The Lidcombe Program Guide

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Mark Onslow, Margaret Webber, Elisabeth Harrison,
Simone Arnott, Kate Bridgman, Brenda Carey, Stacey Sheedy, Sue O'Brian, Verity MacMillan, Wendy Lloyd, Gissella Santayana, Gabrielle Hodes, Kylie Smith, Anna Hearne

Overview

General terminology used in this guide

In this guide, the generic term clinician is used for speech pathologists, who are known by various terms including, but not limited to, speech pathologist (Australia), speech-language pathologist (North America), speech and language therapist (United Kingdom and Japan), LogopädInnen (Germany), orthophoniste (France), logopædagog (Demark) and logopedist (Netherlands). The term parent/s is used throughout in reference to either parents or carers.

Lidcombe Program qualification

The Lidcombe Program is endorsed by the professional associations of several countries: Australia, the United States, the United Kingdom, Japan, Germany, Finland, and the Netherlands. Neither this guide nor any other written material about the program can replace professional Lidcombe Program training.

Professional clinician training is available from the Lidcombe Program Trainers Consortium. The Consortium has 20 members in 11 countries and provides training in other countries as well. This training usually involves two days of instruction and demonstration, often with subsequent follow-up. When interpreters are required, the workshop may involve additional days.

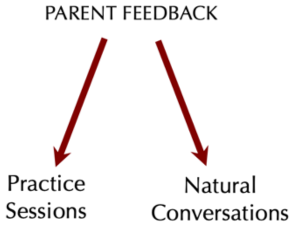
An important note

This guide is intended as a reference tool for use by clinicians as they instruct parents to do the treatment. The Lidcombe Program is not designed to be used by parents independently of a clinician. It is essential that a professionally qualified clinician works with parents to individualise the Lidcombe Program for their child and family.

Program summary

The Lidcombe Program is a parent-implemented intervention for early stuttering, developed for children younger than 6 years. Parent education and training are central to this treatment as speech pathologists and parents work together to individualise treatment procedures for the child and the family. While the underlying concepts of the Lidcombe Program are applicable to all families, there are no identical procedures each time it is used; it is individually tailored and adjusted during weekly consultations between the clinician and parent. The essential components of the Lidcombe Program are (a) measurement of stuttering severity and (b) verbal contingencies for stutter-free and stuttered speech given during practice sessions and during natural conversations. Practice sessions are a critical part of the treatment and require considerable parent training.

Verbal contingencies are referred to as *feedback* throughout this guide. The feedback is individualised and embedded in practice sessions and in everyday conversations. Practice sessions involve activities and conversations that are fun for the child and are structured so that a high degree of fluency is achieved. During the Lidcombe Program, children are not instructed to change their usual speech pattern in any way.



To track progress, the parent measures stuttering severity with a scale where 0 = *no stuttering*, 1 = *extremely mild stuttering*, and 10 = *extremely severe stuttering*. Stage 1 of the program continues until a very low level of stuttering, or no stuttering, has been achieved. Following this, Stage 2, a maintenance phase, commences. During this stage, treatment components are gradually and systematically withdrawn if treatment gains are maintained. If treatment gains are not maintained, then the parent can reintroduce program components in a systematic way with the clinician's guidance.

The origins of the Lidcombe Program are in behavioural treatment. It has a strong evidence base confirmed by 11 independent reviews,[1] including a Cochrane Review.[2] Clinical trials have shown the Lidcombe Program to be effective with individual families, or groups of families, and with clinician instruction given in-clinic or by video telehealth. Research shows that it is effective when used in different countries, cultures, and languages. It is also suitable for some children older than 6 years.[3,4]

Resource materials

On the Australian Stuttering Research Centre website (https://www.uts.edu.au/research/centres/australian-stuttering-research-centre/resources/lidcombe-program) there are several Lidcombe Program resources for clinicians, including the following:

- a downloadable stuttering severity rating chart in eForm and PDF formats
- a downloadable pamphlet
- a reflective clinical questions designed to assist clinicians' reasoning and problem-solving.[5]

The severity rating chart and the reflective clinical questions are reproduced in Appendix A and Appendix B of this guide.

Before starting the Lidcombe Program

Before deciding whether to proceed with the Lidcombe Program, it is important for the clinician, parent, and child to establish a therapeutic alliance. This fosters the clinician's responsive approach to the child and parent. It also facilitates a trusting relationship, which is the foundation of the clinician's and parent's future collaborative decision making. This is important when determining the readiness of the child for treatment and the suitability of implementing the Lidcombe Program.

As part of standard speech-pathology clinical practice, information is gathered through a case history interview. Through observation and discussion, the clinician may explore the child's communication strengths, co-occurring needs, interests, and environmental factors that may support or hinder early stuttering intervention. Additionally, the child's reactions to stuttering are an essential consideration. This includes signs of the child struggling with speech, frustration, and/or situation avoidance. Parents are counselled about how to respond to stuttering and how to manage any emotions they have about it, along with how to address others' reactions to the child's stuttering. The clinician provides a model for the parents, advising how to talk openly about stuttering with their child, using neutral language.

Based on this shared information, the clinician and parent come to an agreement about the suitability of the intervention for the child. If they decide to proceed with the Lidcombe Program, then they determine the optimal time for the child to begin and the best method of instruction delivery for the family.

It is fundamental to advise parents that although the goal of the Lidcombe Program is for stuttering to resolve, there is no guarantee of this, and that this goal may be adjusted. It is also expected that the result of treatment is easy and confident communication, and acceptance of any stuttering during and after treatment.

Overview of Lidcombe Program stages

The Lidcombe Program consists of Stage 1 and Stage 2. All program components are used during Stage 1, with the end of this stage marked by the child's speech containing no stuttering or extremely mild stuttering. This same goal is applied during Stage 2, during which all program components are gradually withdrawn providing that the child's speech continues to show no stuttering or extremely mild stuttering over a substantial period. Particularly in older children, these goals may need to be adjusted.

Stage 1

During Stage 1, the child and parent attend weekly consultations with the clinician (in-clinic or by video telehealth). Throughout Stage 1, the clinician and the parent collaborate to individualise the components of the program to best suit to the child and family.

The clinician begins by introducing the stuttering severity rating scale and helping the parent to accurately identify stutter-free speech and unambiguous stuttered speech. The clinician then demonstrates verbal feedback during a practice session with the child, ensuring that the child enjoys the activity, and that the conversation is natural and engaging. During this demonstration, the clinician highlights for the parent what they are doing to structure the conversation so that the child's speech is mostly free of stuttering.

