



# Lidcombe News



**January 2012**

**Edition 42**

A very happy new year to you all and welcome to the first 2012 edition of Lidcombe News! In this edition we are delighted to bring you, from the Australian Stuttering Research Centre, Ann Packman's views on the question of why the Lidcombe Program may "work". Following on from the last edition about using Skype as a way of delivering the Lidcombe Program, we also have a very interesting report from Kate Bridgman, of La Trobe University in Melbourne, Australia, on her research in progress of a Telehealth Phase II randomised controlled trial of the programme. In addition we have news of courses in the UK as well as dates of the next Link days around the country. 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.

As well as all this we have the ever faithful Dear Sue team expertly solving yet another problem for us as well as answering those seemingly never ending questions about the program in "Just Explain That Again.."



## DATES FOR YOUR DIARY

Norwich is holding a Link day on **Tuesday, March 20<sup>th</sup> 2012** from 9-3.

**Venue:** 40, Upton Road, Norwich, NR4 7PA. Bring/buy your own lunch.  
**Contact:** Sally Lelièvre for details, directions etc. on tel. **01603 508946**, or email: **[Sally.Lelievre@nchc.nhs.uk](mailto:Sally.Lelievre@nchc.nhs.uk)** If you have not been before please let Sally Lelievre know in advance as there is a possibility the venue may have to change.

The North West's Link day is on **Tuesday 27<sup>th</sup> March 2012** from 1-4pm.

**Venue:** Darwen Health Centre, Darwen, BB3 1PY.

**Contact:** Victoria Mangera (Blackburn with Darwen PCT) on email: **[victoria.mangera@nhs.net](mailto:victoria.mangera@nhs.net)** if you require further details.



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

**Central England** is holding its next Lidcombe Link day on **Wednesday 11<sup>th</sup> July 2012** from **13.30 – 16.00**.

**Venue:** The new admin building – Meeting Room 4 (Ground Floor), Paybody Site, Stoney Stanton Road, Coventry CV1 4FS.

**Contact:** **Debbie Middleton** on tel. **024 7696 1453** or

**Email:** [Debbie.Middleton@coventrypct.nhs.uk](mailto:Debbie.Middleton@coventrypct.nhs.uk) for further details if required.

## **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.*

**The March 2012 workshop advertised in the last edition is now full.**

A **London** based course is being held on Tuesday and Wednesday **July 17<sup>th</sup> & 18<sup>th</sup> 2012** at the **Royal College of Speech and Language Therapists**.

Contact: **Sally Wynne** on email: [lidcombe@live.co.uk](mailto:lidcombe@live.co.uk) or

**Mary Kingston** on email: [kingstonamee@talk21.com](mailto:kingstonamee@talk21.com) for the flyer and booking form.

## **MISCELLANEOUS**

We have a new Hot Tip for you – well, for those of you who have a smart phone!

 On iPhones (maybe others) there is an app which you can download free called Songify. You can record anything you like on this and it will turn it into a 'song' with a variety of backing styles. How about recording: "You sound really smooth!" or "Smooth talking!" or something like that. Give it a try or tell parents about it, it sounds great! And if the contingencies need refreshing a little it could just do the trick...

## Why does the Lidcombe Program “work”?

Ann Packman, PhD

Associate Professor and Senior Research Officer,  
Australian Stuttering Research Centre, The University of Sydney

*Ann has worked for over 30 years in the area of stuttering, as a therapist, a teacher and a researcher. She currently conducts research into the nature and treatment of stuttering and has a special interest in theory. She has written a book on this topic.*

I thank Mary for inviting me to write this article. It is a topic that has intrigued me for years, as I am sure it has most people who use the program. Unfortunately, the only short answer I can give is, “I don’t know!” Having said that, I love to theorise, so I am happy to offer some ideas to ponder on.

Does the Lidcombe Program “work”?

First of all, I want to say something about the title, which Mary suggested to me. All too often we say, and we hear people say, that the Lidcombe Program “works”. I think we need to be careful about our phraseology here, because all we know from the research is that the program has an effect on stuttering after 9 months that is greater than that of natural recovery (see Jones et al., 2005). There are people who say that we overplay the efficacy of the program. Perhaps by saying it “works” we are giving the unintended impression that the Lidcombe Program “cures” stuttering in every child. Which it doesn’t. So perhaps it is better to say that the program is “effective”, rather than “it works.”

Having said that, Lidcombe is the only early intervention for stuttering for which efficacy has been demonstrated with clinical trials. And, of course, most of the children we treat with the program recover from stuttering completely, and this is wonderful.

