Lidcombe News

May 2012

Edition 43

Not only is it Lidcombe News' fourteenth birthday but this special edition of the newsletter is entirely dedicated to the theme of bilingualism and the Lidcombe Program. There is an article by Rosalee Shenker from the Montreal Fluency Centre in Canada, and from the UK we hear about the work of Corinne Moffatt and Sunita Shah which is very much involved with this area of expertise. Dear Sue and Just Explain That Again have their input on this topic (problems with measurement, and the use of interpreters are also visited in Corinne and Sunita's article) and I have also included a headline summary and references to all the articles and questions on this theme from previous editions of Lidcombe News. In addition I have collated all of these separately and in their entirety for you and sent them as an attachment with your newsletter.
First of all though we have the usual dates for your diary with the Lidcombe Link Days and news about workshops in the United Kingdom.

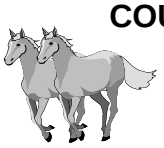
DATES FOR YOUR DIARY

Central England is holding its next Lidcombe Link day on **Wednesday 11th 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 for further details if required.

Contents

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

Norwich is holding a Link day on **Tuesday, October 23rd 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** If you have not been before please let Sally Lelievre know in advance as there is a possibility the venue may have to change.



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.

A **London** based course is being held on Tuesday and Wednesday **July 17th & 18th 2012** 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.

I had hoped to be able to advertise another workshop for March 2013 but our usual venue at the Royal College is not accepting bookings at the moment as refurbishment is taking place throughout the autumn of 2012 and the Spring of 2013. It is hoped that the work will be finished by February of 2013 but until this is confirmed we cannot advertise a course.
We will be looking at other venues either in London or in Norwich, but in the meantime:

If you are interested in attending a workshop:
Contact: **Sally Wynne** on email: **lidcombe@live.co.uk** or
Mary Kingston on email: **kingstonamee@talk21.com**

and we will let you know as soon as there is any news. Could you indicate whether you would be happy to travel to Norwich if there is any difficulty finding somewhere suitable in the London area.

MISCELLANEOUS

I am trying to put together a list of contingencies used in languages other than English for the next edition. If you can help with this please could you send them to me at **kingstonamee@talk21.com** Many thanks in advance!

Treating Stuttering in Bilingual Children: Is the Lidcombe Program viable?

Rosalee C. Shenker
Montreal, QC, Canada

In recent years there has been an increase in requests for information about the treatment of stuttering in bilingual or dual language children. In Canada, my home, there are 100 languages spoken and in Quebec, the province where I live, 41% of the population is bilingual. In Montreal, where I live, one out of every 6 school age children speak a language other than English at home. Worldwide, it is estimated that there are more second language speakers of English than native speakers and that there are as many bilingual children as there are monolingual children. Related to this trend toward increased bilingualism, there is a growing demand to provide appropriate assessment and intervention for dual language learners with all communication disorders. In spite of the need, little clinical research exists to show the effectiveness or efficacy of treating bilingual children who stutter.

Bilingualism does not mean speaking two languages perfectly. In fact the issues cited above are further complicated by the type of bilingualism. For example, some children are raised bilingually from birth or have had two or more languages input before the age of 3. For some children their first language (L1) is a minority language not spoken in schools. Some children will find themselves immersed at school entry in a second language (L2), while others will learn the majority societal language at school entry with little preparation beforehand. Another category of dual language learners with their own special characteristics and unique needs are the internationally adopted children. It is clear that most Speech-Language Pathologist will find themselves faced with the assessment/treatment of a child representing one of these categories of bilingualism at some point in their careers.

There are two types of dual language learners.

Simultaneous Language Acquisition occurs when a child is raised bilingually from birth or when the L2 is introduced before age 3. These children go through the same developmental stages as children learning only one language. They may start talking a bit later, but are still within the normal developmental range. From the beginning of language development they seem to be acquiring two separate languages, and early on they are able to differentiate two languages, and can switch languages according to their conversational partner.

Sequential language acquisition occurs when a second language is introduced after the first language is well established, usually at 4 years or older. This category also includes those children who emigrate to another country where a different language is spoken, or upon school entry. These children may use their home language for a brief time, they often go through a silent or nonverbal period when first exposed to the L2, and it is during this time of a few weeks or months that a base comprehension is built. Younger children may remain at this stage longer and often first start to communicate with gestures or simple words. They begin to speak with short or imitative sentences and may ask for labels, or respond with ‘I don‘t know’. Eventually, when they begin to produce sentences, some of the mistakes made may be due to the influence of the syntax and structure of the first language.

There are several myths about bilingualism. One is that the home language of the child interferes with and impedes acquisition of a majority language as L2 in the context of school. However, there is growing evidence that maintenance of the home language can actually facilitate L2 learning. There is no evidence to support the idea that stopping speaking the home language with a child will increase the child's learning of his L2, or that frequent use of the L2 at home is essential for a child to learn it. Many feel that the risks of a child becoming isolated from family members who only speak the home language greatly outweigh any benefits of reducing or eliminating this language.