The next step is to teach the parent how to provide verbal feedback. This may or may not occur during the first clinic consultation. Feedback for stutter-free speech is always introduced first, and it is necessary that it is individualised to the parent and the child. Feedback for stuttering is introduced later in Stage 1, but only when appropriate for the child and when the parent has mastered implementing verbal feedback for stutter-free speech. The clinician explains that it is essential to listen to the child's message when giving feedback, with the feedback given strategically and sensitively. The structure and activities for the practice sessions are adjusted from week to week to account for any changes in stuttering and the child's interests. The clinician outlines that, as stuttering decreases, the conversations during the practice sessions become less structured.

The parent collects a severity rating each day. These ratings are usually noted at the end of the day and refer to the child's typical speech across the entire day.

The parent conducts practice sessions with the child each day. The parent's aim during the practice session—typically 15 minutes duration—is to structure the conversation so that the child enjoys the interaction, speaks frequently, and speaks with speech that is mostly stutter free.

During each weekly consultation, the parent reports on the severity ratings and practice sessions from the past week. The parent demonstrates a practice session, and the clinician gives feedback on the way in which the parent implemented the session. The clinician discusses any trends occurring in the severity ratings and answers any questions the parent may have. They collaboratively agree on changes for the week ahead.

When the parent is confident with giving feedback in practice sessions and the child is enjoying them—typically after a few weeks—the clinician then demonstrates how to give feedback during everyday conversations. Combinations of feedback in practice sessions and in natural conversations continue throughout Stage 1. During each consultation, the clinician and parent collaboratively decide on the amount of feedback and the context in which it will be used in the week ahead. That is, the nature of the feedback and the contexts in which it will be used will vary across time for each child, and between different children. It is intended that the mix is optimal for each child at any point in time. A strong therapeutic alliance between clinician and parent enables decisions that generate the best outcome for each child.

Stage 2

Stage 2 begins when the child is speaking in everyday conversations with no stuttering or extremely mild stuttering each day for several weeks. During Stage 2, each Lidcombe Program component is gradually withdrawn. This systematic withdrawal is guided by the clinician and parent together and is dependent on the child's speech maintaining the same effortless and mostly stutter-free speech. Consultations reduce in frequency, and parents steadily and slowly reduce their feedback and decrease the number of severity ratings. The collaboration between parent and clinician continues until the child's speech shows no stuttering or extremely mild stuttering for a significant period. If treatment gains are not maintained, the parent can increase the rate of verbal feedback in natural conversations and/or resume feedback during practice sessions.

The stuttering severity rating (SR) scale

Purposes of SRs

Severity ratings are used by the parent to measure the child's stuttering in everyday speaking situations and by the parent and clinician during each consultation. The SR scale that is used in the Lidcombe Program consists of these descriptors: 0 = *no stuttering*, 1 = *extremely mild stuttering*, 10 = *extremely severe stuttering*.

The simplicity of the Lidcombe Program's perceptual SR scale makes the ratings a quick and effective way for the clinician and parent to communicate about the child's stuttering severity. Note that it is helpful to highlight that SR = 10 refers to the most severe stuttering *that the parent can imagine*, rather than the child's most severe stuttering actually observed by the parent. This additional explanation is relevant if the child's stuttering is mild-moderate, and the parent has not heard the child stutter severely.

The clinician makes time during each consultation to collect and keep a record of the parent-assigned SRs. Monitoring SR trends from week to week enables the clinician and parent to identify and discuss variations in the child's stuttering in everyday situations. These discussions move on to discussion of the child's SR in relation to treatment and enable problem solving of any issues. Such discussion and subsequent problem solving is a feature of the Lidcombe Program that allows it to be individualised throughout Stage 1 and Stage 2. The clinician needs to take the time during each consultation to discuss and problem solve around the child's SR scores from the past week. This discussion reinforces the parents' role in the treatment and motivates them to continue to collect daily SR scores.

Valid parent-assigned SRs are essential

Research indicates that parents can typically assign SRs that agree with those of a clinician[6,7] and the general community.[8] It is essential for the clinician to ensure that this agreement occurs because parent-clinician conversations about clinical progress rely on SRs that document changes in the child's speech. If a parent assigns inaccurately low SRs, then Stage I may be ended prematurely. In the opposite situation, if a parent-assigned SRs are too high, then Stage 1 can be drawn out longer than necessary. If a parent does not provide SRs at all, then progress is likely to stall because of the lack of reliable information about the levels of the child's day-to-day stuttering.

Parent-assigned SRs

The clinician gives the parent information about SRs during the first Stage 1 consultation. The clinician starts by explaining the reason for collecting SRs and then explains the scale itself and its three descriptors. The parent or the clinician, or both, then talk for a few minutes with the child until a reasonably representative amount of speech and stuttering has occurred. The clinician then asks the parent to assign a SR to the speech that was just heard. The clinician indicates either agreement with this rating or suggests a different one.

The clinician's judgement is the benchmark for SR scores. Acceptable agreement is shown when the parent-assigned SR is within one scale value of the clinician's assigned SR. It is desirable after the first weeks of the Lidcombe Program for the parent- and clinician-assigned SR scores to be identical. This level of agreement is needed because there is less margin for error at the end of Stage 1 as the child's SRs approach the lower end of the scale. At that time, accurate measures are needed.

The SRs that the clinician and parent agree on during consultations are recorded in the child's file, along with the parent's daily assigned SRs from the past week. It is common for a child's SRs during a consultation to differ from the parent-assigned SRs collected elsewhere. However, the SRs assigned *during consultations* serve primarily to establish and, later, to monitor agreement between the clinician and parent. After that consistent agreement, the parent's daily assigned SRs become the primary indicator of the child's progress from week to week.

Another valid sampling method—particularly useful early in Stage 1—is for the parent to make an audio or video recording of the child during one or more everyday conversations. The clinician and parent can then listen to or watch the recording together during the next consultation so that each can assign a SR score for the recorded sample.

A flexible measurement

SRs are a flexible way to measure stuttering severity. Each day, the parent records a SR that reflects the child's typical stuttering severity for that day. If the child attends early education or care, then the parent assigns SRs that are based on the speech that is heard. It is not necessary to extend the SR procedure to the school setting.

Since stuttering in very young children is likely to be highly variable, adaptations can be made to the procedure for collecting SRs to suit individual children. For example, if a child's stuttering varies a lot across a day, then more than one SR could be collected so that the degree of variability is noted, with one SR for the highest and a second SR for the lowest severity on that day. Alternatively, one SR could be used for typical severity and another for highest severity on the day. In either case, the clinician explains that the intention of the SRs is not to give a single *middle* score for the day, but instead to keep note of the amount of variability across the day.

The clinician may wish the parent to use additional SRs for a particular speaking situation that occurs each day to monitor severity with more detail, such as dinner time, bath time, or playing outside. These SRs are recorded in addition to the usual daily SR.

