



January 2011

Edition 39

A very happy new year to you all from Lidcombe News!

In this month where 'The King's Speech' has taken the world by storm and you can't turn on the radio, tv or computer, or read the paper without hearing about stuttering it seems a good time to bring out the next edition of Lidcombe News! We have news of some changes to the Lidcombe Program following an international meeting of the Training Consortium members in Philadelphia, USA, and also on a more practical note some ideas for using tangible rewards. This is all in addition to our ever popular Dear Sue and Just Explain That Again. We start though, as usual, with news of upcoming courses and Link days in the UK.



#### DATES FOR YOUR DIARY

**The North West** is holding its next **Lidcombe Link** day in **Stockport** on **Tuesday 15th March 2011** from 1pm for a 1.30pm start at **The Children's Therapy Centre, 1st Floor, Beckwith House, 1-13 Wellington Road, Stockport, SK4 1AF**. There is parking in Heaton Lane car park just around the corner on Heaton Lane, SK4 1BS. Contact **Celia Parlett** for further details if required on **tel. 0161 221 5673** or email: **parletts@ntlworld.com**

**Norwich** is holding its next Link day on **Tuesday, 29<sup>th</sup> March 2011** from **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**



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Contributions to Mary Kingston. Send your ideas and questions to:  
Email: **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!

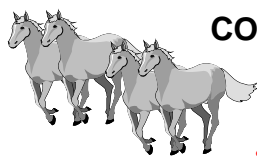
**Central England** is holding its next Lidcombe Link day on **Wednesday 6<sup>th</sup> July, 2011** from **1.30 – 4.30 p.m.**

**Venue: Cape Road Clinic (Cape Road, Warwick , CV34 4JP)**

All LP therapists are welcome, and the focus will be on, amongst other things, discussion and practice of %SS, troubleshooting and sharing of resources. Contact

**Debbie Middleton** on tel **024 7684 4187** or email:

**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.*

**NHS Wakefield District's** Speech and Language Therapy Department is hosting a two-day Lidcombe training event for Speech and Language Therapists. This will be held on **Thursday 24 and Friday 25 February 2011** at **Wakefield Wildcats, Doncaster Road, Wakefield**. The workshop will be led by **Mary Kingston** and **Sally Lelievre**.

For general enquiries about the course, in particular whether there are still places available as the date is very close, please **contact Mary Keeley** on 01977 465417, email: **mary.keeley@wdpct.nhs.uk**

To book a place, please contact **Sarah Yeadon** Tel: **01977 665751**, email: **sarah.yeadon@wdpct.nhs.uk**

A **London** based course is being held on Monday and Tuesday **October 17<sup>th</sup> & 18<sup>th</sup> 2011** at the **Royal College of Speech and Language Therapists**. Contact **Sally Wynne** on email: **lidcombe@live.co.uk** or **Mary Kingston** on email: **kingstonamee@talk21.com** for the flyer and booking form.

The two above courses are the only ones being advertised at present. We do however have other courses in the pipeline which may come to fruition.

These are department based courses which usually have a few places to sell. If you would like information about any of these contact **Mary Kingston** on **kingstonamee@talk21.com** and I will let you know the current position. Please wait until late February/early March before contacting me however as it is unlikely anything will have been firmed up before then.

## **MISCELLANEOUS**

This year both **Rosemarie Hayhow** and **Rosalee Shenker** wrote papers on the Lidcombe Program for the International Stuttering Awareness Day on-line conference 'People who stutter, Inspire'. These papers and the comments that people made and the authors' replies are now archived and can be seen on <http://www.mnsu.edu/comdis/kuster/stutter.html> You may find other articles of interest while you are there!

