

# Lidcombe News

September 2009

Edition 35

As the leaves start to fall here in the United Kingdom we turn to the, for us, autumn edition of the Lidcombe News. We have some more research to look at, a new programme called Westmead to complement the Lidcombe Program, from Natasha Trajkovski, and Rosemarie Hayhow has sent us an article on praise and its use in the Lidcombe Program. In addition we have the usual news about workshops around the world and Link Days in the UK. Dear Sue and Just Explain That Again, our ever popular regular features, have a new 'Sue', Margaret Webber, having retired last July. We wish her a very happy retirement and welcome our new agony aunt, Stacey Sheedey and her team at Bankstown, with grateful thanks.

We start with news of Link days and courses in the United Kingdom, as well as the latest workshops being offered in other European countries.

## DATES FOR YOUR DIARY



The Link Day for the **Northwest** is on **Tuesday, October 13<sup>th</sup>** **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](mailto:sally.wiseman@centrallancashire.nhs.uk).

**Central England** is holding its next Link day on **Monday 7<sup>th</sup> December 1.30 – 4 pm** at **Coventry + Warwickshire Hospital, Stoney Stanton Road, Coventry CV1 4FH**. The day will focus on outcome measures, EKOS, and care pathways. Please also bring a case to discuss. Contact Debbie Middleton on tel **024 7684 4187** or email: [Debbie.Middleton@coventrypct.nhs.uk](mailto:Debbie.Middleton@coventrypct.nhs.uk) for further details if required.

**Norwich** is holding its next Link day on **Tuesday, 26<sup>th</sup> January, 9- 3** 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: [kingstnamee@talk21.com](mailto:kingstnamee@talk21.com)

Contributions to Mary Kingston. Send your ideas and questions to:  
Email: [kingstnamee@talk21.com](mailto:kingstnamee@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!



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## 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.*

I have removed the courses advertised in the last edition which I know to be full.

**Norwich** is holding a workshop on Monday and Tuesday, **October 19<sup>th</sup> & 20<sup>th</sup> 2009**, presented by **Mary Kingston and Sally Wynne**. For further details and a flyer contact **Sally Wynne** on [lidcombe@live.co.uk](mailto:lidcombe@live.co.uk) or **Mary Kingston** on [kingstonamee@talk21.com](mailto:kingstonamee@talk21.com)

**Margate** is holding a workshop on Tuesday and Wednesday, **November 24<sup>th</sup> & 25<sup>th</sup> 2009**. It will be presented by Mary Kingston and Sam David. For further details about costs and venue, contact Sam David on [sam david76@btinternet.com](mailto:sam david76@btinternet.com)

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 10<sup>th</sup> & 11<sup>th</sup> 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](mailto:fhodkinson@clady.bmc.n-i.nhs.uk) with any queries.

**Rosemarie Hayhow and Claire McNeil** are planning a course for therapists from the South West of England though there may be a few places open to people from other areas. This will run in **Bristol**, hopefully in **December 2009**. Contact Rosemarie Hayhow for further details on email: [rosemariehayhow@btinternet.com](mailto:rosemariehayhow@btinternet.com)

### **Further courses are being planned for 2010**

The annual London course should be running in March 2010: details of date and venue are currently being sorted out. Contact **Sally Wynne** on [lidcombe@live.co.uk](mailto:lidcombe@live.co.uk) if you are interested and she will send you the flyer when details are finalised.

Greece will also be holding two further courses- in Thessaloniki and Athens- at the end of April. Further details in the next edition.

*We are delighted to receive the following article from Dr. Rosemarie Hayhow from the Speech & Language Therapy Research Unit at Frenchay Hospital, Bristol, UK, which follows on from her original one in Edition 33, January 2009.*

In January I outlined the different journeys with the Lidcombe Program (LP) that parents described during the interviews I had with them. As my studies progressed I sought out cases where treatment was not straightforward as I was keen to hear about a range of experiences. Parental verbal contingencies (PVCs) were clearly important in the parents' views but differing responses from the children were described. This made me read further about praise in a quest for insight into these differences that parents reported. My starting point was an article by Nan Bernstein Ratner (2005) which led me to Sansone, C. & Harakiewicz, J. (2000) and so the trail went on. In this article I will refer to some of the work on praise that has attempted to account for the differences in reported responses to it. I will then list points that seem particularly relevant to the LP. I first presented these ideas at the IFA conference in Dublin (Hayhow 2007) and have drawn on that presentation in writing this article.