Documenting SRs

The method that is used to record SRs is guided by individual parent preference and convenience. It is important to find a means for the parent to collect SRs that can be used consistently and accurately each day. The clinician may provide a paper chart that the parent writes on each day, or the parent may prefer to use an e-version of the form that is accessible on a digital device. The Child Stuttering Severity Chart in eForm and PDF format can be found on the Australian Stuttering Research Centre website (https://www.uts.edu.au/research/centres/australian-stuttering-research-centre/resources/lidcombe-program).

Bilingual children

When a child speaks more than one language, the parent collects daily SRs in each additional language. Collectively, these SRs allow the clinician and parent to monitor the child's progress in the primary language used to begin Stage 1, and to determine whether progress is generalising to the other language/s. Using all SRs collected during Stage 1, the clinician and parent can make decisions based on the child's ratings about which language to continue with in Stage 1, and about the timing of that change if it is indicated.

Stage 1: Practice sessions

Practice sessions

What they are

Practice sessions are:

- parent-child conversations
- arranged so that they are consistently fun for the child
- designed for the parent to practice using feedback correctly and safely
- designed for the child to speak mostly stutter free
- timed to last for around 15 minutes
- scheduled each day at a time that suits the parent and child.

Initially, the clinician trials a practice session and demonstrates to the parent how to use verbal feedback during a conversation with the child. The conversation is conducted using activities—typically books and simple games—that the child is likely to enjoy. The clinician explains that the purpose of the practice session is to maximise the child's stutter-free speech, and to give the parent many opportunities to provide verbal feedback in a positive and encouraging manner. Following the clinician's demonstration, the parent trials a practice session using the same or similar activities and materials and using the same feedback as the clinician. Parents may require several weeks of the clinician demonstrating practice sessions to feel comfortable to do practice sessions at home independently.

Practice sessions are adjusted in every consultation to suit the changing level of the child's stuttering, and to adapt to the interests of the child and the family routine. Clinicians and parents continue to work together to identify activities and conversations that are fun for the child and enjoyable for the parent, and result in mostly stutter-free speech. The practice sessions should never feel like *work* for the child.

Maximising stutter-free speech

To achieve maximum benefit from a practice session, it is important that the child's speech is mostly stutter free. This is always achieved within a fun and enjoyable conversational context in which the child's intended meaning is heard. The practice session should not involve a repetitive question-and-answer format, or repeated use of the same materials and activities.

Because the likelihood of a stuttering moment increases with syntactic complexity and utterance length, the clinician can teach the parent how to use this information to maximise stutter-free speech during a practice session. A range of utterance durations with differing syntactic complexities may be elicited from shorter or simpler responses to longer and/or more complex utterances. The clinician makes those decisions based on the child's stuttering severity at the time and, with the help of the parent, selects appropriate activities.

Methods that may reduce stuttering during practice sessions include the following:

- turn-taking activities
- word or phrase imitation
- sentence completion
- closed questions
- binary-choice questions
- talking about *here and now.*

The child's stuttering may also be influenced by:

- different conversation partners
- physical location of the practice session
- excitement level generated by the conversation and activities.

The clinician and the parent work together to decide how to arrange these variables in ways that encourage mostly stutter-free speech and result in only occasional stuttering during practice sessions. The clinician encourages the parent to be creative and flexible with these methods during practice sessions. The aim is for the parent to become confident at guiding the conversation so that the child's speech during practice sessions is mostly stutter free and, at the same time, is as long and most linguistically complex as possible. It is important for the clinician to be aware that achieving an optimal balance for each child between extremely mild to no stuttering and the highest level of linguistic complexity, while also maintaining the fun for the child, is a high-level skill. Individual parents will differ in their ability to learn this skill, and it is the clinician's role to guide the parent as they do so. The clinician and parent work closely to achieve this. The child's role during practice sessions is simply to engage in the activity and have fun.

Clinicians and parents may find that low levels of stuttering during practice sessions can be challenging to achieve. Some examples might include the following situations:

- The child's stuttering is severe.
- The child likes to talk in detail and at length about abstract or imaginative topics.
- The child prefers to talk more than the conversation partner and does not enjoy taking turns.
- The child quickly becomes bored or excited with each activity.

In these or similar situations, the clinician and parent discuss how to adapt the features of practice sessions so that the child can achieve the intended result despite these challenges. The clinician and parent both contribute to create solutions that they trial with the child and adapt as needed.

How often practice sessions occur

Practice sessions usually occur once per day and last for 15 minutes. In some cases, it may suit a child to have shorter practice sessions twice per day. One example of this would be a child who has difficulty maintaining attention for that period. In other situations, the clinician may think it advisable to do two 15-minute sessions per day for a few days or weeks.

Where and when practice sessions occur

Typically, the parent and the child sit in a quiet place, at a table or on the floor, with suitable activities such as books and games. Early on in Stage 1, this setup is useful for establishing a routine that assists the practice session to be maximally effective. After a few weeks, and when the parent is comfortable leading the conversation, practice sessions can occur during a variety of daily activities and locations, such as during conversations over meal preparation, bath time, and play.

Stage 1: Parent feedback

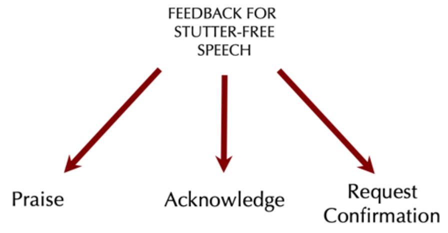
There are five ways that parents give feedback in the Lidcombe Program. Three are for stutter-free speech, and two are for moments of unambiguous stuttering. The term *unambiguous stuttering* refers to speech that is stuttered. If a parent is uncertain about stuttering or typical disfluency, then no feedback is used.

The clinician first introduces feedback for stutter-free speech and typically starts with either praise or acknowledgement (whichever the parent and child prefer). Requests for confirmation are introduced subsequently. Later still, feedback for moments of stuttering is introduced. Not all five types of feedback are necessarily used with all children. The feedback is trialled by the clinician and parent and individually tailored in terms of the types, the wording, and the frequency. It is essential that parent verbal feedback to children is authentic, heartfelt, and not judgmental.

Feedback for stutter-free speech

Overview

Feedback for stutter-free speech is the most common feedback used in the Lidcombe Program. While the overall aim of the Lidcombe Program is to reduce the frequency and severity of the child's stuttering, the most effective way to achieve this with very young children who stutter is by systematically increasing and highlighting the frequency of the child's stutter-free speech. Therefore, parent feedback for stutter-free speech needs to be inherently positive, supportive, and enjoyable for the child. Most very young children enjoy this type of feedback. However, parents and clinicians need to be confident that the child is comfortable with it. If there is any hint that a child is not comfortable with this feedback, then the parent and clinician must immediately adjust it accordingly. This means that feedback may have to be omitted for a period until the child is comfortable with it. Feedback for stutter-free speech should be specific to ensure children do not confuse it with general praise for other activities.