*In November 2010 the Australian Stuttering Research Centre hosted a meeting in Philadelphia, USA, for the Lidcombe Program Trainers Consortium and selected guests from the ASRC. Not all members were able to attend but below you can see those of us who made it there.*

*The following article outlines some proposed new initiatives and changes to the Lidcombe Program and the training as a result of this colloquium.*



Back Row L-R :Stacey Sheedy,Ann Packman (ASRC guest),Barry Guitar,Tina Lattermann,Lis Harrison, Simone Lees,Brenda Carey,Sue O'Brian ( ASRC guest),Wendy Lloyd,Rosemarie Hayhow, Rosalee Shenker  
Front Row L-R :Jane Kelly (ASRC),Verity MacMillan, Mark Onslow, Melissa Bruce, Mary Kingston, Martin Nevdahl

## **A) New initiatives**

### **1.Setting up a website dedicated to the Lidcombe Program.**

This is a huge project and will take a while but we hope that eventually that it will contain some of the following areas and more:

- Forthcoming training events
- An area dedicated to parents outlining, for example, what the treatment should include
- A section on "Why do the Lidcombe Program?" for students, clinicians and parents
- Copies of Lidcombe News
- Preparation materials for clinicians prior to attendance at the workshops

There will also be an area dedicated to and accessible only by clinicians who have attended the official Consortium workshops.

### **2. Extending Lidcombe training to students.**

Workshop participation to be opened to speech pathology/speech and language therapy students who are in the **final semester** of their professional degree.

### **3. Changes to be made to the manual.**

A much more comprehensive treatment manual has been proposed.

## **B) Changes**

### **1. To the Lidcombe Program**

#### **Taking the % Syllables Stuttered measure is no longer mandatory when moving to Stage 2.**

In the last edition of the Lidcombe News, Mark Onslow outlined changes to the use of %SS. He discussed how and why it was no longer necessary to take the %SS on every clinic visit. (see edition 38 pages 10-17). At the meeting in Philadelphia we all agreed to take this one step further and decided that the %SS could now be removed altogether from the Lidcombe Program. Clinicians however should make their own choice as to whether they wish to use it or not while carrying out the programme. There are **no changes** to the use of Severity Ratings.

Preparation for Stage 2 is now as follows:

- Parent home Severity Ratings of 1s and 2s for three consecutive weeks.  
There should be at least four 1s in each week
- **As in all previous visits** focus in on a period of time (around 10 minutes of conversation in e.g. freeplay) with the child before the treatment session with the contingencies begins. Check back on the Severity Rating accuracy with the parent. This Within Clinic Severity Rating must also be a 1 or 2 for three consecutive weeks
- Ask parents to gather extra information e.g. from family, nursery and pre-school staff
- Clinicians may also gather extra information e.g. listening to the child in waiting room

### **2. To the Consortium Training workshops**

We have listened to the feedback that you regularly give us after the workshops and have agreed to make the following changes :

- We will be removing the section dedicated to research. Instead it will now be spread throughout the workshop linked to the practical implications. Some of the research may also be included on the new website in the pre-workshop section. We are also hoping to create a video of a recorded conversation with the theoretical researchers discussing their research which will be available on the new website
- There will be changes to the troubleshooting section which will become more practical and a checklist of questions to help guide thinking in this area will be developed
- Consortium Members will be compiling a new set of videos - we hope to have examples of clinicians working with children from different countries around the world
- Changes to the workbooks. The workbooks will have a new format with three slides per page and a notes section.



## Dear Sue

*I have been working with the Lidcombe Program for some three years now and have had very good outcomes. However I recently received a call from a parent about her child, Amy, who I saw a while ago and who went through all of Stage 1 and 2 without any significant difficulties. Amy is now 6 years 10 months and stuttering again. Her mother says she is averaging a 4-5 on her SRs and asking why her bumpy talking has come back again. She is not distressed but says she needs to see her 'smooth talking' lady again!*

*If this has happened to you how have you managed it? I appreciate individual cases may differ but what procedure do you usually follow? Would you start the Lidcombe Program all over again and is this usually successful?*

Throughout treatment with the Lidcombe Program parents are taught to monitor the severity of the child's stuttering and to allow that to dictate how treatment is implemented. Parents are empowered to proactively manage the child's stuttering without direct advice of the clinician, particularly throughout Stage 2. Some children do relapse and start to stutter again after completing the Lidcombe Program (Jones, M, Onslow, M, Packman, A, O'Brian, S, Hearne, A, Williams, S, Ormond, T & Schwarz, I, 2008). Parents are routinely told about the possibility of relapse and what they should do if it occurs both during and on completion of treatment. Anecdotally I do not see many of these children re-presenting to the clinic after completion of Stage 2. Possibly that is due to parents taking on the role of clinician and re-implementing treatment once relapse is detected and therefore not requiring further clinical contact. Discussions about relapse emphasises the importance of the parent reacting to the stuttering by immediately re-implementing verbal contingencies and contacting the clinic as soon as possible if that has not been an effective strategy. At the Stuttering Unit, we would prioritise these cases so that the relapse may be managed as soon as possible.

