

the child who stutters: to the pediatrician

revised 4th edition

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The Child Who Stutters: To the Pediatrician

Most children go through periods of disfluency as they learn to speak. Some will experience mild stuttering, and for others the difficulty will become severe. Early intervention by the pediatrician can help parents understand and thus minimize the problem.

ETIOLOGY

Although the etiology of stuttering is not fully understood, there is strong evidence to suggest that it emerges from a combination of constitutional and environmental factors. Geneticists have found indications that a susceptibility to stuttering may be inherited and that it is most likely to occur in boys.^{1,2,3} Further support for inheritance comes from twin studies that have demonstrated a higher concordance for stuttering among both members of identical twin pairs than fraternal twin pairs.^{4,5} Congenital brain damage is also suspected to be a predisposing factor in some cases.¹ For a large number of children who stutter, however, there is neither family history of the disorder nor clear evidence of brain damage.

Brain imaging studies conducted in many laboratories throughout the world indicate

that adults who stutter show distinct anomalies in brain function.^{6,7,8} In contrast with normal speakers, individuals who stutter show deactivation of left-hemisphere sensorimotor centers and over-activation of homologous right-hemisphere structures during both stuttered and nonstuttered speech. The essential defect is hypothesized to be a lack of sensorimotor integration necessary to regulate the rapid movements of fluent speech. Both temporary fluency (induced through singing or choral reading) and more permanent fluency (as a result of behavioral treatments) appear to normalize the activation patterns.⁹

The onset of stuttering is typically during the period of intense speech and language development as the child is progressing from 2-word utterances to the use of complex sentences, generally between

the ages of 2 to 5 but sometimes as early as 18 months. The child's efforts at learning to talk and the normal stresses of growing up may be the immediate precipitants of the brief repetitions, hesitations, and sound prolongations that characterize early stuttering as well as normal disfluency*. These first signs of stuttering gradually diminish and then disappear in most children, but some children continue to stutter. In fact, they may begin to exhibit longer and more physically tense speech behaviors as they respond to their speaking difficulties with embarrassment, fear, or frustration. If referral to a speech-language pathologist for parent counseling and treatment is made before the child

*The term "disfluency" means a hesitation, interruption, or disruption in speech. It may be normal or, as in the case of stuttering, it may be abnormal.

Risk Factor Chart <i>Place a check next to each that is true for the child</i>		
Risk Factor	More likely in beginning stuttering	True for Child
Family history of stuttering	A parent, sibling, or other family member who still stutters	
Age at onset	After age 3½	
Time since onset	Stuttering 6–12 months or longer	
Gender	Male	
Other speech-language concerns	Speech sound errors, trouble being understood, difficulty following directions	

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has developed a serious social and emotional response to stuttering, prognosis for recovery is good.^{10,11,12}

PREVALENCE, INCIDENCE, AND RISK FACTORS FOR CHRONICITY

About 5% of all children go through a period of stuttering that lasts six months or more. Three-quarters of those who begin to stutter will recover by late childhood, leaving about 1% of the population with a

long-term problem. The sex ratio for stuttering appears to be equal at the onset of the disorder, but studies indicate that among those children who continue to stutter, that is, school-age children, there are three to four times as many boys who stutter as there are girls.⁴

Risk factors that predict a chronic problem rather than spontaneous recovery include:*

• Family history

There is now strong evidence that almost half of all children who stutter have a family mem-

ber who stutters. The risk that the child is actually stuttering instead of just having normal disfluencies increases if that family member is still stuttering. There is less risk if the family member outgrew stuttering as a child.

• Age at onset

Children who begin stuttering before age 3 1/2 are more likely to outgrow stuttering; if the child begins stuttering before age 3, there is a much better chance she will outgrow it within 6 months.

• Time since onset

Between 75% and 80% of all children who begin stuttering will stop within 12 to 24 months without speech therapy. If the child has been stuttering longer than 6 months, he may be less likely to outgrow it on his own. If he has been stuttering longer than 12 months, there is an even smaller likelihood he will outgrow it on his own.

• Gender

Girls are more likely than boys to outgrow stuttering. In fact, three to four boys continue to stutter for every girl who stutters. Why this difference? First, it appears that during early childhood, there are innate differences between boys' and girls' speech and language abilities. Second, during this same period, parents, family members, and others often react to boys somewhat differently than girls. Therefore, it may be that more

boys stutter than girls because of basic differences in boys' speech and language abilities and differences in their interactions with others.