Praise

Clinicians anticipate that each parent and child will have preferences for the forms of praise that they use. Every parent has a different style, and different children like to be praised in different ways. The clinician consults the parent to identify ways they think their child might like to be praised for stutter-free speech. The clinician can offer suggestions such as "That was lovely smooth talking" or "Such great talking!" It is essential for parents to use words, facial expressions, and phrasing that they prefer and suits their child.

The clinician needs to be sure that the parent's praise is genuine and that it isn't over-used to the point that it ceases to be enjoyable for the child. It is also important that the parent varies the words that they use so that praise sounds fresh and appealing. If a child does not enjoy praise, then acknowledging stutter-free speech, as described next, may be a better option.

Acknowledge

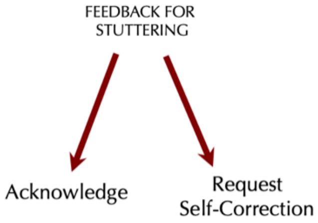
Acknowledging stutter-free speech is more neutral than praise for stutter-free speech. It is a matter-of-fact statement with less intonation than praise. Examples would include “That was smooth” and “Smooth words.” Acknowledge is usually the briefest of the Lidcombe Program feedback and may suit children who prefer a no-fuss approach.

Request confirmation

This verbal feedback is effectively a two-step praise. The parent asks the child a rhetorical question about whether speech was stutter free. The parent’s intonation and facial expression while asking the question makes it clear that the expected response is *yes*. This feedback is only used for stutter-free speech. The parent might ask “Was that smooth?” As soon as the child responds with “Yes”, the parent follows up with the second step by acknowledging the child’s response with a comment like “Yes. That’s right. So many smooth words!” This feedback can be used when a child has been speaking with stutter-free speech for a period as brief as a single utterance or much longer.

Feedback for unambiguous stuttering

Overview



In the same way that the child needs to enjoy the feedback for stutter-free speech, the child needs to be comfortable receiving feedback for stuttering if it is used. This type of feedback is trialled initially by the clinician during a practice session. This happens after the parent and the child are comfortable with the feedback for stutter-free speech. If a parent is uncertain whether they heard stuttering or typical disfluency, then no feedback is used.

Feedback for stuttering needs to be introduced with care because some children may respond negatively. If they do, then this feedback is discontinued for a time or, if indicated, for the remainder of the program.

Feedback for stuttering is used much less frequently than verbal feedback for stutter-free speech. In other words, *most of the verbal feedback that the child receives during the Lidcombe Program is for stutter-free speech*. As is the case with verbal feedback for stutter-free speech, every parent has a different style with a child, and different children need to receive verbal feedback for stuttering in different ways.

Request self-correction

With this kind of feedback, the parent asks the child to say the stuttered word or utterance again. It is important that parents are clear about what they want the child to say again. For example, if the child says “Today at preschool I-I-I-I painted a huge picture of a car,” then the parent would say “Can you say ‘I painted’ again?” Note here that shortening the child’s utterance with the feedback also increases the likelihood that the child will say the word or utterance again without stuttering. If the child says the words again smoothly, the parent says “Such smooth words, and I bet it was a really cool car.” It is important that the self-correction is praised or acknowledged. Another approach to this feedback is for the parent first to comment briefly on the content: “I bet it was a cool car. Can you say ‘I painted’ again?”

It is important that the request for self-correction never results in the *content* of the message being ignored. Should the child stutter when repeating the word or utterance, the parent is instructed to focus on the content and move on, for example, “I hope I get to see the painting tomorrow.”

Sometimes, a parent may be tempted to overuse this feedback. It is the clinician’s responsibility to make sure this doesn’t happen.

Finally, the clinician should keep in mind that this feedback is a *request* for self-correction. If a child declines or ignores the request, then there is no further comment. The clinician, however, notes that the child’s non-response/refusal may signal discomfort with this feedback. If a child reacts negatively in any way, then this feedback needs to cease for a while, or for the duration of the treatment.

Acknowledge

In the same way that the feedback *acknowledge stutter-free speech* is brief and neutral, the same is true for *acknowledge stuttering*. It is a brief, neutral comment that does not interrupt the flow of conversation. The parent just notes that stuttering has occurred and moves on, saying something like “That was a bit bumpy” or “That was a stuck word.”

Examples of parent feedback

Stutter-free speech

Praise

- Wow, that was so smooth!
- Fantastic talking!
- That was so super-smooth!

Request confirmation

- Was that smooth?
- Did you say that smoothly?

Acknowledge

- Smooth talking.
- That was smooth.
- Smooth again.

Unambiguous stuttering

Request self-correction

- Can you say [stuttered word or phrase] again?

Acknowledge

- A little bump then.
- That word was stuck.

Stage 1: Parent feedback during natural conversations

Natural conversations

Once feedback has been individualised during practice sessions and the parent is feeling at ease with it, the clinician and parent work together to identify times of the day where the parent can introduce feedback into natural, everyday conversations. Much of this feedback will be for stutter-free speech. And just as when feedback was introduced in practice sessions, feedback for stutter-free speech is introduced in natural conversations *before* feedback for stuttering. As for practice sessions, there is no pre-determined number of times each day that a parent should provide feedback in natural conversations. Parents are typically asked to start with a small amount of feedback for stutter-free speech for the day, such as 3–5 times, and then increase as needed.

Unlike the parent-child conversations in the 15-minute practice sessions, the natural conversations of everyday childhood life are never modified to increase the occurrence of stutter-free speech. Instead, the parent takes advantage of naturally occurring periods of reduced stuttering during each day to give feedback. Everyday conversations with the child, during which the parent typically gives feedback, might occur during food preparation, at mealtimes, at bathtime, on the way to school, in the park, or while shopping. These should be implemented only by a parent who has had direct training with the clinician to ensure that they are provided accurately and appropriately.

When it is introduced

When practice sessions are well established in the family’s routine, the child and the parent are enjoying them, and the parent is confident with giving feedback, then feedback can be introduced during natural conversations. Depending on how quickly the parent and child become comfortable with practice sessions, and how much stutter-free speech is present in natural conversations, it may be introduced after a few weeks. A prerequisite to the parent using feedback in everyday conversations is that the parent must be able to identify the types of conversations in which the child has spontaneous stutter-free speech.