With any clients who do re-present to the clinic I would recommence the Lidcombe Program as it is quite possible that it could be an effective strategy in managing the stutter. As usual, treatment would be as structured or unstructured as required by the client's stuttering severity. Some differences the program would take on would be that the parent has already been educated about stuttering, thus slightly changing the dynamic of the interactions with her/him, and that Stage 2 might be a more cautious and potentially a longer process. Additionally, you need to consider that the child is slightly older and that would change the clinical interactions. For example, it may be appropriate to involve the child more in discussions to make them more a part of the process.

There is not any research yet to indicate if re-implementing the Lidcombe Program after relapse is a successful approach. Anecdotally I can say that it is often successful and that it is always the best treatment with which to begin. Remember that the only way to discover if any intervention is effective is to measure for a treatment effect. Therefore, use your severity ratings to chart progress, and if improvement is not occurring as expected, problem-solve the reasons for that. If you are certain that the parent is implementing the Lidcombe Program appropriately (including that they have adjusted the contingencies according to their child's age and preferences) and you are not seeing change, you might need to consider a different evidence based treatment.

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



## Just explain that again...



? *I have been monitoring a little boy for his stutter since onset which was 6 months ago. He is now 3 years and 8 months and the stutter is not reducing. Part of the monitoring process has been collecting Severity Ratings and these remain fairly stable at around a 5, sometimes with periods in the day of 6s or 7s. I am wondering whether you would recommend starting therapy at once, and whether you think he might experience difficulties at nursery with his speech at this level of severity?*



Monitoring is a useful process in helping to determine whether the stutter appears to be resolving without clinical intervention (Harrison, E., Sheedy, S., & Lloyd, W. 2004). You mentioned that this little boy has had stable severity ratings now for 6 months. One reason for commencing treatment after a monitoring period is persistent and stable stuttering (Harrison et. al. 2004).


While monitoring the stuttering of young children close to onset is a useful clinical tool, there is now research about the social and emotional cost of stuttering for young children (Langevin, M., Packman, A. & Onslow, M., 2009). Some of the results of this study were summarised by Ann Packman and Marilyn Langevin in a previous Lidcombe News (May 2007, edition 28 p 3-4). Such findings indicate that it is important to question the length of monitoring and may prompt clinicians to intervene sooner than they may have previously. This little boy is attending nursery and so experiences extended periods of social interaction with peers in a relatively large group. The Langevin research indicates that it is imperative to question his experiences at nursery. There is a possibility that other children are responding negatively (either directly or in a subtle manner) to this little boy's stuttering, potentially harming his social relationships and his view of himself as a communicator.


Therefore, as this child's stuttering does not demonstrate any signs of decreasing in severity, and since he is at nursery and is possibly experiencing negative reactions from his peers in direct response to moments of stuttering, the decision to intervene sooner rather than later is supported by evidence.

In summary, monitoring is a good option to screen for natural recovery in young children, but even young children can experience negative social and emotional consequences for stuttering. The factors that may impact this decision need to be considered for each individual client in order to make an informed and sensitive decision about when to start treatment with the Lidcombe Program.


Harrison, E., Sheedy, S., & Lloyd, W. (2004). Timing of early intervention for stuttering: New evidence from clinical practice. In B.E. Murdoch, J. Goozee, B. Whelan, & K. Docking (Eds). *Proceedings of the 26<sup>th</sup> World Congress of the International Association of Logopaedics and Phoniatrists, Brisbane. [CD-ROM]*. Melbourne, Speech Pathology Australia.


Langevin, M, Packman, A & Onslow, M (2009) Peer responses to stuttering in the preschool setting. *American Journal of Speech Language Pathology*, 18, 264-276.

 Please could you clarify something for us- when a child is in Stage 2 of the programme do you follow the schedule 2, 2, 4, 4, 8, 8, 16 week gaps between visits or are there two 16 week visits at the end? There seems to be some confusion around this point!