Ryan & Deci (2000) proposed their Cognitive Evaluation Theory (CET) as a way of explaining the conflicting evidence on the effects of rewards that were apparent in their review of the literature. They propose that the meanings attributed to the rewards will influence the effects on motivation. The model predicts that events which have a negative effect on a person's experience of autonomy or competence will diminish intrinsic motivation, whereas events that support perceived autonomy or competence will enhance intrinsic motivation. Autonomy or control can be communicated by the medium so that verbal rewards are more likely to be informational whereas tangible rewards are more likely to be controlling. Predictability also has an influence so that expected tangible rewards, given while people complete a task, may undermine motivation, whereas unexpected ones will not. Sensitivity to autonomy and control may not be so relevant with children of less than four years but may become increasingly important as children get older.

In this model the interpersonal context will also influence the experience of autonomy, competence & relatedness. Control is an issue when the individual feels pressured to think, feel or behave in a particular way. Conversely, a relatively non-controlling style will lead to the rewards being experienced as more informational. The way the individual experiences the particular behaviour may also have an influence. Some studies suggest that with older children verbal rewards will only have a positive effect if it is important to the individual to perform well at the specified goal.

Much of the work reviewed within the framework of CET involved older children and college students. However, Ryan and Deci (2000) summarise with regard to children; tangible rewards may control children's behaviour in the short term but may have long-term negative effects on children's interest, persistence and preference for challenge. Consideration of the cognitive evaluation theory in relation to therapy makes us think about the meanings of rewards and praise for all involved and provides a possible framework for

exploring cases where PVCs do not work as well as expected.

A different aspect of personal meanings is explored by Molden and Dweck (2000). They suggest that systems of meaning will influence how we view aptitudes, qualities, behaviours etc. For example, if we consider *intelligence*, they suggest that those of us who are *incremental theorists* will view intelligence as something malleable, an attribute that changes over time. Conversely *entity theorists* will view intelligence as fixed. Our orientation will influence the relative strength of learning vs. performance in the goals we set. **Performance goals** predict vulnerability to a 'helpless' response to failure. Failure to reach the goal indicates low ability etc and leads to a decrease in subsequent performance. On the other hand, **learning goals** predict a 'mastery' response to failure. For example, the evaluation of effort or of strategies used leads to steady or increased performance. Entity theorists, whether children, parents or therapists, have a great deal at stake since failure to reach a performance goal threatens their sense of self-worth. They may avoid failure or get caught between a desire to prove their worth and approach a goal on the one hand, and protect themselves from failure and avoid a goal on the other.

Kohn (1999) reviewed similar research and reached similar conclusions but writes for a general audience. He puts the issue of control more simply by stating that working *with* people is more successful than *doing* things to people. In a book for parents, Kohn (2005) argues the case for co-operation and reasoning and takes a strong position against rewards, which he views as usually having the intent to control. Donahue et al (2004) maintain that praise-giving and praise-interpreting are complex speech acts and so praise can be given and interpreted in a variety of ways. They advise using Grice's (1975) conversational maxims of:

- quantity:- not too much-children may tune out or become 'praise junkies';
- quality:- informative and specific;
- relation:- reliable not based on false evidence; and
- manner:- genuine

They also advise against praise for fixed abilities as praise for effort is more likely to lead to persistence and continued motivation.

