Evidence base

7 articles used; 3 investigated impact of LP, 3 investigated impact of PCT and 1 compared the 2.

PCT: Yaruss et al (2006) found all children significantly reduced dysfluency rates. 6 children needed direct treatment following PCT. Limitations are there being no control in the study and reliability and parent compliance weren't closely examined. Millard, Nicholas and Cook (2008) used the casus analyses (monitors data that naturally fluctuate). It demonstrated that systematic reductions in therapy occurred in advance of any fluctuations in the baseline period. Severity ratings reduced from 3.5 on average to 1.1 children needed direct therapy after PCT. Millard, Edwards and Cook (2009) found 46% participants reduced stammering significantly during therapy period and the other 2 significantly at the follow up phase. 1 child in the control group significantly reduced their stammer. Questionnaire showed parents believed their child's stammering was impacting less on them and on their child. Limitations of both these studies were the small number of participants which does not allow for generalisation to the population of children who stammer. There was also relatively high attrition. In the latter study the variability and reliability of parent rating scales were not established.

PCL vs LP: Franken et al (2005) used a RCT to compare both treatments. Results showed no significant difference between treatments in %SS or in severity ratings. Both were fairly high acceptable by parents. All 5 means were slightly higher for PCL but this didn’t reach significance. To have added to the value of these results there could have also been a a no treatment group.

PCL: Jones et al (2005) found the reduction in %SS for LP group was significantly greater than natural recovery with a reduction of 77%. With an estimated effect size of 2.3% SS, double the minimum clinically worthwhile difference. The no treatment group significantly reduced stammering by 45% but 6 of the children received components of LP from elsewhere. Limitations included attrition of 7, who were significantly older by 9 months. Some still hadn’t completed stage 2 of therapy when final analysis was taken. Latterman et al (2008) conducted a similar study with German speaking preschoolers. There was a reduction rate of 70.3% SS for treatment and 17.6% SS for no treatment significantly higher decreases in stammering compared to previous studies which included non-verbal contingencies. Miller and Guitar (2009) assessed long term findings of LP 9/15 at follow up had 0%SS, and 10/15 had 0 on the SSI. Those who had a higher score on SSI were male, had a positive family history and phonological problems. The effect size was 2.3% SS and 3.7 for SS, showing substantial changes. Limitations included small number of participants, not accounting for the possibility that the change was due to natural recovery, and no control group.

Conclusion and future research

PCL: The majority of children only needed minor adjustments in their environment to achieve normal fluency.

References


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Introduction

75% of stammering cases begin before the age of 6 years. Early intervention is essential as when stammering becomes chronic, communication can be severely impaired (Jones et al. 2005). Stammering is also the most tractable with 2-3 year olds (Onslow, 1992; Jones et al. 2005). Two of the most common approaches to early intervention are:

- the Lidcombe programme (LP)
- Parent-child interaction therapy (PCL)

Both are parent-led therapies. The LP is an operant method where parents provide verbal contingencies for stammer free speech periods of stammering, whereas PCL is an indirect method aimed at altering the child’s environment & educating the parent. Comparison between the two has been chosen to determine if one method produces a greater reduction in stammering than the other, along with the clinical implications of each.

Methods

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