Another common myth is that when children mix their languages it means they are confused or having trouble becoming bilingual. This is *code mixing* and it does not reflect the inability to separate the languages. In fact code mixing is used by children to close a lexical gap…to access a word that they know in order to complete an idea…rather than a sign of language confusion. Code mixing is a natural and expected part of bilingual development.

Finally, it is commonly suggested that parents should adopt the 'one language-one parent' approach when exposing their child to two languages. There is no evidence that suggests that this is the best way to raise a bilingual child. Parents should speak to their children in a way that is both comfortable and natural.

A common myth is that speaking two languages might trigger stuttering, or exacerbate it once it occurs. While there is no evidence to suggest that bilingualism itself causes stuttering, there are only a few studies to support this idea.

The ***Lidcombe Program*** should be a useful treatment protocol for young bilingual children since one of its primary objectives is training the parent to provide treatment in beyond clinic settings. This makes it easy to adapt for dual language children. There are at least 7 case studies of the use of the Lidcombe Program with children speaking two or more languages.

In a few cases the treatment was conducted in one language only. Shenker et al (1998) and Rousseau (2006) treated bilingual French/English children in only one language. Shenker and colleagues found that a 3 year old treated initially in English (the stronger language) made significant increases in fluency in both English and French languages after 7 weeks. Rousseau found the same providing the Lidcombe Program in French only with a 7 year old child.

When each parent speaks a different L1 and both parents wish to provide treatment in the Lidcombe Program can it be effective? There are several descriptions of the Lidcombe Program provided by parents in both languages spoken (Roberts & Shenker, 2007 ; Harrison, Kingston, Shenker (unpublished manuscript) ; Shenker, & Roberts, 2007 ; Bakhitiar and Packman, 2009) with all children meeting the criteria for Stage 1 within the same time frame that has been found for monolingual children. These studies are described in greater detail in Shenker (2011 a & b).

Three studies have provided benchmarks for treatment time in Stage 1 for the Lidcombe Program, in Australia, the UK and North America. The clinic files for 250 Australian, 66 British and 138 North American children were

independently audited to see if the duration of treatment time could be predicted. The median number of clinic visits to Stage 2 for monolingual children was about 11 sessions, replicated for each of the three studies.

Findlay and Shenker (2010) replicated these file audits to establish benchmarks for a clinic sample of children from dual language environments. This audit was comprised of 52 preschool age children who were assessed, diagnosed and treated at the Montreal Fluency Centre. All were exposed to two or more languages in the home and/or school/daycare setting, as reported by the parent during the initial assessment of the child. The median onset of stuttering to onset of treatment was 15 months. The median number of clinic visits to complete Stage 2 was 12, with a range of 6-44 visits. By 27 visits 90% of the children had completed Stage 1. The median stuttering severity at first treatment session was 5%SS with a range from 0.5-19.6%SS. All children achieved the manualized criteria established for Stage 1. We concluded that the outcomes of this file audit are similar to other retrospective file audits. This lends support to the notion that linguistic diversity does not impact treatment time with the Lidcombe Program. These findings, although comprised of a small number of cases, lend support to our clinical intuition that being bilingual does not increase the risk of stuttering in preschool age children and is, in fact, 'just a different kind of normal from monolingual'. (Paradis 2011).

References for a general overview of both Bilingualism and Bilingualism and Stuttering

Paradis, J. Genesee, F., & Crago, M. (2011). *Duel Language Development and Disorders: A handbook on bilingualism & second language learning.* Baltimore, MD: Paul H. Brookes Publishing.

Roberts, P.M. and Shenker, R.C. (2007) Assessment and treatment of stuttering in Bilingual speakers. In E.G. Conture and R.F. Curlee (eds) *Stuttering and Related Disorders of Fluency* (3rd edn). New York: Thieme Medical Publishers.

Shenker, R. C. (2011). Treating Bilingual stuttering in early childhood: Clinical updates and applications. In Howell, P. and Van Borsal, J. (eds.). Multilingual aspects of fluency disorders, Multilingual Matters, Bristol, UK.

Shenker, R.C. (2011). Multilingual children who stutter: Clinical issues. Journal of Fluency Disorders, 36(3), 186-193

Dear Sue

I have recently assessed a child with a stutter who I feel would be good candidate for the Lidcombe Program. I discussed with the mother what the treatment would entail and when I mentioned measuring she suddenly became rather unsure about doing the treatment after all. I then discovered that she was unfamiliar with charts or recording measures with numbers and did not think she could cope with this. Has this ever happened to you in your practice and were you able to overcome this difficulty? If so I would be very interested to hear how you solved this problem.