The transition between feedback during practice sessions and natural conversations

While feedback is used exclusively in practice sessions at the beginning of Stage 1, there is a gradual movement towards most of the feedback being given in natural conversations. Consequently, for much of Stage 1, the parent provides feedback during practice sessions *as well as* natural conversations. The transition starts when the conversations during practice sessions are no longer needing much, if any, structure for the child’s speech to be mostly stutter free, and they start to resemble natural conversations. In some cases, the clinician may decide that this transition should not be completed until as late as sometime during Stage 2

This transition is a flexible process. During the period when the parent is providing feedback in practice sessions and in natural conversations, the clinician may recommend several changes to the number and duration of practice sessions. For example, changing from one practice session each day to one every second day while maintaining the same frequency of feedback during natural conversations. Throughout this period, the clinician may suggest other changes to the number, type, and timing of feedback that the parent gives during natural conversations. For any recommended changes, the SRs are monitored to ensure that progress continues. These recommendations are then adjusted accordingly.

Summary of essential things about parent feedback

Teach feedback for stutter-free speech first

The clinician does not teach the parent how to give different types of feedback all at once. Feedback for stutter-free speech is introduced first. Feedback for stuttered speech is included when the clinician is sure that the feedback for stutter-free speech is enjoyed by the child, well established during practice sessions, and comes easily to the parent.

Not all five types of feedback are used for all children

The clinician and parent work together to decide which types of feedback are appropriate for the child and how this feedback should be worded.

Parent feedback must be a positive experience for the child

All feedback, both for stutter-free and stuttered speech, must be a positive experience for the child. Feedback must not be used in ways that are invasive, intensive, or annoying for the child. Feedback must not detract from the content of the child’s message or disrupt the flow of conversation.

It is essential to identify when feedback is not a positive experience for the child or—even better—to anticipate when this might occur and prevent it. In some cases, it is necessary to slow down the introduction of feedback and to proceed slowly and carefully to ensure that the child is receiving supportive and enjoyable feedback. There should be far more verbal feedback for stutter-free speech than for stuttered speech.

Be sure the parent is using feedback appropriately

During each clinic consultation, the clinician seeks to ensure that the parent has been using verbal feedback at home in a manner that is consistent with the guidance given during the previous consultation. At each consultation, parents demonstrate how they have been providing feedback to the child during the past week, and the clinician provides encouragement and suggestions. Parents might bring an activity or book that worked well at home to use in this demonstration at the clinic consultation. Or they may bring video recordings of practice sessions at home and play them to the clinician. Or the parent may demonstrate the way that feedback from the original plan for that week was adjusted in response to the child’s needs. For example, different words used in feedback, or a different activity in response to the child’s increasing stutter-free speech. In all cases, the clinician gives encouragement, support, and constructive feedback.

The clinician may demonstrate a suggested change to the practice session or the feedback so that the parent can trial the clinician’s suggestions. Practice sessions are continuously adjusted in this way. Failure to make adjustments week-by-week will affect progress and may cause a child to become tired of practice sessions.

The parent gives feedback as is suitable

There is neither a traditional standard nor ideal number of times to give feedback for stutter-free speech or stuttering for all children. This statement applies to practice sessions and natural conversations. The parent and clinician need to determine collaboratively how much feedback is suitable for each child. This determination is made based on parent and child comfort with feedback, as well as progress shown in daily severity ratings and parent reports.

Nonverbal additions to spoken feedback

Spoken feedback for stutter-free speech during practice sessions can be supplemented with nonverbal methods if the clinician thinks it may be helpful. For example, stickers, stamps, ticks on a page, blocks, and gestures such as high-fives, thumbs-ups, winks, or nods. As with spoken feedback, nonverbal forms of feedback must be discussed between clinician and parent to determine if they are suitable for the child. When it is used, nonverbal feedback usually supplements, but does not replace, spoken feedback.

Stage 2

Criteria for Stage 2

To progress to Stage 2, the following two criteria need to be met for three consecutive weekly consultations:

- Parent-assigned SRs of 0–1 during the week preceding the consultation, with at least four of those seven SRs being 0
- Clinician-assigned SRs of 0–1 during the consultation.

It is possible that for some children the criteria to progress to Stage 2 will be modified to allow for more stuttering. This is an individualised decision taken collaboratively with the parent. For example, it may be needed if a child is older or has medical or speech/language conditions in addition to stuttering.

The purposes of Stage 2

The first purpose of Stage 2 is to guide the parent to manage the child's stuttering with fewer consultations and decreasing support from the clinician. Second, Stage 2 is designed to maintain the extremely mild to no stuttering that the child has attained during Stage 1.

Relapse after successful Lidcombe Program intervention can occur. Half of the children in a report[9] showed some signs of stuttering relapse, with a mean of 5 years after they began Stage 1. Therefore, is important to prepare each parent for this possibility and reinforce capacity to deal with a relapse. By the time Stage 2 begins, the parent is highly skilled in implementing the intervention and monitoring severity ratings over weeks and months. Consequently, in most cases of relapse, the parent is independent of the clinician, and able to decrease stuttering by increasing the rate of feedback in natural conversations and/or resuming practice sessions. If such attempts to reduce stuttering to the target range are not successful, the parent contacts the clinician for advice prior to the next scheduled Stage 2 clinical consultation.

Systematic decrease of verbal feedback

During Stage 2, the parent progressively decreases the amount of feedback during natural conversations while concurrently monitoring severity ratings for signs of potential relapse. The clinician makes suggestions for the timing of that decreasing feedback. Suggestions are based on the child's severity ratings and discussions with the parent.

Once in Stage 2, providing the stuttering remains low or absent, consultations with the clinician continue to become less frequent:

- two consultations 2 weeks apart, then
- two consultations 4 weeks apart, then
- two consultations 8 weeks apart and, finally,
- one or two consultations 16 weeks apart.

It usually takes around 12 months or more to complete Stage 2. Parents are asked to note SRs during the week preceding each consultation so that decisions about the amount of treatment and the timing of future consultations can be made.

A common Stage 2 problem

Children finish Stage 1 with severity ratings of 0–1, so it can be tempting not to follow through with Stage 2. This creates a serious risk of relapse. It is essential that feedback—even if only for stutter-free speech— continues to occur during Stage 2. The authors of a long-term follow-up study[10] suggested that clinicians should encourage parents to observe and listen carefully for any signs of post-treatment stuttering during *and after* completing Stage 2.

Typical sequence of Lidcombe Program consultations

Stage 1 consultations

During Stage 1, the parent and child have consultations once per week. Each consultation typically takes 45–60 minutes. The following events normally occur, in the following sequence:

[1] Conversation with the child

The parent or the clinician, or both, chat with the child for about 10 minutes or until sufficient speech has been produced to be able to check the parent-assigned SR (see next point). Alternatively, the parent and clinician listen to a recording or a selection of recordings of the child conversing during everyday life.

