Lidcombe Program checklist: Treatment in structured conversations

Swift, M., O'Brian, S., Onslow, M., Packman, A., & Ryjenko, O. (2012). *Lidcombe Program checklist: Treatment in structured conversations.* Available from http://sydney.edu.au/health_sciences/asrc/health_professionals/asrc_download.shtml

Checklist Instructions

The checklist requires clinicians to make subjective judgements about the presence or absence of Lidcombe Program treatment components used in beyond-clinic treatment conversations. The instructions are only meant as a guide to possible responses.

Definition of response – Almost never/Sometimes/Most of the time

Almost never – the treatment component is either not observed at all during the treatment session or is present but only in a limited number of instances.

Sometimes – the treatment component is used but is inconsistent or omitted enough times that a designation of "most of the time" is not applicable.

Most of the time – the treatment component is used consistently during the vast majority (or all) of the treatment session. If the treatment component is omitted on 1-2 occasions and this did not have a negative impact on overall treatment delivery, a designation of "most of the time" would be appropriate.

As you listen to the home treatment recording, you may like to make notes next to the checklist items to aid in your completion of the checklist. Once you have listened to the whole recording, place a tick in the appropriate column. For each item on the checklist, score it as either "almost never", "sometimes" or "most of the time" based on how often it occurred overall during the whole session. If you cannot decide between two columns, choose the more conservative option.

Checklist development

The checklist was developed from the *Manual for the Lidcombe Program of early stuttering intervention* referred to henceforth as the "Manual" and *The Lidcombe Program of early stuttering intervention: A clinician's guide* referred to henceforth as the "Clinician's guide". Full references for each are outlined below. Each checklist item includes a reference to the page number(s) of either the Manual or the Clinician's guide from which the checklist item is derived.

1) Onslow, M., Packman, A., & Harrison, E. (Eds.). (2003). *The Lidcombe Program of early stuttering intervention: A clinician's guide.* Austin, TX: Pro-ed.

2) Packman, A., Webber, M., Harrison, E., & Onslow, M. (2008, April). *Manual for the Lidcombe Program of early stuttering intervention*. Retrieved 18 March, 2010, from http://www.fhs.usyd.edu.au/asrc/docs/LP_Manual_English_April_2008.pdf

Additionally, the first and last authors listened to over 350 recordings of parents and children conducting beyond-clinic treatment conversations and modified the checklist so that all variations of treatment evident in the recordings could be captured using the checklist. The checklist was trialled by three independent speech-language pathologists (SLPs) experienced in the Lidcombe Program with further refinements made to the items to increase clarity of wording. Reliability checks were conducted with three different independent SLPs experienced in the Lidcombe Program. Having completed the checklist on three beyond-clinic recordings, the overall agreement in ratings by the three SLPs was 84%.

Treatment components

1. *Parent verbal contingencies (PVCs) provided immediately after response* – parental verbal contingencies are to be provided immediately after the child's stutter or stutter-free speech, not following continuation of the conversation nor provided generically at the end of a topic/session (e.g.,

"You've said some very smooth words today").
For example, Child "There's the green sheep", Parent "Very smooth talking. It's sleeping isn't it?" would be as soon as possible.
Child "There's the green sheep", Parent "Yes, it is. It's sleeping by the bush, just like you were sleeping by the heater the other day. It looks very happy. Very smooth talking" would not be as soon as possible.
Reference: Manual p.5

2. *Parental verbal contingencies provided with a neutral, natural, non-punitive tone* – tone and wording of PVCs, especially contingencies for stuttered speech, do not imply that the child has done something wrong. The parent sounds genuine in their delivery of PVCs, rather than forced and unnatural. This component can still be marked if there are no contingencies for stuttered speech given.
Reference: Manual p.5, Clinician's guide p.75

3. *Parent verbal contingencies provided by the trained parent only* – the parent who attends clinic sessions provides PVCs during treatment and other people do not. PVCs are not to be provided by an untrained parent as he/she walks past the session, or by an untrained older sibling. If you are not the treating clinician, assume that the parent who is conducting the treatment with the child is the one who has been trained and that other people have not.
Reference: Clinician's guide pp.94 & 135

4. *Parent verbal contingencies applied to conversations rather than speech known to induce fluency, such as counting* – parental verbal contingencies are to be applied to conversations between the parent and child rather than learned/automatic speech such as counting, reciting nursery rhymes and singing, imitating the parent, reading, producing animal noises or talking in an accent.
Reference: Manual p.7

5. *Parent verbal contingencies clearly for stutter-free or stuttered speech and not another child behaviour* – PVCs used by the parent are clearly for stutter-free or stuttered speech and not easily confused with feedback for other speech/language tasks (e.g., speech sound production) or activities.
Reference: Clinician's guide pp. 71, 72, 104, 121 & 123

6. *Parent verbal contingencies accurate for child response (e.g. parent verbal contingencies for stutter-free speech not given for stuttering)* – parents provide contingencies for stutter-free speech when the child is stutter-free (i.e., no stutters present) and contingencies for stuttered speech when the child has stuttered (i.e., not for fluent speech or normal non-fluencies). The parent does not have to comment after everything the child says (in fact they should not) but when they do provide contingencies they must be accurate. If the parent provides more than two inaccurate PVCs, a designation of "most of the time" is no longer appropriate.
Reference: Manual p.4, Clinician's guide p.135

