Continental Lidcombe in Germany
by Susan Schelten Cornish

As a Canadian speech clinician working in Germany, I have been using the Lidcombe Method for the past 1½ years. I am a "general practitioner" in private practice (in Germany, therapy in private practice is funded by health insurance). I completed my first university degree in languages in Canada, then completed my second in speech pathology in Germany.
Until I trained in Lidcombe, in Norwich with Rebecca Ledzion in September 2002, I had treated one or two stuttering children per year. In the 1½ years since I trained I have provided assessment and/or treatment for 22. I have as yet no explanation for the increase, unless the families of stuttering children can sense where there is a therapist who is happy to see them.
This was not always the case. Before I started with Lidcombe, I used a combination of parental counselling, play therapy, modelling, Svend Smith's accent method and non-avoidance techniques. I was never pleased to see a stuttering child, and did not feel confident about my therapy.

Children in Stage II or finished treatment

Nine of the children I have treated with Lidcombe are either in Stage II or have completely finished treatment, with only occasional telephone contact with the parents. The ages of these nine children range from 3 to 13. Their stuttering before treatment was mild to moderately severe (range, 4 – 23%SS). The end results range from 0% to 1%SS . The length of treatment to Stage II varied from 5 (an absolute exception!) to 48 weeks.

Children who discontinued treatment

I am no longer seeing 5 children for various reasons. One 5-year old girl with a severe stutter moved away before the end of therapy. She presented with 23% SS or higher; I could rarely count 300 syllables as her blocks were so severe. After only 9 sessions she was down to 4% SS and her kindergarten teachers, who were unaware of the therapy, had commented on how much improved her speech was. I was bitterly disappointed when the mother said they were moving!
One family terminated therapy after 4 months: the six-year-old boy was then at 1.5% SS down from 5% SS The mother found it very difficult to find the energy after her full-time job to pay attention to her son's speech. Had I been more experienced, the boy could likely have been in Stage II by this time.
Two children I opted to observe, and both had a spontaneous remission within six months. The mother of the fifth child is a psychologist; she rejected Lidcombe on the grounds that it is behavioural therapy.

Children in Stage I

One of the children I am still treating with Lidcombe after one year (!) is an old friend of mine. He is now 12 and has been in treatment periodically since the age of four for a severe speech delay, which resolved into articulation problems (successfully treated), dysgrammatism, speech comprehension problems, and an inadequate vocabulary (all treated with moderate success). The stuttering began with school and became progressively worse as the problems in school increased, but fluency treatment was rejected as the language problems were seen as having priority. Finally I flatly refused to continue any treatment unless his stuttering were directly addressed. Both the boy and his mother were taken aback but have co-operated well considering the treatment was not their idea! In one year of treatment, the %SS has reduced from 8 to 0.5. The reduction of a "mere" 7.5% does not adequately describe the difference in his speech, as it was becoming completely unintelligible due to the blocks combined with his high rate of speaking. Also his active vocabulary has increased tremendously. Stage II is now in the realms of possibility.

The remaining children still in Stage I have been in treatment from 1 to 10 weeks. Their ages range from 4 to 15. They presented with mild to moderate stuttering. None will be moving into Stage II in the near future.

Two things will have become obvious from this report.

Firstly, I do not hesitate to use Lidcombe with older children. My experience has been that if the parents are willing to co-operate, and the children – or adolescents – are willing to work with their parents, the results are good, and have been stable up to now. I do stress both to parents and to the older children themselves that their results could be less stable than one could wish, and they should react to a relapse immediately if one occurs.

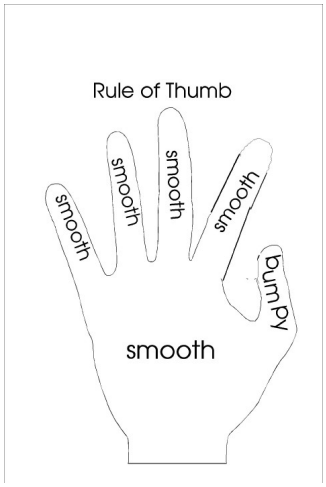
Secondly, my treatment times are much longer than any I have ever read about in the Lidcombe News!!! I think there are several possible reasons.