Possible explanation

I think the most likely reason for the effects on stuttering of the Lidcombe Program is the verbal contingencies that the parent gives the child for “smooth” and “bumpy” speech. The message the child gets from this, whether consciously or unconsciously, is that he or she should talk “this” way and not “that” way. We know that children do not stutter on every word/syllable, so it seems that they can somehow draw on this to be more fluent (see Hayhow, 2011, for an interesting discussion of this). How they do this (if in fact that is what

they do!) we do not know. We do know, however, that they do not do it by reducing linguistic complexity (Bonelli et al., 2000; Lattermann et al., 2005), so that is comforting.

Recent brain research is telling us that stuttering is probably underpinned by a “glitch” in the neural processing associated with speech production, especially in the white connecting fibres (e.g. Chang, et al., 2008). I do not see how the program can change this. However, there is some support for the idea that once a child starts talking fluently, this may change structure in a young brain that is still plastic. Those of you who were at the 2011 Oxford Dysfluency Conference may have heard Martin Sommer, an eminent German brain researcher, supporting the idea that this may happen with the Lidcombe Program.

However, we know that not all children who initially do well with the program remain fluent in the long term. Our follow up study showed this to be the case (Jones et al., 2008) and I think many therapists have experienced this. It can be distressing to see a child return to the clinic when stuttering reappears after a long period of fluency.

My view is that those children who do well with the program and never stutter again may have been predisposed to recover anyway. However, for those who respond well but who never actually stop stuttering, either in the short term or the long term, it may be that parental contingencies are needed to keep the stuttering under control. The implication here is that the parent may need to continue providing contingencies, albeit infrequently, for much longer than we think. From what I hear therapists say, parents often stop doing this once the child’s speech is sounding good.

This explanation may at first blush sound depressing, as it suggests there are some children who will never become completely fluent with the Lidcombe Program. However, on the positive side, I think it may also have the effect of removing the burden of therapist guilt when a child continues to stutter (the caveat here, of course, is that the program was implemented according to the manual in the first place). Further, if a child’s stuttering can be kept at a very low level with on-going parental contingencies, this has to be a good thing. In this scenario the child is probably much less likely to suffer the social penalties and bullying that we know can occur going in to the school years. And perhaps this protracted period of fluent, or near fluent speech, will change brain structure for the better, as Martin Sommer suggests. Let’s hope so.

The explanation I have given also suggests that we are treating many children who are destined to recover anyway. However, I think we already know this (see Packman, Onslow & Attanasio, 2003). And this is justified by some recent epidemiological research here in Australia (manuscript in preparation), which suggests that fewer children recover in the first year after onset than previously thought. Our general rule of thumb, based on available evidence, is that waiting a year before implementing the program is unlikely to jeopardise a child's responsiveness. Given that we cannot predict whether an individual child will recover naturally, and the likely negative effects of stuttering on pre-schoolers (Langevin et al., 2009), we cannot leave so many children to stutter for much longer than this before intervening, in the hope that they will recover without treatment.

I must say again that this explanation for the mechanism underpinning the Lidcombe Program is hypothetical. I am theorising and trying to find an explanation that best fits the facts, as we know them. However, the hypothesis that contingencies are responsible for the effectiveness of the program is testable; all we need is a randomised controlled trial comparing straight Lidcombe with Lidcombe minus contingencies. For theoretically, at least, it is possible that the mechanism underpinning the program's effects is simply that parents have positive talking times with their child each day!

## Conclusion

Does the explanation I have given have implications for how we do the Lidcombe Program? I think all we can do is to continue to deliver it as best we can but encourage parents to continue giving contingencies for smooth speech and for stuttering (if the child has residual stuttering) in the long term, after the conclusion of Stage 2. Here at the ASRC, Sue O'Brian and the team are investigating the use of fridge magnets to remind parents to do this. Stay tuned!

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## **Dear Sue**

*I have been working with a family with a little girl called Meera, aged 4 years, 3 months for 20 weeks now. She has made progress over this time with a drop from SR 7s and 8s to SR 3s and 4s.*

*My problem is that Meera's mother is becoming exhausted with the daily treatment as she is trying to cope with a large busy family and now her own mother has become unwell and is also needing her time. While she wants to do her best for Meera she is unable to cope with all these pressures and we both feel that a break from treatment is necessary.*

*Meera is not as yet ready for Stage 2 of course so I am unsure what to advise her mother to be doing during this break. Can you give me some ideas about how to proceed?*

It may be difficult for long term Lidcombe Program clients to keep up the amount of treatment that is required for progress. Since Meera's stuttering was quite severe then her treatment with the Lidcombe Program is likely to take longer than milder cases (Jones, et al. 2000). It is good that you have tuned in to the mother's needs and are responding to them. Treatment for stuttering when she is low in motivation is probably not going to be in Meera's best interests.