 It is important to remember the purpose of Stage 2 which is to ensure that the treatment effects of the program are maintained over an extended period and that the gradual, systematic withdrawal of verbal contingencies is done in such a way that severity ratings remain the same (1-2 with majority of them being 1). The typical schedule for stage 2 is described in Webber and Onslow, 2003. It is 2, 2, 4, 4, 8, 8, 16 weeks between visits. This schedule is not always followed. As with all of the components of the Lidcombe Program, it needs to be administered in a way that is sensitive to the needs of the individual client. Some clients require two 16 week visits, and some might even benefit from an additional 32 week visit on the end, particularly if they had relapses throughout Stage 2. The role of the clinician is to gather information about the stability of the child's speech including how they progressed through treatment and how they have responded to the reduction of verbal contingencies throughout stage 2 and to use this information to make an informed decision about the Stage 2 visits a child would need.

Webber, M., & Onslow, M. (2003). Maintenance of treatment effects. In M. Onslow, A. Packman, & E. Harrison (Eds.), *The Lidcombe Program of early stuttering intervention: A clinician's guide* (pp. 81-90). Austin, TX: Pro-Ed.

 I am about to start the LP with a child of 4 but he seems completely unaware of his stutter. Is this likely to be a problem with treatment?

 It is not a requirement of the Lidcombe Program that children are aware of their stutter. However, some children learn to differentiate between stutter-free and stuttered speech throughout the course of treatment. Some may ask for evaluation of their fluent speech (e.g. "Was that smooth?") or evaluate their own speech (e.g. "I'm a smooth talker" or "Oops, I did a bump!"). Although these are desirable responses, they are not essential.

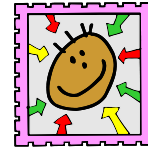
The purpose of verbal contingencies for stuttered speech is to occasionally help the child achieve fluency. It is not to make them aware of moments of stuttering. Therefore, when implementing contingencies for stuttered speech, it is important that they are delivered in a supportive manner that is sensitive to the child's temperament.

**Our very grateful thanks as ever to the Bankstown team for Dear Sue and Just Explain: Verity MacMillan, Stacey Sheedy, Mary Erian, Wendy Lloyd and Sally Nicoll**

## Using Tangible Rewards

by Mary Kingston

*At the Lidcombe work shops we do have some discussion about tangible rewards. However there never seems to be enough time to discuss them in the detail that therapists are looking for. The following article is an attempt to fill that gap. Its aim therefore is purely practical, and is designed as a resource sharing exercise rather than a discussion about the theoretical aspects of tangible rewards, or why children and their parents (and clinicians) may or may not respond to them. It is a pooling of ideas gathered together over a number of years from both parents and clinicians which will, I hope, prove useful to those of you who like to use tangible rewards.*



Tangible rewards are used in many different ways in treatment and the following ideas are just some of the more commonly used ones.

### Stickers and stampers

Stickers are commonly handed out at the end of a clinic session as a reward for the smooth talking accomplished within a session. There are innumerable websites selling these resources which are easily accessed by searching for “stickers and stampers” or “merit stickers” etc. There are also many different colourful stampers to buy but personalised ones are fun and the children love them. For example I have one that says : “Mary says ‘smooth talking’ which I obtained at a very reasonable price from an internet site.



Stickers are also used generally as a motivating agent (see the case study by Sam David, Edition 37, p 4) and as a way of emphasising smooth talking in unstructured situations. Children may for example be told that they will receive x number of stickers if they can achieve a 1 in a day’s severity rating, though this would only be used if the child were for example already on 2s, and possibly a bit stuck at that level.

### Tangible rewards as part of structured treatment



In the early stages of treatment rewards may be handed out with contingencies for stutter-free speech. Typically these are elements of a game - the swords from Pop Up Pirate is a perennial favourite. When the therapist/parent says e.g. “That was smooth” the child is given a sword. When all the swords have been won the child and parent/therapist play the game together. Basically any games with elements to them can be used e.g. Hungry Hippo, Kerplunk, Manic Martians, peg boards, collecting parts of a magnetic car, bits of lego and so on though the number of elements should be regulated. The advantages of using these rewards are many, among the most important being: a) to reinforce the verbal contingencies b) to provide a prompt for parents to give the verbal contingencies and c) to give a structure to the talking time i.e. a beginning and an end and d) to have fun and motivate the child.