• Other speech and language factors

A child who speaks clearly with few, if any, speech errors would be more likely to outgrow stuttering than a child whose speech errors make him difficult to understand. If the child makes frequent speech errors such as substituting one sound for another or leaving sounds out of words, or has trouble following directions, there should be more concern. The most recent findings dispel previous reports that children who begin stuttering have, as a group, lower language skills. On the contrary, there are indications that they are well within the norms or above. Advanced language skills appear to be even more of a risk factor for children whose stuttering persists.

At present, none of these risk factors appears, by itself, sufficient to indicate a chronic

problem; rather it is the cumulative or additive nature of such factors that appears to differentiate children for whom stuttering comes and goes versus those for whom stuttering comes and stays.

THE PHYSICIAN'S ROLE

The physician is often the first professional to whom a parent turns for help. Knowing the difference between normal developmental speech disfluency and potentially chronic stuttering enables the physician to advise parents and refer when appropriate. Early intervention for stuttering—which may range from parent counseling and indirect treatment to direct instruction—can be a major factor in preventing a life-long problem.

Data from several different treatment programs indicate substantial recovery if treatment is initiated in the preschool years.^{7,8,9}

DIFFERENTIAL DIAGNOSIS

Normal developmental disfluency and early signs of

stuttering are often difficult to differentiate. Thus, diagnosis of a stuttering problem is made tentatively. It is based upon both direct observation of the child and information from parents about the child's speech in different situations and at different times. The following section and Tables 1 and 2 at the end of this booklet should help the physician distinguish between normal disfluency, mild stuttering, and severe stuttering, so that appropriate referral can be made.

Normal Disfluency

Between the ages of 18 months and 7 years, many children pass through stages of speech disfluency associated with their attempts to learn how to talk. *Children with normal disfluencies* between 18 months and 3 years will exhibit repetitions of sounds, syllables, and words, especially at the beginning of sentences. These occur usually about once in every ten sentences.

After 3 years of age, children with normal disfluencies are less likely to repeat sounds or syllables but will instead repeat whole words (I-I-I can't) and phrases (I want...I want...I want to go). They will also commonly use fillers such as "uh" or "um" and sometimes switch topics in the middle of a sentence, revising and leaving sentences unfinished.

Normal children may be disfluent at any time but are likely to increase their disfluencies when they are tired, excited, upset, or being rushed

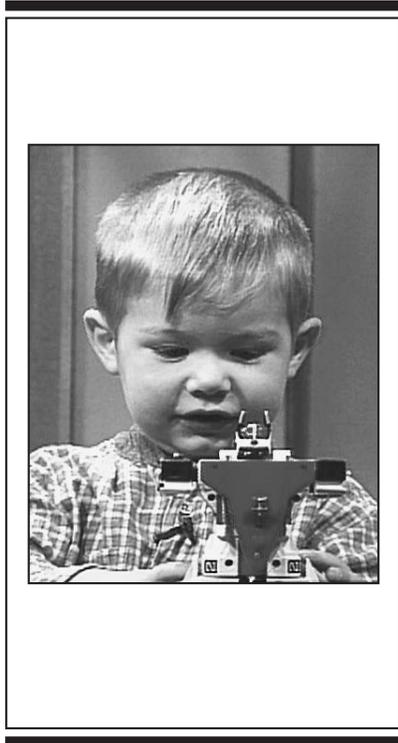
*Longitudinal research studies by Drs. Ehud Yairi and Nicoline G. Ambrose and colleagues at the University of Illinois provide excellent new information about the development of stuttering in early childhood. Their findings are helping speech-language pathologists determine who is most likely to outgrow stuttering versus who is most likely to develop a lifelong stuttering problem. Research reports include:

Yairi, E. & Ambrose, N. (1992). A longitudinal study of stuttering in children: A preliminary report. *Journal of Speech, Language, and Hearing Research*, 35, 755-760.

Ambrose, N. & Yairi, E. (1999). Normative disfluency data for early childhood stuttering. *Journal of Speech, Language, and Hearing Research*, 42, 895-909.

Yairi, E. & Ambrose, N. (1999). Early childhood stuttering I: Persistence and recovery rates. *Journal of Speech, Language, and Hearing Research*, 42, 1097-1112.

Yairi, E. & Ambrose, N. (2005). *Early Childhood Stuttering: For Clinicians by Clinicians*, ProEd, Austin, TX.



to speak. They also may be more disfluent when they ask questions or when someone asks them questions.

Their disfluencies may increase in frequency for several days or weeks and then be hardly noticeable for weeks or months, only to return again.

Typically, children with normal disfluencies appear to be unaware of them, showing no signs of surprise or frustration. Parents' reactions to normal disfluencies show a wider range of reactions than their children do. Most parents will not notice their child's disfluencies or will treat them as normal.