1.Most German speech treatment professionals reject any behavioural therapy out of hand. Hands-on experience and successes with behavioural treatment of ***any*** speech problem are not seen as convincing arguments: both are often regarded as a professional disgrace. During the 50's and 60's, behaviourism was well accepted in Germany, and the definitions in respected psychological textbooks are usually objective. These textbooks are however occasionally slightly defensive about their objectivity. Perhaps one reason for the present rejection of behavioural therapy is a professionally active critical post-war generation. I myself certainly do not have any emotional bias, but I do believe that there is quite a bit of "implicit knowledge" about using behavioural therapy for speech treatment which I do not have, as I studied speech and language here in Germany. I think that due to a total lack of experience with this type of therapy, I am a complete beginner when it comes to implementing the method on a day-to-day, problem-solving basis.

2.On my visits to Canada, friends and family used to comment on my monotonous speech. This doesn't happen any more, since I now make a conscious effort to regain my original "dialect". Interestingly enough, I think that what seems to be a comparative lack of melody in the German language makes it more difficult to use the non-verbal aspects of the contingencies – i.e. that one is pleased, enthusiastic, or happy that the child is speaking so well. This non-verbal information actually has priority, especially for children. This theory is supported by the experience of my colleague Tina Lattermann, who trained in Canada and imported the Canadian heartily enthusiastic tone into her contingencies here in Germany. Parental reactions were negative – the enthusiasm was regarded as insincere, even though it was definitely genuine.

3.Generalizations are always dangerous, but there is an aspect of German – or possibly Continental European – culture which I believe also plays a role in lengthening treatment times. In comparison to the Canadian culture in which I grew up, I find that criticism is regarded much more positively here. There seems to be a very deep-seated belief that it is working on *reducing undesired behaviour* which leads to improvement, in contrast to working on *increasing desired behaviour*. Therefore it must be criticism which leads to improvement, not praise. The direct result of this on Lidcombe therapy is that parents must be coached again and again in the use of positive contingencies. As soon as the point in therapy is reached where the parent is told to identify stuttered words to the child, positive contingencies are often forgotten completely. Identifying ***smooth*** speech is then considered more or less the icing on the cake - nice but unnecessary. I would stress that I find this attitude even among the most concerned, loving and supportive parents.

In order to test this theory I developed a "Rule of Thumb" and two sets of "contingency cards". The Rule of Thumb is a picture to be hung up as a reminder: one thumb (asking for correction) needs 4 fingers and a palm (five remarks on smooth speech). One set of contingency cards consists of Cliparts of bricks with printed contingencies underneath (i.e. "good talking", "every single word smooth", etc). These cards are given to the child as contingencies in structured sessions. Two out of 12 cards are windows, which have "that was bumpy" on them.



I gave these cards to the mother of the 12-year-old who has been in Stage I for a year, and who could not get below 2% SS (SR 4). I explained that there are only two cards pointing out stuttering, and the rest indicate fluency, and compared this to building a house, where one needs many more bricks than windows. I also gave them a "Rule of Thumb" to hang up. The result was an immediate three-week run of SR 3s, starting the next day, and a %SS at the next appointment (3 weeks later due to illness) of 0.5%! Occasional reminders are still necessary to make sure the cards are still in use.

With another family the contingency cards were introduced and used religiously in structured sessions. However the next week the boy actually

complained to me that he was tired of being told he wasn't fluent "all day long". He had only been hearing about his fluent speech in the structured sessions, and to quote his own words the rest of the day was "bumpy, bumpy, bumpy". This was only the third therapy session, and I hadn't introduced the use of *any* contingencies outside structured sessions yet.
The other set of contingency cards consists of Cliparts of various foodstuffs. The requests for correction are salt shakers. I gave these to one family as soon as we started treatment. This mother shows no signs of forgetting positive contingencies at any time. The SRs and %SSs are definitely coming down now, in the seventh week of therapy.
So I am hoping that the contingency cards will end up making a difference and will prevent misunderstandings if I stress the explanations a bit more.