Another area to consider in relation to children's self-evaluations is the context in which stuttering occurs. Speaking is a social phenomenon and this has the potential to increase the stress children feel when stuttering occurs. Older pre-school children may know that most children talk smoothly and so being praised for smooth talking may not always be encouraging but rather could remind them that they are 'failing' to do this in the way their peers do. If children think talking is easy then they may experience shame when they stutter, not necessarily resulting from parental responses but due to their own evaluations. Children may also have stronger stress responses and longer recovery times when they lose control of their speaking in situations where there is a social-evaluative element (Dickerson & Kemeny, 2004). Lewis &

Ramsay (2002) report that children as young as four have been found to experience two different types of embarrassment, one resulting from negative self-evaluation and the other from a sense of exposure, when they are the object of attention of others. Children may feel both these types of embarrassment when others notice or comment on their stuttering. It seems inevitable that feelings of embarrassment and shame would make it harder for a child to self-correct their stuttered speech

The parents who described a straightforward journey with the LP did not report any significant problems with contingencies. This is an interesting chicken and egg situation- did therapy progress smoothly because the parents intuitively, and with therapist guidance, used contingencies in the best possible way. Or was it because the children's stuttering was relatively simple, progress was rapid and everything was completed before issues around contingencies had a chance to surface. My feeling is that a combination of these two options happens in straightforward cases. If a sense of autonomy is important for our stuttering children then the more successful they are at self-correction the more likely they are to feel in control. More severe, more persistent and more variable stuttering can in itself affect children's perceptions of autonomy around speaking.

Some ideas from the research to consider when PVCs are problematic:

- Praise was seen as an important aspect of the treatment and helped children respond constructively to parental feedback. The praise and talk-times seemed to work together to provide a 'special' context for home treatment. When, however, talk-times are not viewed positively by children the parents' use of contingencies and their children's responses should be investigated more closely.
- Sensitivity to praise may occur when children perceive the controlling aspects of this parental response. A shift of emphasis from praise to information may help children feel more autonomous. This in turn may help children take more responsibility for their communication behaviour.
- Parents who find praise difficult may be helped by thinking that acknowledgement provides the child with information. This information will help them speak more smoothly and self-correct their stammering.
- It is possible that encouraging an incremental view towards speaking skills helps SLTs, parents and children to take pleasure from small steps and to manage setbacks more productively. However, it may be hard to be an incremental theorist with an on /off problem like stuttering or when progress is erratic and the child has unexplained episodes of stuttering and not stuttering.
- The focus on behaviour rather than upon the children as a whole helps reduce the negative feelings associated with stuttering and may help children separate speaking behaviour from self. Speaking and progress become therefore less tied up with feelings of self-worth. When self-worth is undermined, self-correction is likely to be harder to achieve.

When I related the literature on praise to the way we teach SLTs to use contingencies I was heartened to find that the empirically derived guidelines fitted well with the literature. What the literature offers that the LPTC training does not is some possible explanations for the range in responses to PVCs that we see in children and some indicators for how we might address problems when they arise. This more detailed exploration of contingencies is not relevant when treatment proceeds well- if it's working don't fix it- but can be helpful when problems arise.

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*Dear Sue,*

*I am working with a little boy called Amos aged 4years 6months. When we began, 5 months ago, his stutter was extremely severe with SRs of 8s and 9s, and an average of 25-30%SS with blocks, prolongations and repetitions of long duration. His mother has been very dedicated to the treatment and over the time we have worked together his severity ratings have come right down to mainly 2s, and WC %SS of 0.5-1.5. While we are delighted with his progress and Amos is a very much happier little boy, the problem is that although most of the time he is a good 2, every day two or three times a day, his SRs go up, sometimes to as much as 5 for perhaps 5 minutes at a time. His mother has been scoring his SRs as a 2 with another point each day to show the change in severity. The reasons for the change vary, sometimes it is when he is describing an event that has happened, sometimes it is when he is excited about something such as a relative coming for a visit, sometimes it is hard to know what triggered it. This instability has lasted several weeks now and I am not sure what we should be doing about it, whether there is anything apart from his mother increasing the contingencies at these times, and prompting him for fluency when she thinks there may be a problem time coming. Is it a question of persevering and giving Amos time, or is there anything else his mother and I should be trying?*

Five months of therapy for this child so far is reasonable considering the severity of Amos' stutter at the beginning of treatment. However, it is certainly worthwhile problem-solving about how to get further progress since it seems that Amos' severity has plateaued over the past few weeks.