There are some parents who do have more difficulty with using the rating scale than others and occasionally parents who are unfamiliar with charts or recording measures. Some get confused and use the scale in reverse or add a zero to the scale. When these situations have arisen, I have found it helpful to remember what the ultimate purpose for collecting these measures is, in order to determine whether the child is improving or not, and when they have met criteria for Stage 2. If you keep that in mind then you might be able to come up with a suitable method for gathering that information. I have used visual representations of a line scale with end points marked and asked the parent to indicate the point that they think represents the severity of the stutter.

Additional strategies may also be useful in your situation such as relying more on questions about the types of stutters and whether they seem more or less severe than the day before. I would also use recordings of the child's speech from home to supplement this.

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Our grateful thanks for this edition's Dear Sue go to Stacey Sheedy, Mary Erian and Angela Nikolas from the Bankstown Stuttering Unit, in Sydney, Australia.

Many thanks too for the "Just Explain That Again…" question below from edition 33 to Margaret Webber, Verity MacMillan & Kylie Farnsworth from the Stuttering Unit in Bankstown, Sydney for their very full and considered response to this question.

Just explain that again...

I know that the area where the Lidcombe Program was developed is a multi-cultural area. Do you have parents who do not speak English at all? If so, do you use interpreters? What problems, if any, do you have working through interpreters? How have you overcome these?

Yes we do have a number of parents who do not speak English and so we often use the interpreter service. Some of the problems and potential solutions are as follows.

1. Difficulty demonstrating therapy (especially if child doesn't speak English either)

Solution: Allow for increased time spent on description about how to do or change therapy. Allow for increased observation of parent doing therapy (clinician watching with interpreter) followed by discussion. Allow for increased use of videoed therapy sessions, watching these with parent and interpreter, to address specific aspects of therapy.

2. **Clarifying identification of subtle stutters for both clinician and parent.**

Solution: It may take longer to ensure stutters are identified accurately before therapy can proceed. Plan for taped or videoed footage to play back examples of stuttering behaviours.

3. **Appointments often move more slowly (things said twice) and so the amount of information given/received may be reduced & may extend amount of therapy required**

Solution: Be prepared for this and just work with it.

4. **Increased numbers in the room (3 adults to one child). If the child is shy or uncertain, this number of adults may reduce their comfort communicating at all in the clinic**

Solution: Use observation room if this is available. Use recorded footage of child for speech samples and for therapy.

WORKING WITH CHILDREN AND FAMILIES FROM DIVERSE COMMUNITIES USING THE LIDCOMBE PROGRAMME

Corinne Moffatt & Sunita Shah
Corinne has worked in Tower Hamlets in London's East End for a number of years as a dysfluency specialist, where she has had the opportunity to gain experience in offering the LP to a diverse community. She also works as a clinical educator at the Compass Centre, City University, in the stammering clinic, seeing clients across the age range and using the Lidcombe Program (LP) with younger children.

Sunita has worked as a clinician for over 10 years. She works for Brent Community Services, which has a vast multi-lingual community and over 120 languages are spoken in her geographic area. Sunita is multi-lingual, and has delivered the LP in Gujarati and Hindi. She is currently the chair of the London SIG Bilingualism.

In this article we are combing both our personal and clinical knowledge and skills to discuss the delivery of the Lidcombe Program to children and families from diverse communities.

Prevalence of Additional Languages

There are approximately 200 countries in the world and approximately 6,909 living languages. *(Ethnologue:Languages of the World).* In the UK, particularly in the cities, we have communities that are linguistically diverse, and with the movement of people due to immigration, migrant labour, refugees and those seeking asylum, we see a constant change in the range of languages in use in any given population. There are therefore a significant number of children accessing Speech and Language Therapy services who we would describe as bilingual.

<u>What is Bilingualism?</u>

Definitions of bilingualism vary. Dictionaries tend to define bilingualism as being two languages spoken with equal or near equal proficiency to each other.
For example the *Cambridge Dictionary* states (of a person): able to use two languages for communication, or (of a thing): using or involving two languages.