4.Another factor that I believe is slowing my proficiency in Lidcombe is the traditionally infinitesimal role of the parents in speech treatment in Germany. Many speech treatment professionals do not even have the parents present during therapy. My own attitude has always been that I cannot effect change in speech with one treatment per week, and so I have almost always had parents observing therapy and doing exercises with the children at home. However I have had no training in instructing parents. Asking parents to carry out the observed exercises or games regularly at home is very different from actively coaching parents in a technique, and laying down the law that sessions must be daily or the method is ineffective. The first few sittings found me virtually mute, and I still would be, were it not for the pressure of Ratings and % Syllables Stuttered. Judging by the frequent hair-raising misunderstandings, my coaching is still often ineffective.

5.Whether this is another culture difference or related to my inefficient coaching is unclear, but the parents of the children I am treating have rarely let themselves be convinced to use concrete reinforcement for speech achievements. Most will only agree to rewarding their child with stamps that lead to small rewards such as a special meal. Also, none up to now have been willing to visit flea markets or even a library in order to find games or books which will keep the child's interest high at home. The result is that I myself have been haunting flea markets, and now have a "lending library" of old games.

Parent questionnaire

Because another of the objections to the Lidcombe method in Germany lies in the perceived over-burdening of the parents, I decided to try a parent questionnaire with the 9 families whose children have moved on to Stage II. I used a shorter version of the one developed by Rosemarie Hayhow, which she generously gave me permission to use. My small database can of course only indicate tendencies. The main point of interest for me right now is the parent's view of the success of the therapy, and their attitude towards Lidcombe. The tables show only the results of those questions dealing with these points:

Question 2.1 “My child now:”

Seldom/never stutters	Stutters less	No change	Stutters slightly more	Stutters much more
7	2			

Question 4.2 “This method demands too much of the parents”:

Agree completely	Tend to agree	Unsure	Tend to disagree	Disagree completely
			4	5

Question 4.3 “This method disturbs family life and is therefore difficult”

Agree completely	Tend to agree	Unsure	Tend to disagree	Disagree completely
			4	5

Question 4.5: “I was pleased to be able to help my child myself”:

Agree completely	Tend to agree	Unsure	Tend to disagree	Disagree completely
5	4			

Question 4.5 “I will be able to help with a relapse”

Agree completely	Tend to agree	Unsure	Tend to disagree	Disagree completely
5	4			

Question 4.4 “I would recommend the method to other parents”

Agree completely	Tend to agree	Unsure	Tend to disagree	Disagree completely
6	3			

Tables: responses to questions concerning parents’ view of success and of their role in therapy.

All parents thought that Lidcombe does not demand too much, but not surprisingly nearly half did have some doubts (cf. questions 4.2, 4.3) In comments they described having to work at fitting sessions into daily life. Of the four who were not certain of their abilities to help with a relapse, one indicated to me that she expects one. Five parents listed outsiders’ remarks on their child’s new fluency, one was pleased that neighbours had remarked on increased intelligibility and two gave positive concluding remarks saying both they and their sons had enjoyed therapy. Both of the latter also remarked positively on their principal roles in helping their children achieve fluency. All would recommend the method to others, though three with some reservations.

None of the 3 families who left before the child had achieved Stage II were targeted. Their attitudes would not have been as positive: both the family who moved away and the family who found the method too time-intensive were not

at all convinced that the child's growing fluency had anything to do with Lidcombe. And the parent who was herself a psychologist found the method morally offensive.

I myself perceive Lidcombe as a difficult and complex but very rewarding method which is stable enough to produce successes even when used by a beginner. With the children I have treated, it not only reduced stuttering but also had a noticeably positive effect on other parameters of speech such as stability of voice, rate of speech, clearness of pronunciation and active vocabulary. Since these all contribute to whether a child's speech is understandable, a positive development in any of them often results in communication being more effective for the child.

Despite the often negative attitude toward Lidcombe here in Germany, I feel that there are enough speech treatment professionals who think practically and independently to make a first training workshop here a success, and I was happy to hear that Tina Lattermann and Anne Huber have one planned for October 2004.