption and noise that goes along with having several children in a shared space. Engaging all three children considering differences in gender, interests and personalities and selecting activities in order to meet the needs of each child has also been challenging. The group model clearly requires additional clinical skills, as it's not as simple as just 'doing individual Lidcombe' with a bunch of children and parents. Overall though, I am enjoying dealing with the challenges and feel very privileged to be trialling a new service delivery model, with the support of such experienced researchers from the ASRC.

So, no doubt you want to know if the group treatment model 'works'? Can you run groups or not? Well, group treatment looks viable so far. But is it more effective or at least similar in outcome to individual treatment? And how does it compare for efficiency? This complex research process has taught me to trust the data, not just my clinical judgement, and all of the results are not yet in. So, the short answer to "To group or not to group?" is "not yet!"

But again, watch this space and we look forward to sharing the results in the very near future. It may well change the way we 'do Lidcombe' or, at the very least, give us evidence that we shouldn't!

S.Lees@latrobe.edu.au



Lidcombe News is delighted to include this 'Parents' Perspective' from Becky Willis who tells us about her experience following the Lidcombe Program. Her son Theo is now well into Stage II and continues to do very well according to his therapist, Polly Mitchell, from Oxford, who sent us this article.

Our Experience of the Lidcombe Programme by Becky Willis

We have 4½-year-old twins, Cara and Theo, and a 2-year-old, Luca. Not surprisingly we're a noisy, busy family and I often worry about whether the children feel listened to and valued.

Around the time Luca was born, we were seeing quite a bit of our wonderful health visitor, Trisha. She visited us at home several times, and gave as much time to Cara and Theo as she did to the baby, helping them to weigh their dolls on the baby scales. When Luca was about two months old, I rang Trisha because Theo was suddenly stammering. It had been going on for about a week, and I was a bit thrown because he was the most talkative and confident of the twins, with really quite advanced vocabulary. Trisha asked if it seemed to be bothering him, and I said no. She said it would probably stop as suddenly as it had started, but if it didn't stop within another week or if it recurred later, she would consider getting us some help. As if by magic, the stammering stopped a few days later.

A few months later, when Theo was about three, there was another episode of stammering. Again he didn't seem at all phased by it, but Trisha referred us to a speech therapist just to make sure we had the right tools to deal with it, should it continue. The speech therapist gave us some helpful advice and worksheets, and saw us three times over the next six to nine months. Between us, we found it difficult to decide whether the stammer was serious enough to do anything further. He stammered a little bit most of the time, but it didn't seem to bother him at all, and it seemed to me that lots of children of that age stammered a bit. I thought he'd just grow out of it, and I didn't want to get into a treatment programme unless it was really

onerous, and I was now confident that it was worth the commitment. I hadn't realised until then that there was so much to do at home, but my partner and I talked about it, and we felt we could manage it now.

In about July, Theo and I started to visit Polly once a week at the Apple House. The first time she measured the frequency of his stammering, it was 7%. It wasn't as bad as it had been during the worst episodes, but I could see that he was struggling a bit when she got him to describe the fire engine he'd seen at the school fete. She showed me how to break sentences down by playing turn-taking games, and how to comment on each short sentence, praising him every time he spoke smoothly. On the way home (on the back of my bike) he chatted about this and that, then said, "Mummy, can you tell me when I do bumpy talking?" I was surprised that he had taken on board what Polly was explaining to me.



Our visits to Polly became a highlight of our week. It was sometimes hard to arrange, with Jasper taking time off work to look after the other children, but Theo loved the attention from Polly and from me, and I enjoyed the time with him. He made a big improvement between the first and second visits; so much so that I felt a bit embarrassed to be taking up Polly's time. But she reassured me that she was happy to spend the time with us, and she was sure Theo could benefit. I plotted my impression of the severity of Theo's stammering every day, and during weeks 3, 4 and 5 I was a bit frustrated that things didn't seem to be improving much, if at all. There would be a little bit of stammering during talk time, and a bit scattered through the day, especially when Theo was tired - some days better, some worse.

We managed to put aside time for talk-time almost every day. Somehow it was much easier to do it knowing that it was part of an official 'programme' and we had to record the result - we just got on and did it. Sometimes for Cara too, since she felt left out and wanted some of this special one to one time. Some days it was hard work, and often it had to be fitted in after the other children were in bed - not ideal, as both Theo and I would be terribly tired. But gradually the stammering during talk time reduced, and Polly introduced ways of lengthening sentences and descriptions. Over a few weeks, we started to have lengthy conversations as well as games, and there were usually only one or two 'bumps' during each talk time, if any. Theo loved

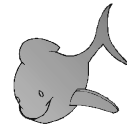


all

the praise he got for his smooth talking, but there were always quite a few bumps during the rest of the day.

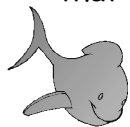
Then, in September, after about nine weeks, Polly went on holiday and we didn't see her for three weeks, but continued the programme at home. The first time we saw her after her holiday, I said "I think he's better." The chart I had been plotting, showing the severity of stammering each day, read '1' for the previous six days, and Theo had talked excitedly on the way to the appointment about how impressed Polly would be with him.

That was it. Neither I nor my partner has noticed a single 'bump' for the last six weeks or so. We've got all the information about how to react if bumpy talking should start again, but it doesn't seem very likely. Theo delights in telling anyone who will listen how he learnt to talk smoothly:



"When I used to say 'B-b-b-b-b-b" or "but-but-but-but-but", that was bumpy talking, but now I do smooth talking".

I'm glad we started the programme when we did. Starting school is a big thing, with so many challenges at the best of times. I'm just so grateful that we had help with sorting out Theo's speech. Being teased about a stammer, or struggling to express himself, simply aren't challenges that he has to deal with any more. In fact I'd say that he is more confident about his speech than most children - he's had such a lot of praise and attention for his "lovely, smooth talking".



We meant to keep up with talk time. We haven't. It's just too difficult to fit it in when there's no immediate, impelling reason to, and we're all exhausted, and the packed lunches still have to be made. (*Ed note: Theo is on Stage II and doing very well*).

Maybe we should sign up for a 'give your kids some quality time' programme next!