7. *Variety of parent verbal contingency phrasing* – parental verbal contingencies delivered with variety in the wording of the contingencies. This item subjectively measures how different the feedback sounds.
For example, contingencies for stutter-free speech which include variety such as "beautiful talking", "was that smooth?", "smooth words", "great speech" would receive a tick for this item; contingencies which only include "good smooth talking" and "smooth talking" would not. If part of the session has variety and part does not, choose between "almost never/sometimes/most of the time" as applicable to the session overall.
Reference: Manual p.5

8. *A range of parent verbal contingency types are used (as individualised for the client)* – parents deliver PVCs which include a range of different types listed in the manual, i.e., praise, acknowledgement and request for self-evaluation for stutter free speech, and acknowledgement and request self-correction for stuttered speech. Parents are not expected to use equal numbers of each type but 4-5 of the contingency types would be present for a designation of "most of the time" to be given. If you are the

treating clinician and have advised your client not to use some contingency types (e.g., PVCs for stuttered speech) do not include these when marking this item. If you are not the treating clinician of the client, use all five PVC types when marking this item.
Reference: Manual p.5

9. *Only Lidcombe Program guide parent verbal contingencies used* – parental verbal contingencies listed in the manual for stutter-free speech are:
1) praise (e.g., great talking),
2) acknowledgement (e.g., smooth words), and
3) request for self-evaluation (e.g., "was that smooth?" or "was that bumpy" after stutter-free speech).
PVCs listed in the manual for stuttered speech are:
1) acknowledgement (e.g., that was bumpy), and
2) request for self correction (e.g., can you say that again?).
PVCs not included in the manual, which would be counted as incorrect, include:
1) request for self-evaluation of stuttered speech (e.g., "was that bumpy?" or "was that smooth?" after a stutter),
2) mixed use of PVCs for stutter-free and stuttered speech (e.g., "That's nice & smooth. There's a little bump in there but it's mostly nice and smooth"), and
3) prompts to change speech pattern in response to a stutter (e.g., "slow down", "take a breath").
Parents do not have to use <u>all</u> the PVCs listed in the manual for this to be correct. However, they must <u>only</u> use those in the manual.
Reference: Manual pp.4 & 5, Clinician's guide p.73

10. *More parent verbal contingencies for stutter-free than stuttered speech* – The treatment is overwhelmingly positive overall and without clusters of contingencies for stuttered speech during the treatment.
An example of a cluster of contingencies for stuttered speech is, Child "sh-sh-sh-she go to the door", Parent "That was bumpy", Child "wh-wh-why she doing that?", Parent "Can you say 'why' again?", Child "wh-wh-why?", Parent "That was still bumpy". If there are no PVCs given for stuttered speech, this item would be marked "most of the time".
Reference: Manual p.5, Clinician's guide pp.6, 71 & 95

11. *Child appears to enjoy parent verbal contingencies for stutter-free speech.* If the child indicates either verbally or non-verbally that they don't want the parent to give any stutter-free contingencies, or contingencies with specific wording, then it is assumed that the child found the contingencies non-rewarding. If the child appears ambivalent towards the contingencies, this would also count as non-rewarding, but this may be difficult to judge on an audio tape.
Reference: Manual p.11

12. *Parent verbal contingencies for stuttered speech are not received negatively by the child.* If the child doesn't indicate either verbally or non-verbally that they don't like the contingencies for stuttered speech, or contingencies with specific wording, then it is assumed for the checklist that the child did not find the contingencies negative. If the child did not receive the PVCs for stuttered speech negatively, this would be marked as "most of the time" on the checklist. If the child received the majority of PVCs for stuttered speech negatively, this would be marked as "almost never". If there are no PVCs for stuttered speech given, write "none given" on the checklist.
Reference: Manual p.11, Clinician's guide pp.76 & 95

13. *Parent verbal contingencies non-invasive to the conversation* – parental verbal contingencies are delivered so as to not interrupt the flow of the child's conversation and at a frequency that does not appear excessive in the context of the conversation. Providing PVCs after every child utterance or frequently in the middle of a sentence would be invasive for this item. Providing a PVC following a child question and neglecting to answer the question would be inappropriate. Insistence on the child keeping self-correcting until smooth speech is obtained would also be inappropriate.
Reference: Clinician's guide p.7 & 74

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14. *Treatment conversation is a positive experience for child.* If the child indicates either verbally or non-verbally, that they want to discontinue with the activity or the parental feedback then it is assumed for the checklist that the child found the activity a negative one at that point in time. For the checklist, if no indication is given to suggest otherwise, the treatment is assumed to be positive for the child.
    Reference: Manual p.3, Clinician's guide pp.5 & 71

15. *Primary focus of conversation is stuttering treatment, not correct pronunciation or the rules of the game* – the therapy conversation focuses on stuttering therapy (i.e., child speaking, enjoying the activity and parent giving verbal contingencies) rather than focussing on other things such as, child's speech or language skills, correct rules of the game and turn taking.
    Reference: Clinician's guide p.121