## Things to remember about using tangible rewards

- The rewards need to be organised so that they don't become a distraction. It is a good idea e.g. to have a box in which to put the swords from Pop Up Pirate during the treatment time and not to play the game until they have all been won.
- Try to keep the treatment conversation more entertaining than the rewards or the focus of treatment will be lost and they will become a distraction.
- The rewards don't all have to be elements of expensive games- parents have to do this every day after all. Anything can be used. For example, tokens, tiddlywinks, bits of playdoh, even torn up bits of paper which when they have been won allow the child to choose the activity they would like as their reward. Once the concept has been understood the possibilities are as endless as the parents' creativity!
- The tangible rewards used as part of structured therapy may be faded out after a couple of weeks or so, in order that the **verbal** contingencies are perceived as the important part of treatment. If children ask for their 'game' after therapy it can still be played but without the elements needing to be won along with the contingencies. It is just used as a reward after the smooth talking time. Eventually, as more unstructured treatment takes over, and toys and games are able to be used in the actual treatment time, this fades out naturally.

### Tangible rewards as part of Unstructured Treatment times

While rewards (apart from e.g. stickers after a clinic session) may have been faded out after the first few weeks of treatment, they sometimes come back into their own towards the end of Stage I. They are not always necessary, and some parents/children don't like them, but in the right circumstances they can have their uses. These might include children who are stuck on 2s or who have become over accustomed to contingencies so an added extra is required.

They may therefore become an added reinforcement for contingencies for stutter-free speech in the unstructured conversations of everyday life. The Star Chart concept is useful here and it can be used in many different ways. Over the years that I have worked with parents with the Lidcombe Program I have been hugely impressed by the ideas they have come up with following this theme. Here are a few of the best (and there are some more at the end of this article in the Hot Tips section which has been published before but which newer readers may not have yet seen).

#### A) **The basic Star Chart.**

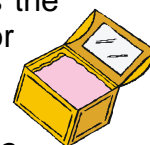
The child and parent decide what the chart should look like. They also decide what the ultimate reward will be. Then they design the chart together e.g. a picture of a Thomas the Tank Engine, Spider Man etc (whatever delights the child) which has a grid of about 24 spaces on it which will mean it lasts about a week. During a week of treatment when the parent is giving many contingencies for stutter-free speech throughout



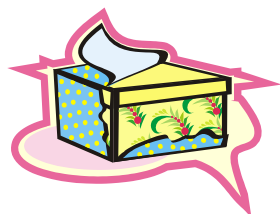
the day they pick on about 3-4 each day as 'star worthy'. "That was SO smooth when you said that, I think you should get a star!" The child then puts a star/colours in one of the spaces in the grid. When all the spaces are filled the child wins the ultimate reward which has been agreed upon in advance. This need not necessarily be an item the child wants but could be e.g. choosing their favourite meal, going to the park with Dad, staying up a bit later one night and so on...whatever feels rewarding to the child.

## B) Some variations on the same theme...

- One parent, instead of using the star chart, used the concept of a treasure hunt. It worked in just the same way but instead of winning stars to stick on a chart, the child won arrows. After they had won all the arrows the parent put these down around the house and garden as a trail for their child to follow and at the end was the 'treasure'!



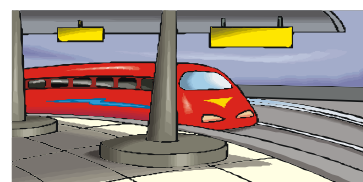
- Another parent used the idea behind 'pass the parcel'. (*This is a game that is played at children's parties in the UK (and elsewhere I'm sure) where the children sit in a ring while music is playing in the background. There is a parcel which contains a small reward wrapped in many many layers of paper which is passed from child to child while the music is playing. When the music stops the child who happens to be holding the parcel at that time is allowed to tear off a layer of paper from the parcel. No-one knows when the reward will be won and it is luck who will win it!*) Using this idea the parent adapted the game to her child's smooth talking. She wrapped a small gift in many layers of paper and placed it on a shelf where it was visible to her



child. As she gave out contingencies in unstructured situations throughout the day she randomly decided that a particular utterance of her child was worthy of taking off a layer of paper. The

child was very motivated to speak smoothly as he wanted to win the gift and the game had the added bonus of reminding the parent to give the contingencies.