It would be useful to have a look at Amos' pattern of response to treatment to determine whether he has shown this same pattern during the course of treatment. By that I mean that if throughout treatment his severity ratings have decreased by one score for several weeks at a time, then you might expect him to take a few weeks to step down further. If on the other hand, his severity has changed more quickly in general, then it seems that some additional strategies might be needed to elicit further change.

Some of the things to consider and discuss with his mother would be:

- How much therapy is already occurring? i.e. how much structured/unstructured therapy? How structured is therapy in set times? If Amos is not stuttering very much in structured treatment times, and stuttering tends to occur when he is describing or excited, bringing in elements of this into therapy time might be useful. It is important to do this in a careful manner to set Amos up to succeed.
- How often is his mother providing verbal contingencies across the day and how are they given - is it intermittent, in patches etc? The amount of therapy given is something that you can vary and then monitor the impact of.
- Prompting for stutter-free speech as you mentioned may be beneficial but it is important that these prompts are effective in decreasing the severity of the stutter. If they are not, then Amos' stutter may still be too severe for this strategy. Another idea is to take advantage of the periods of lower severity that naturally occur and to reinforce Amos' speech during these periods of the day.

Our grateful thanks go to Stacey Sheedy and her team at the Bankstown Clinic in Sydney, Australia, consisting of Verity MacMillan, Wendy Lloyd and Mary Erian.

## Just explain that again...



? *What is the generally accepted number of syllables to count when taking a WC sample of a child's speech for the % SS? Is this based on research or experience?*



According to the Lidcombe Program manual (April 2008) the "measure of %SS is based on a conversational sample that typically is a minimum of 300 syllables or 10 minutes duration." However, according to Sawyer & Yairi (2006), it is important to weigh the time factor associated with sample length, against the information to be gained. There may be cases where it is a waste of clinical time to gather a lengthy sample. On the other hand they reported that longer samples may be warranted for some children, particularly those who present with mild or borderline stuttering in order to gather valid information.

To summarise, it is important to consider the purpose of the measure being taken. According to Lincoln & Packman (2003), the role of the %SS measure is to establish the extent of stuttering, to influence decision-making, to determine a response to therapy, to be used to decide on the timing of commencement of treatment, and to determine when Stage 2 entry criteria have been met. There are occasions where the clinician might decide that a longer sample is warranted if they do not think that they have a valid measure. On the other hand, if it takes too long to gather a 300 syllable sample e.g. for a quiet child, the clinician might choose to rely more on severity ratings or recordings from home.

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? *I was taught that it is important in the weekly LP session that the parent demonstrates what they have been doing at home, then we demonstrate any changes that need to be made, and then the parent has a go implementing these*

*changes. Do we always need to follow this routine, even when the parent has become competent at all the procedures and further changes are not needed? How should we proceed if this is the case?*



It makes clinical commonsense to observe the parent doing treatment so that you can watch their therapy without influencing it by modelling in the clinic first. In that way you have the best chance to see therapy as it has been done at home since the last visit and to see the impact that it has on the child. However, as you mentioned, there may be occasions when you decide that this information is less relevant, such as when you are confident that the parent is competent in doing the treatment (usually towards the end of Stage 1). At that point in time, it may be more useful to spend the time in the session discussing ongoing management and problem solving how to elicit further progress. Even for diligent parents I suggest that it is useful to continue this process of watching the parent do therapy from time to time, as you may assume that the parent is doing therapy appropriately when they are not.



*If a child has a very variable SR throughout the day I have learned that one way round this is to give a situational score- for a different situation each day- and follow a weekly pattern for these situations. Is this the only way to show variability each day, or are there other ways this can be done? As we need all day scores to help determine when the child is ready for Stage II, at what point should we start asking the parent to use these?*



The severity ratings need to reflect what is happening with the child's severity in order to determine recommendations for treatment and to monitor treatment progress. Therefore this should be considered in order to decide what information is needed when collecting severity ratings.