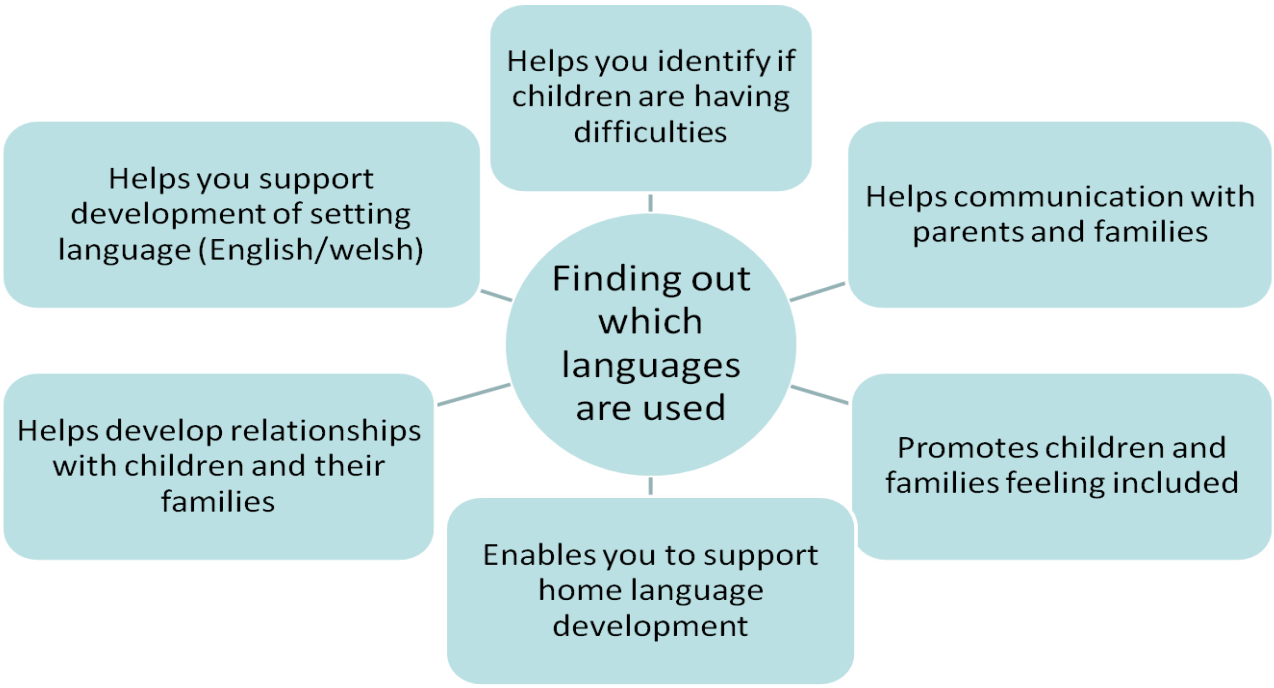
The Royal College of Speech and Language Therapists (2006) defines the term bilingualism rather differently as: "individuals or groups of people who acquire communicative skills in more than one language. They acquire these skills with varying degrees of proficiency, in oral and/or written forms, in order to interact with speakers of one or more language at home and society. An individual should be regarded as bilingual regardless of the relative proficiency of the languages understood or used".

Similarly, the Department for Education in the UK in "*Excellence and enjoyment: learning and teaching for children in the primary years" (DFES*

2006) defines the term as follows: “Bilingual is used to refer to those children who have access to more than one language at home and at school. It does not necessarily imply full fluency in both or all of their languages”.

Delivering Speech and Language Therapy (SLT) Services in the UK

As speech and language therapists we need to be prepared to rise to the challenge of providing an equitable service to children and families for whom English is not the home language. It is important therefore for services to know which languages are spoken by the communities in the area they serve:



Stuttering and Bilingualism

About five in every hundred children stutter for a time when they are learning to talk. Given that it is considered that about 50% of the world's population is bilingual, there is a large number of children who show signs of stuttering whilst learning to speak more than one language. However, this does not mean that there is a link between stuttering and being bilingual. There has been little evidence to suggest that learning more than one language causes stuttering. However, a relatively recent study by Howell et al (2009) aimed to examine the stuttering of children who speak an alternative language to English and the possible effects of being bilingual on dysfluency. It concluded that bilingual children are more prone to start stuttering and that if a child uses a language other than English in the home, deferring the time when they learn English may reduce the chance of onset of stuttering. One point of interest was that many children in the study presented at clinic a long time post-onset and so, without help, were possibly at greater risk of their stuttering persisting.

John Van Borsel (2011) recommends caution when interpreting studies about the prevalence of stuttering in bilinguals. He cites difficulties with making accurate assessments of stuttering in bilinguals where the researcher is likely to only have linguistic skills in one of the languages being assessed and

therefore may not be able to make accurate assessments of stuttering in the other language.

The question as to whether bilingualism is at the root of their child's stuttering is often a concern to parents. The advice we tend to give is that there is no real evidence to suggest that children who have two languages in the home are more likely to stutter. The leaflet published by the British Stammering Association is often useful for parents with these concerns and can be found at:
http://www.stammering.org/bilingual.html

Using the Lidcombe Program with children where English is not the home language

There are a number of challenges to be faced by a speech and language therapist in providing the LP to children for whom the home language is not English. We hope that by sharing some of the ways in which we work, we can provide some ideas that may be useful.