Some parents, however, may

be extremely sensitive to speech development and will become unnecessarily concerned about normal disfluencies. These overly concerned parents often benefit from referral to a speech clinician for an evaluation and continued reassurance.

Mild Stuttering

Mild stuttering may begin at any time between the ages of 18 months and 7 years, but most frequently begins between 3 and 5 years, when language development is particularly rapid. Some children's stuttering first appears under conditions of normal stress, such as when a new sibling is born or when the family moves to a new home.

Children who stutter mildly may show the same sound, syllable, and word repetitions as children with normal disfluencies but may have a higher frequency of repetitions overall as well as more repetitions each time.

For example, instead of one or two repetitions of a syllable, they may repeat it four or five times, as in "Ca-ca-ca-ca-can I have that?"

They may also occasionally prolong sounds, as in "MMMM-MMMommy, it's mmmmy ball." In addition to these speech behaviors, children with mild stuttering may show signs of reacting to their disfluency.

For example, they may blink or close their eyes, look to the side, or tense their mouths when they stutter.

Another sign of mild stuttering is the increasing persistence of

disfluencies. As suggested earlier, normal disfluencies will appear for a few days and then disappear. Mild stuttering, on the other hand, tends to appear more regularly. It may occur only in specific situations, but it is more likely to occur in these situations, day after day. A third sign associated with mild stuttering is that the child may not be deeply concerned about the problem, but may be temporarily embarrassed or frustrated by it. Children at this stage of the disorder may even ask their parents why they have trouble talking.

Parents' responses to mild stuttering will vary.¹⁰ Most will be at least mildly concerned about it, and wonder what they should do and whether they have caused the problem. A few will truly not notice it; still others may be quite concerned, but deny their concern at first.

Severe Stuttering

Children with severe stuttering usually show signs of physical struggle, increased physical tension, and attempts to hide their stuttering and avoid speaking. Although severe stuttering is more common in older children, it can begin anytime between ages 1½ and 7 years. In some cases, it appears after children have been stuttering mildly for months or years. In other cases, severe stuttering may appear suddenly, without a period of mild stuttering preceding it.

Severe stuttering is characterized by speech disfluencies in practically every phrase or

Case Example: Sally, a child with Mild Stuttering

Sally's mother and father were concerned because Sally, age 3, was beginning to avoid speaking. The problem had begun several months earlier when Sally was repeating parts of words, like, "Ca-ca-ca-can I ha-ha-ha-have some?" Then a few weeks ago she had difficulty getting started making the first sound of a word. She would open her mouth, quite wide at times, but nothing would come out. Once she asked her mom, "Why can't I talk?"

Sally's speech and language development had been normal. She began using single words at an early age—9 months—and was speaking in 2–3 word sentences by 13 months. She talked fluently and enjoyed the family's fast-paced conversations and word games.

When Sally's father discussed her speech with Sally's pediatrician, she referred Sally to a speech-language pathologist in private practice who was known to have expertise in stuttering. Once-a-week treatment sessions consisted of parent counseling and play-oriented interactions between Sally and her speech clinician. Over a period of six months the clinician's model of a relaxed, accepting style of interacting, combined with Sally's parents' changes in the intensity of speech and language stimulation at home, eliminated Sally's avoidance of speaking and her inability to get sounds started. She continued to show a slightly greater than normal amount of word repetition and phrase repetition for several more years and gradually developed normal speech.



Case Example: Barbara, a child with Mild Stuttering

When Barbara was 3, her pediatrician noticed she was repeating and prolonging sounds when he talked to her. He discussed this with her mother and father and found them to be aware of it. In fact, they had been instructing her to stop and start over again when she repeated sounds. He gave them guidance about slowing their own speech rates and refraining from criticism.

When her parents brought Barbara to his office six months later for a minor illness the pediatrician inquired about her speech. Barbara's parents were frustrated by the lack of change in her speech and had begun to correct her again. Barbara herself seemed reluctant to talk to him. The pediatrician referred Barbara to a speech-language pathologist and continued to counsel the parents to ease conversational pressures on Barbara and refrain from direct correction.

A month later, the pediatrician received a copy of the speech-language pathologist's written evaluation of Barbara. This indicated that her stuttering had progressed from mild to severe, and that the parents seemed willing to change some key variables in the home speaking environment. The plan for treatment included some direct treatment of Barbara's stuttering in the speech clinic.