16. *Parent and child are engaged with and focussed on treatment, not distracted by others* –The parent has sufficient behavioural control over the child to enable effective treatment to take place. The parent's focus is on the treatment process. Siblings are not distracting the parent and/or child from the therapy activity.
    Reference: Manual p.12

17. *Therapy given during an everyday activity a child and parent would conduct together* – therapy takes place in an everyday activity that a child and parent would conduct together (e.g., game, storybook, cooking, gardening, tea party).
    Reference: Manual pp.3 & 6, Clinician's guide p.5

18. *Activity results in an interactive conversation* – activity encourages conversational interaction between the parent and child.
    Reference: Manual p.9

19. *Child stutters only occasionally* - only judge this from the parts of the tape where the child can be heard clearly. Throughout the conversation the parent needs to structure the conversation to achieve a severity rating which is "quite low" (SEV = 1-3). Any higher severity rating (SEV = 4 or above) is considered more than occasional stuttering for this item.
    Reference: Manual p.7, Clinician's guide p.76

20. *When the child responses range in length, parent verbal contingencies are primarily given for longer rather than shorter stutter-free utterances* – when a child is producing stutter-free utterances which range in length (e.g., some single words, some short sentences), the parent primarily gives PVCs for the longer utterances rather than the short ones. The parent may give PVCs for both longer and shorter phrases but if shorter utterances are routinely given PVCs and longer utterances are not, that would be considered incorrect for this item.
    Reference: Manual p.11, Clinician's guide pp.77 & 95

21. *Treatment duration 10-15 minutes (or as directed by clinician)* – The Lidcombe Program Manual states that the home treatment conversation should last between 10-15 minutes. In clinical practice, a clinician may recommend a different length of time based on parent/child factors. In this case, the clinician should use this item to check that the treatment is of an appropriate duration given the previous recommendation. If you are not the treating clinician of the client, use the manual durations to answer this question. This item has different responses to be ticked. Choose "yes" if the conversation was an appropriate duration. If the conversation was not an appropriate duration, choose "no – shorter" or "no – longer" as applicable.
    Reference: Manual pp.7 & 9, Clinician's guide p.77

Note: If no PVCs are provided at any stage of the treatment session, all items relating to PVC use are to be marked "none given".

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Clinical implications

When interpreting the clinical implications of this checklist it is important to remember that the Lidcombe Program is to be individualised for every client. It may not be appropriate for a given client to use all of these treatment components. What the checklist does provide is an overview of what the parent and child are doing during their beyond-clinic treatment conversations. The treating SLP can then use this information to refine parental treatment delivery. In general terms the following clinical implications are likely to apply.

Almost never – if the SLP has not intentionally told the client to omit this component, this is most likely an error in treatment delivery which may be having a deleterious effect on the effectiveness of the program for the client. The reasons behind the parent's omission of this component need to be discussed and if appropriate the component taught again to the parent, with opportunities for the parent to observe the SLP using the component and then practise in clinic before using it at home. Work on this area should start immediately.

Sometimes – this indicates a lack of consistency in the use of this treatment component which may have a negative impact on the efficiency of the program. This component needs to be revisited with the parent, with its importance emphasised. Work on this area should start as soon as practicable.

Most of the time – this indicates a treatment component which is being used appropriately by the parent. The parent should be informed of their success in this area. No further work is required on this component at this stage of treatment.

Publications about the checklist

Swift, M., O'Brian, S., Onslow, M., & Packman, A. (2012). Checklist of parent Lidcombe Program administration. *Journal of Clinical Practice in Speech-Language Pathology, 14*(1), 12-17.

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Client name _____

	Almost never	Sometimes	Most of the time	Comments
1. PVCs provided immediately after response				
2. PVCs provided with a neutral, natural, non-punitive tone				
3. PVCs provided by the trained parent only				
4. PVCs applied to conversations rather than speech known to induce fluency, such as counting				
5. PVCs clearly for stutter-free or stuttered speech and not another child behaviour				
6. PVCs accurate for child response (e.g. parent verbal contingencies for stutter-free speech not given for stuttering)				
7. Variety of PVC phrasing				
8. A range of PVC types used				
9. Only Lidcombe Program guide parent verbal contingencies used				
10. More PVCs for stutter-free than stuttered speech				
11. Child appears to enjoy PVCs for stutter-free speech				
12. PVCs for stuttered speech are not received negatively by the child				
13. PVCs non-invasive to the conversation				
14. Treatment conversation is a positive experience for child				
15. Primary focus of conversation is stuttering treatment, not correct pronunciation or the rules of the game				
16. Parent and child engaged and focussed on treatment, not distracted by others				
17. Therapy given during an everyday activity a child and parent would conduct together				
18. Activity results in an interactive conversation				
19. Child stutters only occasionally				
20. When the child responses range in length, PVCs are primarily given for longer rather than shorter stutter-free utterances				
21. Treatment duration 10-15 minutes (or as directed by clinician)	No – longer	No – shorter	Yes	