1. Issues to consider before offering the Lidcombe Program.

A. Equality of Access

As the LP is designed to work on *early stuttering* the age at which children access services is important if it is to be offered as a treatment option. Clinical audits in Tower Hamlets have shown that bilingual children, or monolingual non-English speaking children, tend to be referred considerably later post onset than their monolingual English speaking peers. Some Universal level work, to promote early identification and referral, can therefore be an important task to undertake when serving a multi-lingual community in order to ensure equity of access to specialist dysfluency services. This could be offered through giving brief talks to Early Years workers and community groups.

B. Deciding whether to offer LP

It is vital before beginning the LP with any child that the clinician is satisfied that the programme will be delivered safely. When working with bilingual families it is particularly important to bear in mind some additional factors before commencing therapy.

Firstly, it is essential that the parent who comes to the clinic is the one that will do the treatment at home. In some cultures it might be the case that the father comes to clinic but he may be unlikely to do the required activities at home with the child, as this is more likely to be the mother's role. In addition where children are living within an extended family there is a greater likelihood that people other than the parent attending clinic would see it as their role to assist in treatment at home. Therefore some careful negotiating about who is delivering the treatment is needed before therapy begins.

Secondly, it is vital to establish whether the parent is able to operate in English or whether support is required. In order for the Lidcombe Program to

be safe, it has to be conducted accurately; parents must be able to understand all instructions and demonstrations and the clinician must be confident that the parent has been observed conducting therapy in the correct way and that the feedback has been understood. Where parents do not have a level of English that would enable safe implementation of the program, careful consideration needs to be given to how they can be supported via bilingual co-workers or interpreters. It is important to note that, whilst it may be necessary to modify the delivery of therapy when working bilingually, if the program is altered too much you are not doing LP and the intervention you are providing is not therefore evidence based. It could even have a negative effect on the child's stuttering.

We find that the LEARN model (Berlin EA; Fowkes Jr WC, 1983) is useful in helping us work with children who stutter and their families, to ensure that the necessary conversations have taken place before therapy begins.

LISTEN with sympathy and understanding to the patient's perception of the problem

EXPLAIN your perception of the problem and your strategy for treatment

ACKNOWLEDGE and discuss the differences and similarities between these perceptions

RECOMMEND treatment while remembering the patients' cultural parameters

NEGOTIATE agreement. It is important to understand the patients' explanatory model so that treatment fits in their cultural framework

We need to spend time *listening* to parental views and understanding of stuttering and what they hope for their child; *explaining* our understanding of stammering and how therapy can help; *acknowledging* that this way of working, with parents conducting therapy at home, might feel alien to families at first and not meet their initial expectations of what therapy might be; *recommending* the approach that seems most likely to be beneficial and *negotiating* how the LP could help their child and how it could fit into their everyday lives. Through having these discussions, it is more likely that parents will go on to engage fully in the process of therapy.

2.Things to consider within the Programme itself

A. Issues with measurement

Some general points to consider...

In Edition 14 of Lidcombe News (September 2002, page 6/7) Rosalee Shenker made the following comment about the difficulty of making accurate judgements about stuttering in a language not the clinician's own. "Finn & Cordes (1997) raised concerns about the clinician's ability to make accurate judgements about frequency and severity of stuttering in a language that is not their own, citing the fact that no empirical evidence exists that would indicate how well clinicians are able to perform this task. They point out that one way of achieving more reliable judgements about the presence of stuttering may be through consensus between parent and clinician. This may be particularly useful when the second language is not one in which the clinician is familiar with and helps the clinician to make reliable judgements about the presence of stuttering in unfamiliar languages".

This clearly illustrates that the reliability of measurement is always an issue if the clinician does not share a language in common with the child and family.

Assessing frequency of stuttering can be particularly problematic making the calculation of percentage syllables stuttered (if used) in another language potentially invalid. For example, if the therapist does not understand the language spoken by the family then they will not be able to count stuttering accurately in the sample of language spoken e.g. a word like "baba" (Arabic for father), maybe counted as a dysfluent word (syllable repetition), when this is an accepted structure for this language.

Another issue we encounter is where the child may be reluctant to speak their mother tongue in clinic, preferring to speak to the clinician in English. The sample of speech obtained may therefore not be representative and it could also be difficult for the parent to make an accurate Severity Rating if they are not comfortable or able to do this in English.

Some other issues we come across in relation to measurement are parents' lack of familiarity in recording data on a graph and so alternative ways of doing this might facilitate them in doing the daily ratings.

<u>Ideas to help with recording measures</u>

- For families who speak English in addition to the home language, collect Severity Ratings for both languages from the parent. Ask the parent to listen to the child across the day and provide severity ratings **in each language**. Discuss and decide how this will be recorded. In addition listen to both languages in clinic, if the child will use them, to help verify the parents' ratings. Be aware that the child may mix languages, and this is perfectly normal, and acceptable.