One way that I measure variability if parents report that severity is too varied to give one score is to ask parents to give best/worst or average/worst scores each day. As time and treatment progresses, there should be less variability of severity ratings across the day/week. Therefore, severity ratings will be more stable and situational scores will become redundant and eventually 1 daily severity rating will be sufficient.

There are other measurement methods (eg stutter counts, SMST). These could be used to supplement the information gained via severity ratings if more information is needed.

Our grateful thanks go to Stacey Sheedy and her team at the Bankstown Clinic in Sydney, Australia, consisting of Verity MacMillan, Wendy Lloyd and Mary Erian.

*Our thanks for the following article go to Natasha Trajkovski, a Speech Pathologist working at the Australian Stuttering Research Centre. It comes from her PhD thesis which she has just completed under the supervision of Mark Onslow, Ann Packman, Cheryl Andrews, Sue O'Brian and Ross Menzies. Her email address for correspondence is [n.trajkovski@usyd.edu.au](mailto:n.trajkovski@usyd.edu.au)*

### **We have a problem...**

The epidemiology of stuttering is not known with any certainty. The assumption is that around 5% of preschool children start to stutter and around 80% of them will recover naturally by adulthood (e.g. Bloodstein, 1995; Craig, Hancock, Tran, Craig & Peters, 2002; Mansson, 2000; Yairi & Ambrose, 2005). Due to poor methodological standards, however, this information is likely to be incorrect. All epidemiological studies to date have been cross sectional rather than prospective, do not have an expert diagnosis of stuttering, begin after the onset of stuttering, are clinic samples or self-selected samples from advertisements, or are some combination of the foregoing. Consequently, the outcomes of these studies have not aided in the planning of appropriate healthcare services for preschool children who stutter.

Recently, however, the first prospective, community-ascertained cohort study was conducted in Australia (Reilly, Onslow, Packman, Wake, Bavin, Prior, Eadie, Cini, Bolzonello & Ukoumunne, 2008). In that study, parents of young children were given a refrigerator magnet with instructions to telephone the clinic if they thought their child had begun to stutter. Once children were verified as stuttering by two expert clinicians, video recordings were taken of the children in conversation with their parents at home every month for one year. The study found that from a cohort of 1,619 children, 8.5% started to stutter by 36 months. The cohort is now being followed up to determine the cumulative incidence at 48 months, and recovery rates are also being estimated for a subsequent paper. Without revealing too much, it can be said that both figures are looking alarmingly higher than the original estimates.

If this information is correct, stuttering is a more serious public healthcare problem than originally thought. According to the U.S Census Bureau, the world population of children aged 0-4 is 627,680,317. Applying the Reilly et al., (2008) results to this figure, it is estimated that by 3 years of age around 53,352,827 children worldwide will have started to stutter, and there is no way that an appreciable number will recover before the window of opportunity closes for successful treatment. In short, millions of children worldwide who will require treatment for stuttering in the preschool years before the disorder becomes intractable.

In contrast, specialist speech pathology services are in disturbingly short supply around the world. Within Australia, for example, there are

presently only around 3,600 paediatric speech pathologists (SPs) registered with the professional organisation, Speech Pathology Australia (SPA). Of these, only around 1,000 have nominated themselves as stuttering specialists on the SPA website. With an average generalist treatment time of at least 18 hours for the standard Lidcombe Program treatment (Rousseau, Packman, Onslow, Harrison & Jones, 2007), and more than double that for the telehealth version (Lewis, Packman, Onslow, Simpson & Jones, 2008), it is clear that the profession does not have the resources to manage the disorder of early stuttering, as the situation currently stands. So, is that it? Do we give up? Not just yet.