We know from the literature that parents report that when the treatment is not straightforward the clinic visits become burdensome, that they feel their children become less responsive to the verbal contingencies and that parents start to doubt themselves (Hayhow, 2009). Additionally the Goodhue (2010) article indicated that most parents expected faster improvement, that many felt a sense of responsibility and of failure if they did not achieve expected gains, and that some felt guilt associated with not getting enough therapy done or with the child not improving fast enough. It is possible that these issues are part of the reason that Meera's mother is "becoming exhausted". It is important to address this in your management of Meera's treatment recommendations and to be non-judgmental regarding the decision to take a treatment break.

While the literature describes feelings and situations similar to that of Meera, it does not go on to investigate the results of clinical responses to these parental concerns. As clinicians we need to consider each case carefully and make a decision specific to

the family. You have chosen to give Meera's mother a break from treatment. The next step will be to decide the length of the break by considering factors such as when Meera will be starting school and how long her mother will need to spend with her own mother who is unwell. The length of and reason for the break will impact on what the clinician recommends for the duration of the break. Since the reason for stopping treatment here is that the mother is becoming exhausted and she needs time with her unwell mother, then I would advise her to stop her Lidcombe Program treatment altogether for now. Doing some therapy will not allow for a complete break and the mother may fatigue further, nullifying any rejuvenation a break might generate. Such therapy would also be without your guidance and may not be effective. It may also dilute the impact of the treatment when it is reintroduced.

I would ask Meera's mother to continue severity ratings if she is able to, so that the impact of the decision to stop treatment can be monitored. She needs to be free to contact you to discuss any changes that might be happening and the timing about when to reintroduce treatment needs to be clearly and deliberately discussed.

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## Just explain that again...



**?** *I have heard that it is possible to do a child's severity ratings on Google docs. As we are about to 'go paperless' in my department this seemed like a good option. Can you explain exactly how I find this system on the internet and how it works?*



You can access Google Docs via the Google website. Once you have set up a free account you click on "Documents" and start a spreadsheet with dates. You can then give private shared access to particular email addresses, inviting parents to add to the document. A parent could enter their severity ratings straight onto the spreadsheet and then you could view them immediately when you log on.

This might be useful for a parent who is often on the internet (e.g. at work or on an iPhone). Google docs will not be convenient for all parents, but it is an option that may make recording severity ratings more efficient for some families.

**?** *I recently read a paper about Parents' Experiences of the Lidcombe Program. In it some parents expressed the idea that a self-help group for parents would be useful. Have you ever done this (or know anyone who has), and was it in fact considered a good idea by the group?*



This paper is very interesting and I recommend that all clinicians who use the Lidcombe Program should read it.

The paper explores many issues that parents raised during interviews. Indeed one of those issues was parents expressing that self-help groups could be useful. At this clinic we have recently held a morning tea for Lidcombe Program parents with the goal of promoting discussion and support in an informal setting between parents. While the parents who attended were positive about the opportunity to share together, they needed some help to initiate their conversations, resulting in more guided discussions. We hope that if the group was run regularly and parents became familiar with the process, the conversation might become more open. In response to the success of this first morning tea and the literature supporting the potential worth of such a venture

for parents, our clinic plans to host more of these groups and to evaluate their effectiveness.

The reference is:

*Goodhue, R., Onslow, M., Quine, S., O'Brian, S., & Hearne, A. (2010). The Lidcombe program of early stuttering Intervention: mothers' experiences. Journal of Fluency Disorders, 35, 70-84.*

 *I know some people think paper handouts are useful, but others feel they are not a good idea with the Lidcombe Program. What is your view on this? Do you use any yourself in your clinic? If so are they generally accessible to others who like to share information this way?*

 I have not used generic handouts as I have not felt the need to do so. I am cautious as I want to avoid second and third hand distribution of "how to" information, potentially resulting in attempted treatment without clinician guidance. I prefer to individualise the information that I give to parents so that I have tailored it to their child and their learning style. For parents who indicate that they prefer written information, I suggest that they use a book and make some notes for themselves. Generally if they do this I check what they write to ensure that it is consistent with what was discussed. The types of things that some parents in my clinic have written are reminders about therapy ideas and ways to reinforce stutter-free speech. These are obviously different for each child/parent.

I do have some colleagues at other clinics who use handouts and as I understand it, they have specific handouts for specific topics given to parents according to the appropriate timing for a particular child. Other colleagues report finding it helpful to give parents the Lidcombe Program guide once they have commenced treatment. This is available from the ASRC website (in several different languages) under downloads.

In the future Lidcombe Program trained clinicians will have access to a website that is still in the early planning stages. Shared ideas and resources may be available on this website.