- Yet another very creative parent used her son's love of trains to help with contingencies in unstructured situations. Together they drew a train track with stations spaced along the track at intervals. As she gave contingencies for smooth talking during the day she would randomly decide whether one was worthy of colouring in a space on the train track.



When all the spaces were filled, and the child arrived at a station, he won the reward which was written beside the station. These rewards included such things as "A visit to Norwich train station" or "Choosing a sticker book with trains" and it culminated in the ultimate prize which was a ride on a train. In this way she was able to keep the chart going for quite a while!

- Yet another idea is one that a parent of a child who loved puzzles thought up. She and her child decided together what he was going to win and the child drew a picture of this reward. The mother then cut the picture up into many pieces, like a jigsaw puzzle, and then, following the same principles outlined already, gave out pieces of the picture with the contingencies for 'smooth talking'. The prize therefore grew before his eyes!



### Things to remember

- The ultimate reward must be something the child really wants to do/have.
- It is of course up to you and the parent how long to make a star chart, and its variations, last (a day, a week or whatever is appropriate for the child and family) and how you do this will depend on how many spaces are made on the chart and how many contingencies are chosen as special per day.
- Where there are siblings who are aware of the rewards the stuttering child is receiving, the chart needs some thought. After all, these siblings may say, "We talk smoothly all the time and we don't get anything for it..!" Parents have worked around this by e.g. making star charts for other things for the brothers and sisters of the stuttering child, or by making the reward the child receives something which **all** the family can do together. In this way siblings will want to work **with** the stuttering child!
- I have heard that some parents interpret the star chart idea in a pass/fail way i.e. that unless a child has done smooth talking (e.g. all day) they don't get any reward. This does not seem to me to fit the principles of the Lidcombe Program and is not recommended. The way outlined in the examples above fits in much better and is very rewarding for the child.
- It is imperative that the reward that the parent has promised does actually materialise. It is essential therefore that the chosen reward is something that the parent can manage and is fairly immediate.

*These are just a few ideas that I have come across while working with the Lidcombe Program, some from parents, some from colleagues. If anyone has any other ideas they would like to share through the Lidcombe News please do send them in. We would also be very happy to print any comments you may have about the use of tangible rewards in general.*

*On the following page is a reprint of Hot Tips originally published in editions 12 and 17 but which newer readers may not have seen. It contains a synopsis of some of the ideas above and a few others not mentioned in the article.*

## Hot Tips

Some of you will have seen a few of these before but newcomers may like to try them out. Some are ideas from my own clinic, and some were sent in by Rosemarie Hayhow and Lizzie Hunt.



If you are looking for a new idea for a star chart, how about this one from Lizzie Hunt in Cambridge, UK? Instead of a chart use a parcel, and instead of sticking **on** a star, take **off** a layer of paper! In other words 'pass the parcel', with the prize at the end, to make praise for smooth talking extra special. This is good for children who need a more immediate type of reward. *(See article above for full description)*



A parent of a child I have been seeing came up with another good idea for the same process. Instead of stars her son won cardboard arrows, and when he had won the requisite number she laid them down as a Treasure Hunt trail which he then followed until he found his prize. *(See article above for full description)*



More hot tips from Lizzie in Cambridge! One of her parents came up with this idea for a reward. Instead of using a star chart the child drew a picture of the prize they were going to win, cut it up like a jigsaw, and then won the pieces one by one. The child could then see the reward growing in front of his eyes! *(See article above for full description)*



One of Rosemarie's parents drew a page of stick people without faces and the reward was to put a smiley face sticker onto each one.



Another idea on the star chart theme is to draw some sheep in a field and stick a piece of cotton wool onto each one as the reward. A similar idea would be to draw a snail with a spiral shell which is divided into segments, and then put a sticker, or colour in each section.



Again on the same theme, a parent of mine had the idea of making a train track (her son was mad on trains) and putting stickers into the sections. The final reward was at the station where her son had drawn a picture of what he was going to win when he got there. *(See article above for full description)*



One parent of Rosemarie's had the idea of drawing each letter of their child's name onto a page in a scrap book. They made each letter quite wide so that there was space to fill it up with stars.