[2] Check parent-assigned SR

The clinician asks the parent to assign a SR to the conversation that was just heard and establishes agreement within one scale point. Some discussion regarding why a rating was given may occur. It is important to be mindful that an in-clinic assigned SR is not necessarily representative of the child's speech during everyday activities.

[3] Discussion of progress during the past week

The parent shows the clinician severity ratings from the past week, and these are used as the starting point of an in-depth discussion of progress or challenges experienced during the past week. Discussion questions normally include the following:

- When were practice sessions planned? Did they occur as planned? How often did they occur? For how long?
- What activities and conversations were used as the basis for practice sessions?
- Did the child enjoy practice sessions and feedback? If not, why not? If yes, what was enjoyable?
- During practice sessions, how was the required low stuttering severity achieved?
- How frequently did the parent give feedback during practice sessions?
- How frequently did the parent give feedback during natural conversations?
- Which type of feedback was used during practice sessions and/or natural conversations?
- How was this feedback worded?
- During what periods of the day did the practice sessions occur?
- What were the child and parent doing at the time of feedback during natural conversations?
- In which natural conversations did the feedback occur?
- How long were the natural conversations in which feedback occurred?
- How much was the child speaking during these conversations?
- Does the parent think anything related to the treatment did or did not work particularly well during the week?

The following issues commonly emerge:

- The child's stuttering was too high during practice sessions because the parent found it difficult to structure the conversation and/or because the activity was inappropriate.
- The parent was not able to give feedback during practice sessions each day as planned.
- The parent was not able to give feedback during natural conversations each day as planned.

The clinician needs to be encouraging and supportive, and to offer constructive suggestions during this conversation. The more the parent feels free to share the challenges faced, the more opportunity there will be to problem-solve them.

[4] Parent demonstrates a practice session

The parent demonstrates to the clinician how feedback was given during the past week, as planned in the last consultation. Alternatively, the clinician and parent listen to a recording of feedback implemented with the child during the past week. When the clinician observes a practice session, either in the consultation or on a recording, the clinician checks for the following:

- The child is enjoying the practice session.
- The parent is accurately identifying stutter-free and stuttered speech.
- The practice session is structured to attain low stuttering severity while still being engaging and fun for the child.
- The linguistic complexity of the conversation during the practice session is suitable.
- The feedback is appropriate for the child.
- Most feedback is for stutter-free speech.
- The feedback is varied.

[5] Parent and clinician discuss the feedback demonstrated by the parent

First, the parent and clinician discuss whether the demonstration in the consultation is representative of how intervention was done in the past week. Early on in Stage 1, in particular, it is important to acknowledge that it can feel strange for parents to demonstrate a practice session to the clinician. It is best if during the demonstration, the clinician also joins in the activity but lets the parent take the lead. This will still give the clinician a good idea of how the practice session was done at home. The clinician and the parent discuss what went well and what was challenging, and how the child has reacted. Together, they decide how the practice session and/or feedback needs to be changed for the coming week.

[6] Planning changes for the coming week

The changes that are recommended for the coming week are based on trends in SRs as well as information from the parent's description and demonstration. The clinician makes suggestions to take account of the many factors affecting progress, such as any changes in SR, the child's level of enjoyment during practice sessions, the frequency of the practice sessions, and the child's response to the feedback. Suggestions may include changes to the following:

- the strategies to achieve low stuttering severity during practice sessions
- activities to use during practice sessions
- time of day of the practice sessions
- number of practice sessions
- types and frequency of feedback during practice sessions
- when and where to provide feedback during natural conversations.

Depending on changes that are recommended, the clinician tries and then demonstrates to the parent any changes to procedures for the coming week. The parent then tries the changed procedures while the clinician is watching, and the clinician gives feedback to the parent. The clinician then decides if the parent is ready to implement this change during home practice, or whether further training is needed during the next consultation. Every consultation contains collaborative problem-solving between parent and clinician to decide on the best way to do treatment for the coming week.

[7] Concluding the consultation

The clinician concludes the consultation by summarising the plan for the coming week. It may be useful for parents to write the plan down.

Stage 2 consultations

A typical Stage 2 consultation is 30 minutes. The consultation begins with a conversation with the child to establish a SR and the reliability of that rating between the parent and the clinician. The parent and clinician then discuss the SR scores the parent has noted during the past week. Some parents may choose to document scores for more than a week, but one week should be recorded as a minimum. The SRs are used as the starting point of a discussion about trends in stuttering, whether the ratings represent all the weeks since the last consultation, and how the parent has responded to any fluctuations in SRs. Then, the clinician and parent discuss the amount and type of feedback that has typically been used during natural conversations since the last consultation.

If the child's stuttering continues to be consistent with the Stage 2 entry criteria, the clinician arranges progression to the next step in the Stage 2 schedule. If the child's stuttering is higher than the criteria for Stage 2, then progression to the next step is not recommended. Instead, depending on the child's stuttering severity and the parent's confidence in responding to stuttering fluctuations, the clinician either:

- schedules a consultation for the following week, or the week after that, and makes recommendations about how to adjust treatment to reduce stuttering
- schedules a return to an earlier stage of the sequence of Stage 2 clinic consultations, or
- on rare occasions, recommends a return to Stage 1.

Stage 2 continues until the child's stuttering severity has been extremely mild, or there has been no stuttering, for around a year. After the conclusion of Stage 2, the parent is advised to contact the clinician if any increase in stuttering occurs that cannot be managed by short-term reintroduction of feedback.