- Using a table format for severity rating scales may be easier for the parents to fill in if they are unfamiliar with graphs. Below is an example that Corinne uses in Tower Hamlets. Parents are first given a pictorial representation of stuttering severity. Then the days of the week are written in table form where the parent just needs to put the SR in a box (see fig.1). Corinne then transfers this onto the graph in the case notes during the session. This system has worked well and has allowed SRs to be recorded accurately each day.

Fig 1 Severity Ratings

Listen to your child's speech carefully each day. Rate their stammering on a scale of 1 to 10:

1= completely fluent or smooth
_____

2= very small amount of stammering or bumpy talking
_____**/**_____**/**___

10= very severe stammering
_/__/___/_____/_____/_/_/___/___/_/\/\/\/____/___/\/___

Record your daily ratings below:

DATE /DAY	**Severity Rating 1-10**	
	Language A	Language B
Tuesday 8th		
Wednesday 9th		
Thursday 10th		
Friday 11th		
Saturday 12th		
Sunday 13th		
Monday 14th		

B. Issues with the process of treatment

Some general points to consider..

The Lidcombe Program requires a high level of parental commitment for all families. The clinician needs to encourage families to engage in the treatment process as many parents can feel under confident in their skills in the initial stages. For non- English speaking families a breakdown in communication (interpretations lost in translation), can reduce morale/commitment and common ground, and these families may cease attending.

When delivering the LP in another language it is important to have a consistent person delivering and validating its use. It may not be possible to book the same interpreter for each weekly session in which case a delivery model using interpreters would be less favourable. Services have to be aware of equity and which other options for treatments are available for these families.

The therapist is unable to identify/ monitor/ model the use of language in the family's home language and therefore cannot gauge whether the parent has learnt to structure the treatment appropriately. It would not, for example, be clear whether the parent is aware of how to elicit short, stutter-free responses from a child. In some languages the structures are different and modifying the utterances to 2-3 words may lose the main content/vocabulary of what the child is saying, thereby losing the sense of the sentence. If treatment is not appropriately structured we cannot be sure that the verbal contingencies are being used correctly.

The way in which treatment is delivered will depend upon whether the family does or does not have a level of English adequate to carry out the LP. The following suggestions are ways in which we work to assist bilingual children and families who do have functional English:

- Encourage parents to generalise the therapy at home in the language/s that they would usually speak with their child. Parents are more likely to be able to structure treatment appropriately whilst using the language that feels natural to them and their child.

- Book an interpreter at regular intervals to discuss the progress of the LP and to clarify any points that the parent or clinician may not have fully understood.

<u>Ideas to help with treatment</u>

- **Resources**

It is particularly important to pay attention to **resources** when working with children and families from a range of cultures as parents may feel more supported and involved when these are adapted to their needs. We have found the following helpful:

(i) Keep written information clear and simple
(ii) Use pictures and symbols
(iii) Ensure different cultures are represented in resources and materials
(iv) Think of alternatives to written information
(v) Use translation and interpreting services
(vi) Ask for parents' feedback

As LP therapists we are always keen to keep **therapy materials** engaging for children and their families so that they are happy to do their "smooth talking" practice. Bearing in mind the following points may be helpful:

(i) Reflect different language and cultures through using diverse e.g. familiar objects to the child.
(ii) Include real familiar objects and props
(iii) Include real examples and scenarios
(iv) Use familiar vocabulary and names
(v) Include familiar pictures, symbols, photographs
(vi) Include translated materials where appropriate
(vii) Include words to support language learning (i.e. a balance between familiar words and introducing new vocabulary)
(viii) Follow the child's interest, e.g. if they like Ben 10 use this to engage them in therapy but take care not to over stereo-type with the resources presented.

Through the use of appropriate and familiar materials effective inclusion will be supported. The child may feel more confident, and a clearer picture of the treatment process will gained if familiar materials and approaches are used. In addition any difficulties in the child's development of their home language will become more apparent.