The present lack of treatment accessibility and efficiency may be resolved, in part, by the development of an innovative, alternative early stuttering treatment. That treatment is called the Westmead Program. The Westmead Program involves training children to practice a speech pattern known as syllable-timed speech (STS) with their parents frequently, each day. STS is achieved by saying each syllable in time to a rhythmic beat with minimal differentiation in stress contrasts across syllables (Packman, Code & Onslow, 2007). The STS pattern has been known for centuries as being the most powerful agent for the control of stuttering in a laboratory context (Bloodstein, 1987; Ingham, 1984; Van Riper, 1973; Wingate, 1976); more powerful than verbal response contingent stimulation, on which the Lidcombe Program is based. Unfortunately though, the ameliorative effects of STS on stuttering are only temporary in adults, lasting only for as long as the speech pattern can be maintained. This is because, in adulthood, the neural pathways for speech have already become established and are intractable to change (Craig & Hancock, 1995; Wohlert & Smith, 2002). In children however, neural pathways for speech are still being laid down and long-term changes in the speech mechanism may still be possible (Packman, Onslow & Menzies, 2000). It is the foregoing line of reasoning that has driven the development of the Westmead Program.

Compelling empirical support has recently been generated for the Westmead Program. Initially, outcomes were reported for the treatment in a single case study (Trajkovski, Andrews, O'Brian, Onslow & Packman, 2006). Independent, blinded measures showed that seven clinic visits were required for the participant to reach and sustain a beyond-clinic percent syllables stuttered (%SS) below 1.0. Subsequently, outcomes were reported for the treatment in a multiple baseline design across three participants (Trajkovski, Andrews, Onslow, Packman, O'Brian & Menzies, 2009). Independent, blinded measures showed that participants required a mean of six clinic visits to reach and sustain a beyond-clinic %SS below 1.0. Finally, outcomes are being gathered for the treatment in a Phase II clinical trial. At the point of writing,

independent, blinded measures showed that participants required a mean of 11.7 clinic visits to reach and sustain a beyond-clinic %SS below 1.0.

In addition to the reductions in stuttering reported in these studies, a number of other advantages were associated with the treatment. Firstly, the Westmead Program protocol was straightforward. Participants were only required to practice STS for around one cumulative hour per day and have their daily severity rating scores recorded. In contrast to other treatments for early stuttering, there was no need to change the dynamics of the child's family interactions (Millard, Nicholas & Cook, 2008), to provide verbal contingencies for stuttering moments during the day (Jones, Onslow, Packman, Williams, Ormond, Schwarz & Gebiski, 2005), or to specifically instruct the child in detailed speech pattern changes (Boberg & Kully, 1994). Secondly, the Westmead Program involved minimal clinic contact. Participants in the Phase II study (Trajkovski et al., 2009) required a mean of 11.7 clinic visits to progress to Stage 2. In contrast, the Lidcombe Program prescribes a mean of 17.9 clinic visits to achieve the same criteria (Rousseau et al., 2007)\*. Thirdly, the treatment was suitable for very young children. A mean of seven clinic visits were required for all children under the age of 3 years 6 months to progress to Stage 2. With regard to the Lidcombe Program at least, intervention at this age is not advisable because responsiveness depends to some degree on the cognitive development of the child (Kingston, Huber, Onslow, Jones & Packman, 2003). Finally, independent listeners judged the speech of all participants who completed the treatment as sounding natural on post-treatment recordings taken beyond the clinic. This result is of particular interest because it suggests that the ameliorative effects of STS on stuttering in childhood may persist, even when the child is no longer speaking rhythmically.

On balance, it is reasonable to predict that the development of the Westmead Program may help to overcome the access barriers to early stuttering intervention that exist around the world. With the associated improvements to treatment efficiency, services may become available to more children, at a younger age, without compromising safety or exceeding budgetary constraints. Furthermore, given the inherent simplicity of the Westmead program, not only would the development of alternate models of service delivery be likely, but it may also be possible for the Westmead Program to be completely computerised and made available to parents with little or no SP input at all. Consequently, development of the Westmead Program is warranted, not to replace the Lidcombe Program, but to add to the inventory of efficacious treatment options available for early stuttering. That way, clinicians will be better equipped with a viable treatment alternative to address their individual, clinical and institutional needs. Maybe then, we will

be closer to solving the current under-supply crisis for early stuttering intervention within our profession. If not, I am unsure of the future ...

Editors note: \*Other studies e.g. the Jones et al (2000) and Kingston et al (2003) papers give 11 as the median number of sessions to Stage II in the Lidcombe Program, a number which we now read as 13, to take account of the 3 weeks at the specified criteria rather than 1.

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