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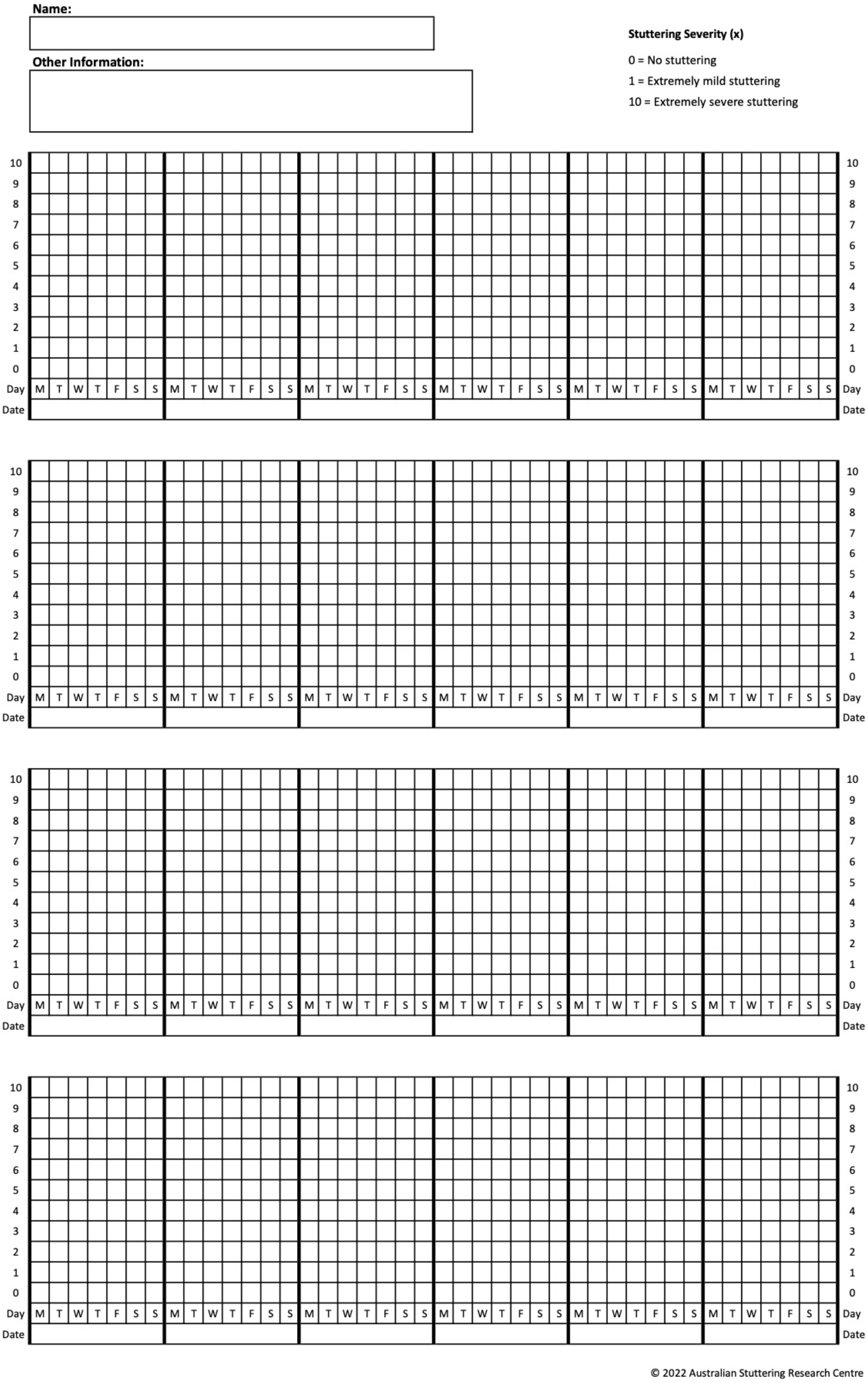
Appendix A: Child Stuttering Severity Chart

Downloadable from the Australian Stuttering Research Centre website in eForm and PDF format (https://www.uts.edu.au/research/centres/australian-stuttering-research-centre/resources/lidcombe-program).



Name:

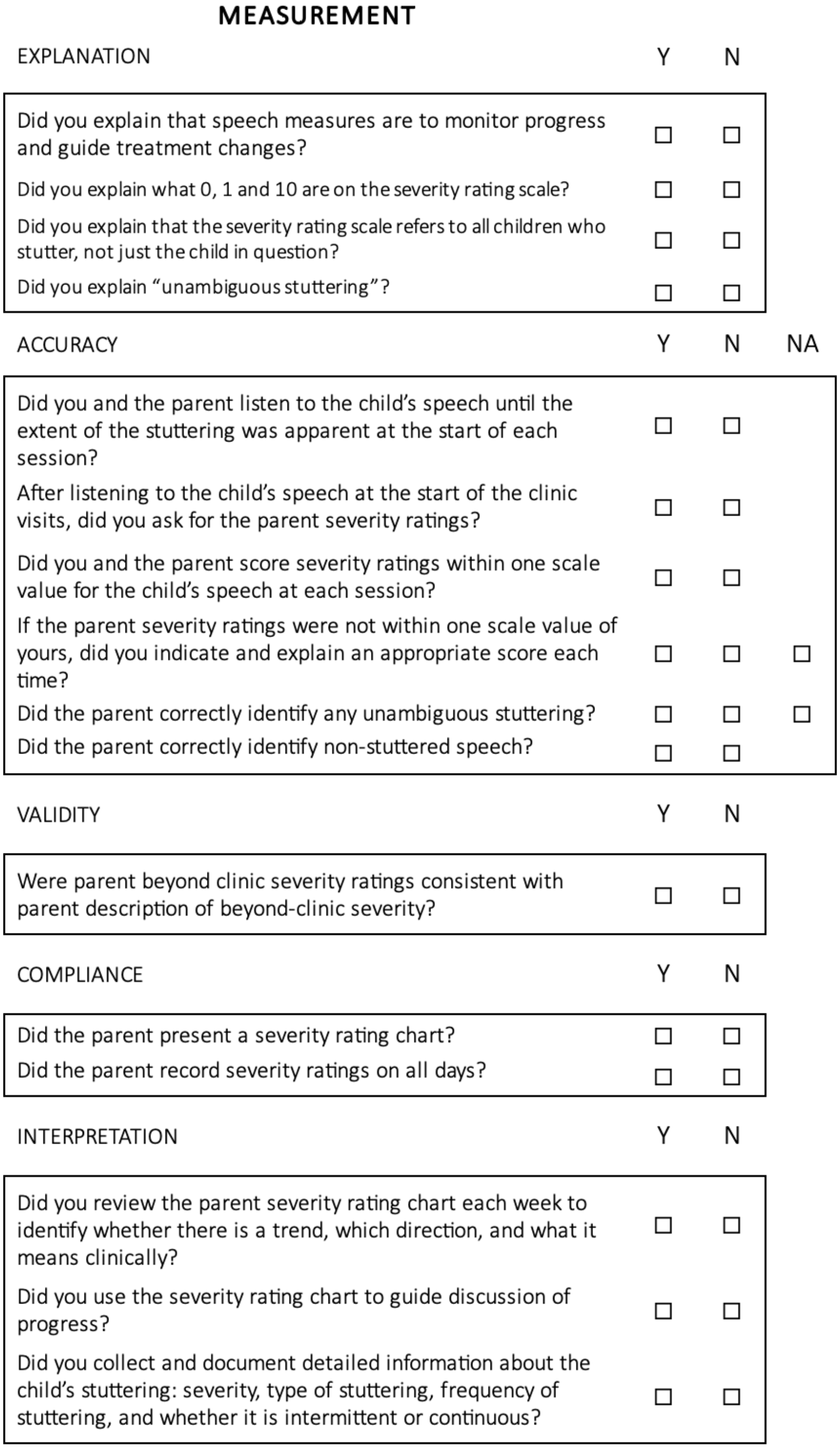
Other Information:

Stuttering Severity (x)

0 = No stuttering
1 = Extremely mild stuttering
10 = Extremely severe stuttering

Appendix B: Lidcombe Program Reflective Clinical Questions

Adapted and reproduced with permission: Sheedy, S., MacMillan, V., O'Brian, S., & Onslow, M. (2017). Lidcombe Program: Development and validation of reflective questions. *Journal of Clinical Practice in Speech-Language Pathology, 19,* 151–156, © 2017 Speech Pathology Australia.