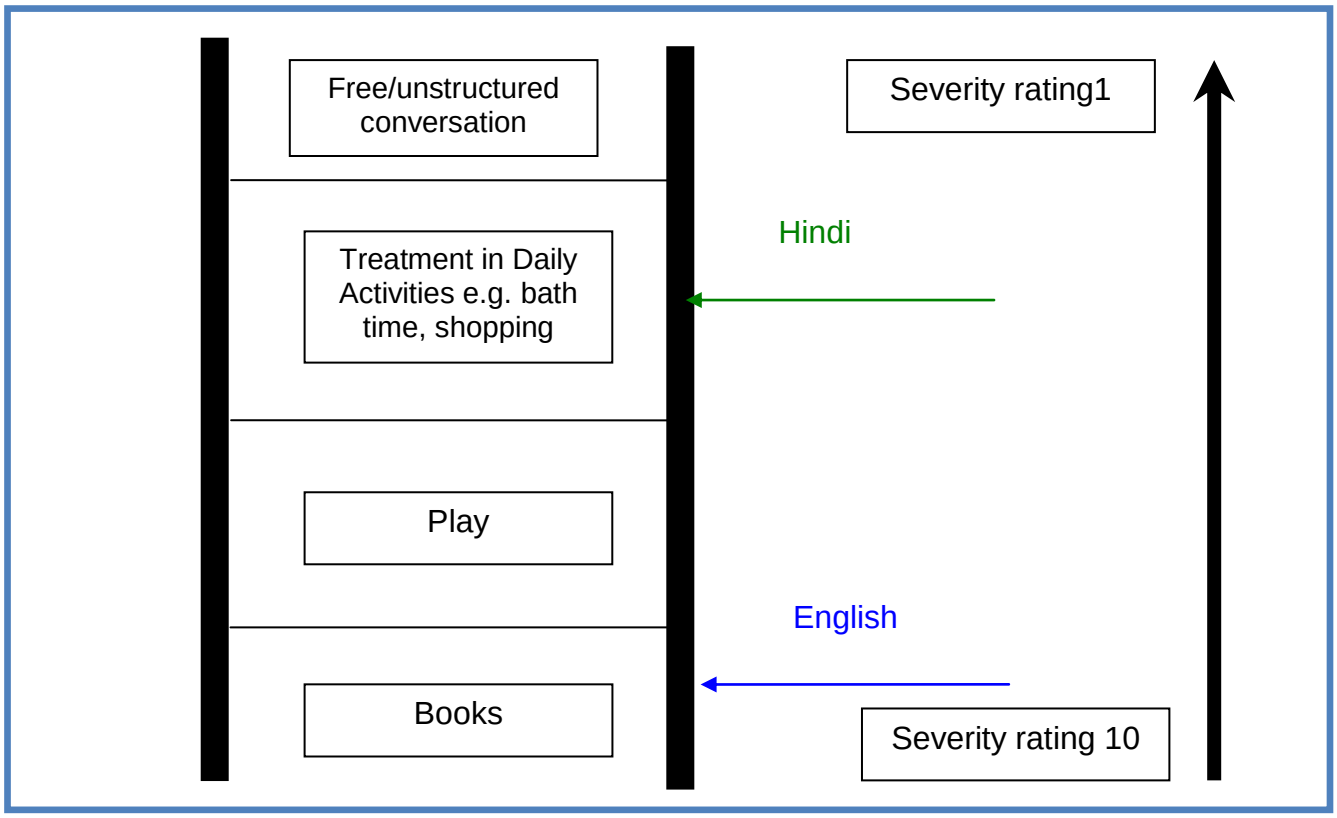
For more specific ideas on resources see Corinne's article on Story bags / toy bags in Lidcombe News edition 23, September 2005, pages 14-16. These 'smooth talking bags' are designed for parents who have limited resources when treating at home.

- **Structure**

It is a common pattern in a child who is bilingual that the level of dysfluency is higher in one language than another. It is appropriate therefore to vary the structure when using verbal contingencies for each language. For example, if a child is fully competent in Gujarati and Severity Rating are 1-2s we advise parents to use verbal contingencies in unstructured situations. If the same child's speech is more dysfluent in English, with ratings of 4-5s, we encourage the parent to use a structured activity when delivering verbal contingencies in this language.

In order to help parents structure treatment for each language when there is a disparity in Severity Ratings between the two languages, Sunita uses the following visual representation (Fig 2, below) in her borough of Brent, London, UK.

Fig 2



- **Contingencies***:*

It may be useful to collect terminology in different languages for "smooth and bumpy talking", although it is fine to continue to use "smooth" and "bumpy" and mix these words into the home language for consistency. In some languages is may be difficult to translate smooth and bumpy into a single word or find a suitable translation at all.

Models of Service delivery for the Lidcombe Program

We have described below the models of Service delivery in our respective boroughs.

Tower Hamlets

We are fortunate in having the support of bilingual co-workers to enable us to deliver therapy for all children, including the LP for children who stutter. This enables us to work effectively with children and families who may have very little English. The co-worker works alongside the SLT in the session to:

- assist in teaching parents to do a severity rating and verifying these each session
- enable parents to learn to structure activities
- model treatment through the use of verbal contingencies
- support parents in thinking of ways to carry out treatment at home.

The co-worker assigned to work with children who stutter will be trained specifically in the identification of stammering and judging severity as well as in giving verbal contingencies. He or she will also of course need to be able to accurately interpret the SLTs questions and feedback to the parent, as well as from parent to therapist. Sessions tend to run in a triad format - SLT models treatment, co-worker then picks it up and models in the home language, the parent then does treatment and the co-worker and SLT give feedback. This of course does mean that sessions are slightly longer and more complicated and it does seem that a higher than average number of sessions is required to work through Stage 1.