*Our grateful thanks for this edition's Dear Sue and "Just Explain That Again..." go to Stacey Sheedy, Verity MacMillan and Wendy Lloyd from the Bankstown Stuttering Unit in Sydney, Australia.*

## **Research In Progress: Telehealth trial of the Lidcome Program**

**Kate Bridgman, PhD Student, Australian Stuttering Research Centre.**

*Kate is a Paediatric Speech Pathologist with a background working in community health and private practice. She is currently completing her PhD with the Australian Stuttering Research Centre investigating the Lidcombe Program delivered by Skype.*

### **What?**

A Phase II randomised controlled trial is currently underway at La Trobe University. It is a joint project between La Trobe University and the Australian Stuttering Research Centre. Participants are randomised to receive Lidcombe Program treatment either in the clinic or via the internet using a webcam and Skype. They receive their entire treatment, both Stage 1 and 2 this way. The entire Lidcombe Program is delivered to both groups, in its manualised form (Packman et al., 2011), with no program changes made for telehealth. Eligibility criteria include children aged 3;0-5;11 who have been stuttering for at least six months, who have functional English and no co-morbid language or developmental delays. All families are required to use their own resources and must prove adequate internet connection to support quality audio and visuals when using Skype.

### **Why?**

Early intervention provides children who stutter with the best chance of avoiding the lifelong problems associated with stuttering. However, many children are unable to access treatment because of distance from clinics and lifestyle factors. These difficulties are reported for both metropolitan and regional populations around the world.

Telehealth, therefore, is an innovative way of increasing access to treatment for young children and their families. With the increasing access to the internet and affordability of webcams and software, real-time treatment using Skype is a viable solution for many of these children. Additional benefits of this model may include increased access to specialist clinicians, reduction of costs and resources for outreach service provision, reduction in costs for time and travel for the consumer, and increased equality of service provision to children despite where they live.

### **Will it work and how?**

Telehealth is currently used for a range of health-related issues (DePalma, 2009). Mashima and Doarn (2008) completed an overview of the use of telehealth in the discipline of speech pathology. They report that use of this practice occurs in Australia, Canada, Greece, Ireland, Japan and the United Kingdom. The authors recommend that real-time (p. 1105) interaction is required with equipment that supports both audio and visual information. Clinicians were reported to have 'initial skepticism' (p. 1105) but are now accepting of telehealth.

In relation to the stuttering population, telehealth has proven to be a viable service option for adults who stutter (O'Brian, Packman, & Onslow, 2008; Carey et al., 2010) and also adolescents (Carey, O'Brian, Onslow, Packman, & Menzies, 2011).

Initial telehealth studies targeting preschool children who stutter have been completed. The initial studies using low-tech methods used the telephone and mail to deliver the Lidcombe Program. They proved effective but not efficient (Lewis, Packman, Onslow, Simpson, & Jones, 2008; Wilson, Onslow, & Lincoln, 2004). However, in these reports the program was different from the manualised version on which the within-clinic benchmarks are based. The treatment was not delivered weekly and the clinician did not observe parents giving the treatment, nor did they measure the child's stuttering severity online, or engage in problem solving and treatment alterations online.

In 2010, another Phase I trial was completed. The recommendations from Wilson et al. (2004) were considered and the Lidcombe Program was delivered in real-time to preschool children using the internet and a webcam. Participants who received treatment via the internet and webcam met benchmark treatment standards for in-clinic treatment (Farnsworth, 2010).

This clinical trial, compared to previous, low-tech telehealth (phone and mail) trials of the Lidcombe Program, allows the principles of standard delivery of the Lidcombe Program to remain unchanged. This can occur by using webcam and live videoconferencing (Skype), as recommended by Wilson et al (2004). The clinician-parent-child triad will retain face-to-face contact, real-time measurements, online demonstration of verbal contingencies and parent feedback.

## **Outcomes**

Given that the trial is currently in progress, we are not yet able to report. We do, however, plan to investigate treatment efficiency by comparing the number of weeks and sessions taken for both groups to attain entry to Stage 2. We will also compare the duration of sessions, and any possible trends in attendance or cancellation patterns.

Further, we will investigate the efficacy of the program. We assess the children nine and eighteen months following the start of their treatment to see if they maintain their near-zero stuttering levels. We will also report parental attitudes, satisfaction and experiences with the webcam format.

In addition to analysing the data and parent questionnaires, we will also explore trends and observations made by the clinician. This includes the clinical implications of this service model, including how to develop clinical boundaries, how to teach children and their parents, and possible treatment adaptations that need to be considered. Currently, it is unclear about whether any aspects of the Lidcombe Program treatment process will be altered for telehealth presentation.

Finally, we will assess the health economics of this service delivery model in terms of cost and resources required for families and services.

STAY TUNED.

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