MEASUREMENT

EXPLANATION	Y	N
Did you explain that speech measures are to monitor progress and guide treatment changes?	☐	☐
Did you explain what 0, 1 and 10 are on the severity rating scale?	☐	☐
Did you explain that the severity rating scale refers to all children who stutter, not just the child in question?	☐	☐
Did you explain "unambiguous stuttering"?	☐	☐

ACCURACY	Y	N	NA
Did you and the parent listen to the child's speech until the extent of the stuttering was apparent at the start of each session?	☐	☐	
After listening to the child's speech at the start of the clinic visits, did you ask for the parent severity ratings?	☐	☐	
Did you and the parent score severity ratings within one scale value for the child's speech at each session?	☐	☐	
If the parent severity ratings were not within one scale value of yours, did you indicate and explain an appropriate score each time?	☐	☐	☐
Did the parent correctly identify any unambiguous stuttering?	☐	☐	☐
Did the parent correctly identify non-stuttered speech?	☐	☐	

VALIDITY	Y	N
Were parent beyond clinic severity ratings consistent with parent description of beyond-clinic severity?	☐	☐

COMPLIANCE	Y	N
Did the parent present a severity rating chart?	☐	☐
Did the parent record severity ratings on all days?	☐	☐

INTERPRETATION	Y	N
Did you review the parent severity rating chart each week to identify whether there is a trend, which direction, and what it means clinically?	☐	☐
Did you use the severity rating chart to guide discussion of progress?	☐	☐
Did you collect and document detailed information about the child's stuttering: severity, type of stuttering, frequency of stuttering, and whether it is intermittent or continuous?	☐	☐

GENERAL FEEDBACK

DEMONSTRATION	Y	N	NA
Did the parent demonstrate the feedback used during the previous week?	☐	☐	
Did you suggest any improvements to the parent use of feedback?	☐	☐	☐
Did you demonstrate suggested improvements?	☐	☐	☐
Did the parent demonstrate the treatment change to your satisfaction?	☐	☐	
Did you conclude the session by summarising changes for the coming week?	☐	☐	

PARENT SKILL	Y	N	Reported	Observed
Did the parent give feedback mostly for stutter-free speech?	☐	☐	☐	☐
Did the parent give feedback in a positive manner?	☐	☐	☐	☐
Did the parent vary the wording of the feedback?	☐	☐	☐	☐
Did the parent use all the seven types of feedback or those that were recommended by you?	☐	☐	☐	☐
Did the child seem to enjoy parent feedback for stutter-free speech?	☐	☐	☐	☐

RATE	Y	N
Did the parent report using feedback as often as you directed?	☐	☐
Did the parent report that feedback did not disrupt communication with the child?	☐	☐
Did you suggest changes to the number of times feedback is used during each day?	☐	☐

PRESENTATION	Y	N
In the clinic did parent feedback occur immediately after stutter-free or stuttered speech?	☐	☐
In the clinic did the parent appear genuinely pleased when giving feedback for stutter-free speech?	☐	☐
In the clinic did the child react in a positive or neutral manner to the feedback?	☐	☐
Did the parent report that feedback was given only by those you trained to do so?	☐	☐
In the clinic were feedback given in a manner so that they did not disrupt parent-child communication?	☐	☐

FEEDBACK DURING PRACTICE SESSIONS

PRESENTATION	Y	N	NA	Reported	Observed
Did the child appear to enjoy the activity?	☐	☐		☐	☐
Did the parent manage the treatment activity while remaining focused on the child's speech?	☐	☐		☐	☐
Was the child's speech a low severity rating during the treatment conversation?	☐	☐		☐	☐
Did the parent modify the interaction to retain a low severity rating?	☐	☐		☐	☐
Did the parent keep the child's speech at a low severity rating whilst decreasing the structure during the practice session as much as possible?	☐	☐		☐	☐
Did the parent report that activities were varied from day to day at home?	☐	☐			
Did the parent report that the time and place for the practice sessions varied?	☐	☐			
If tangible reinforcers were used, did they increase the impact of the feedback without distracting the child?	☐	☐	☐	☐	☐
If tangible reinforcers were used, was it because they were necessary?	☐	☐	☐	☐	☐

CONSISTENCY	Y	N
Did the parent report that practice sessions occurred each day?	☐	☐
Did the parent report that the practice sessions occurred for 10–15 minutes once or twice daily?	☐	☐
Did the parent report that practice sessions occur during the morning most days of the week?	☐	☐
Did the parent who did most of the practice sessions attend most clinic visits?	☐	☐

FEEDBACK DURING NATURAL CONVERSATIONS

PRESENTATION	Y	N
Did the parent report that time and place varied?	☐	☐
Did the parent report that feedback was presented as often as you recommended?	☐	☐
Did the amount of feedback used result in improvement in severity ratings?	☐	☐

CONSISTENCY	Y	N
Did the parent report that the feedback occurred throughout the day?	☐	☐
Did the parent report that feedback for stutter-free speech occurred more often than feedback for stuttering?	☐	☐
Did the parent report that the ratio of feedback for stutter-free speech and stuttering were given as recommended by you?	☐	☐

PARENT ISSUES	Y	N	Reported	Observed
Did the parent express confidence with giving feedback when asked?	☐	☐		
Did the parent independently problem solve?	☐	☐	☐	☐
Did the parent independently make appropriate treatment adjustments?	☐	☐	☐	☐
Did the parent seem positive about treatment?	☐	☐	☐	☐

STAGE 2	Y	N	NA
Did the parent report continuing with feedback as recommended?	☐	☐	
Did the parent report withdrawing feedback systematically as recommended?	☐	☐	
Did the parent report increasing feedback for stuttered speech if severity increased?	☐	☐	☐
Did the parent report continuing to give feedback for stutter-free speech as recommended?	☐	☐	
Did the parent independently solve problems during Stage 2?	☐	☐	

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