Brent Community Services for Ealing Hospital NHS Trust Model

Brent Community Services offers the LP within a community clinic setting. There are five clinics around the borough and each clinician working in that setting is trained to provide the LP to local children and families.

Currently on the stuttering care pathway we provide the LP only to families who are bilingual and have access to English. We deliver it in English and ask the families to generalise the treatment at home in their additional language. Unlike Corinne, we do not have access to bilingual support/co-workers, so from time to time we will book an interpreter to discuss with the parent how they feel the child is progressing. We also listen to the stutter in the other language and parents are asked to collect a severity rating for both languages daily.

We currently do not have the resources to provide the LP to families who are unable to access English, and are monolingual in their additional language. There is no system to book the same interpreter throughout the programme and using a different person each time brings its own challenges.

Brent has also run bilingual Lidcombe self-help groups where families with a language in common can meet to discuss their child's progress and how they are engaging with the programme. This gives parents time to share experiences and problem-solve any issues they would like to discuss.

The challenges of providing the Lidcombe Program to bilingual children and families are many and varied. The fact that many families with whom we work are contending with economic and social issues means that being bilingual is only one of the factors that might serve as a barrier to them receiving an equitable service. However, with a high level of commitment from speech and language therapy services to provide a high quality service to the community, good results can be achieved with the Lidcombe Program for children who stutter.

On-line Resources:

- For lots of useful information on bilingual assessment, treatment, advice, publications and more:
  www.londonsigbilingualism.co.uk
  www.speechtherapy.co.uk
  www.bilingualism.co.uk

- For advice about stammering and bilingualism:
  http://www.stammering.org/bilingual.html

- For useful bilingual resources:
  www.eastwesteducation.org/index.htm
  www.positive-identity.com
  www.mantralingua.com
  www.newburypark.redbridge.sch.uk/langofmonth

References:

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References for articles and questions about bilingualism from previous Lidcombe News editions.

This edition has a pair of excellent articles on bilingualism but it is not the only edition to carry such information. Over the 14 years that Lidcombe News has been reporting on the programme we have carried many other features on this topic. Below I have headlined the previous articles and given their location so you can find out anything else you think might be useful. I have also collated them in their entirety and sent them as an attached document with your newsletter.

1. Edition 5. September, 1999, pages 5-6. Article by Fiona Richards.Before Corinne Moffatt started her work in Tower Hamlets (as reported above) the post was held by Fiona Richards, an Australian therapist. She writes of her experiences in this post in an article called "Working with bilingual families in Tower Hamlets".

2. Edition 11. September 2001, page 9. FAQ about how to proceed with a child who stuttered in one language while the other language was stutter free. Answered by Jackie Brown, Elisabeth Harrison, Angela Nikolas, Stacey Sheedy, & Margaret Webber from the Stuttering Unit, Bankstown Stuttering Unit, Sydney, Australia.

3. Edition 12. January, 2002, p.9. FAQ about whether treatment with a bilingual child in one language spontaneously generalises into the other. Answered by Lis Harrison, Vanessa Harris, Margaret Webber, Stacey Sheedy and Verity McMillan from the Bankstown Stuttering Unit, Australia.

4. Edition 14. September, 2002, pages 6-9.Article by Rosalee Shenker entitled "Treating Early Stuttering In Bilingual Children- exploring some of the issues"

5. Edition 23. September 2005, pages 14-16. Article by Corinne Moffatt and Tashia Pillay about "Smooth talking bags" i.e. equipment leant out to parents where there are few resources for treatment at home.

6. Edition 27. January 2007, pages 3-7. Article by Corinne Moffatt writing specifically about her work in Tower Hamlets, London, UK, entitled "Providing the Lidcombe Program to an Inner-city, Multi-cultural Population"

7. Edition 33. January 2009, pages 11-12. FAQ about using interpreters at Bankstown Stuttering Unit, Sydney, Australia. Repeated in this edition (43), and answered by Margaret Webber, Verity MacMillan & Kylie Farnsworth from the Stuttering Unit in Sydney.

8. Edition 33. January 2009, pages 13-15. Article by Rosalee Shenker entitled "Bilingualism and the Lidcombe Program".

9. Edition 36. January 2010, pages 9-10. A Dear Sue about delivering the LP when the mother speaks English but the child does not. Issues to consider. Answered by Stacey Sheedy and Verity MacMillan of the Bankstown Stuttering Unit, Sydney, Australia.

10. Edition 43. May 2012- whole edition dedicated to bilingualism.

And finally…a reference to an article about Bilingualism from New Scientist, which I found extremely interesting. It is in the May 5th 2012 edition pages 31-33 and called Mon Esprit Partage/My Two Minds
This article looks at the huge benefits given to children by learning another language in the areas of mental flexibility and focus i.e. "brain boosting", behaviour and memory as well as some fascinating observations about how people can give different views depending on in which language they are being asked questions. Well worth a read!