Several months later, Barbara's parents brought her to the pediatrician for treatment of an infected insect bite. The pediatrician noticed that Barbara's speech seemed to be the same as before. The parents indicated that they didn't see the sense in using slower speech rates themselves and have continued to try to correct Barbara's stuttering by instructions. They had discontinued speech therapy because they were unable to afford it. At present the pediatrician has given them a copy of *If Your Child Stutters: A Guide for Parents*, and *Stuttering and Your Child: Questions and Answers*, and is counseling them to continue changes at home.

sentence; often moments of stuttering are one second or longer in duration. Prolongations of sounds and silent blockages of speech are common.

The severely stuttering child may, like the milder stutterer, have behaviors associated with stuttering: eye blinks, eye closing, looking away, or physical tension around the mouth and other parts of the face. Moreover, some of the struggle and tension may be heard in a rising pitch of the voice during repetitions and prolongations. The child with severe stuttering may also use extra sounds like “um,” “uh,” or “well” to begin a word on which he expects to stutter.

Severe stuttering is more likely to persist, especially in children who have been stuttering for 18 months or longer, although even some of these children will recover spontaneously. The frustration and embarrassment associated with real difficulty in talking may create a fear of speaking. Children with severe stuttering often appear anxious or guarded in situations in which they expect to be asked to talk. While the child’s stuttering will probably occur every day, it will probably be more apparent on some days than others.

Parents of children who stutter severely inevitably have some degree of concern about whether their child will always stutter and about how they can best help. Many parents also believe, mistakenly, that they have done something to cause the stuttering. In almost all

TAKE-HOME MESSAGE

A child who stutters often feels that he is the only one to have the problem. He will appreciate hearing from his pediatrician that other children stutter, too.

cases, parents have not done anything to cause the stuttering. They have treated the child who stutters just like they treat their other children, yet they may still feel responsible for the problem.

They will benefit from reassurance that their child’s stuttering is a result of many causes and not simply the effect of something they did or didn’t do.

The distinctions among normal disfluency, mild stuttering, and severe stuttering are summarized in Table 1: Checklist for Referral.

COUNSELING PARENTS **Counseling Parents of a** **Child with Normal** **Disfluencies**

If a child appears to be normally disfluent, parents should be reassured that these disfluencies are like the mistakes every child makes when he or she is learning any new skill, like walking, writing, or bicycling. Parents should be advised to accept the disfluencies without any discernable reaction or comment.

Particularly concerned parents may find it helpful to slow

their own speech rates, use shorter, simpler sentences, and reduce the number of questions they ask.

They may also want to arrange times the child can talk to them in a quiet, relaxed environment. They should not instruct the child to talk more slowly or to say a disfluent word over again. Instead, they should concentrate on calmly listening to what their child is saying.

Counseling Parents of a **Child with Mild Stuttering**

Parents of the child who has a mild stuttering problem should be advised not to show concern or alarm to the child, but instead be as patient listeners as they can. Their goal is to provide a comfortable speaking environment and to minimize the child’s frustration and embarrassment. Parents are usually upset when their child repeats sounds or words, but they should be reassured that these are just slips and tumbles as the child is learning to match his ability to speak with the many ideas he wants to express. If the parents let the child know that repetitive stuttering

Case Example: Jeremy, a child with Severe Stuttering

Jeremy's speech and language developed more slowly than that of his older sister. He didn't start to speak until he was two; until then, he would point to what he wanted. When he started to speak, he was difficult to understand. Jeremy's parents often had to ask him to repeat what he said. His speech became a little clearer at age 3, when he was using 2–3 word sentences. But at about that time he began to repeat initial sounds of words and soon he was prolonging sounds and opening his mouth extra wide when he couldn't get sounds started. Jeremy's cousin had also been late in developing speech, but never stuttered, so Jeremy's parents assumed he would just outgrow it in time. Unfortunately, the stuttering worsened. Soon Jeremy was saying "um" several times just before a word to get it started, in addition to using facial grimaces and wide mouth postures when he got stuck. When he made several attempts to get a word started without success, Jeremy would say "Oh, never mind" and give up. He was gradually becoming more and more reluctant to talk.

By this time, Jeremy's parents became concerned enough to ask their family physician for advice. After talking to Jeremy, the physician referred them to a speech-language pathologist in a local pre-school program. The speech clinician soon determined that immediate treatment was needed and worked with Jeremy and his family in their home for a year with good initial success. Following this, Jeremy entered first grade and was seen twice a week by the school speech clinician and continues to make good progress. Although he still gets hung up on a word occasionally, his language development is normal and he participates fully in class and in social situations.

is acceptable to them, this can help the child's speech and language develop without increased physical tension and struggle.

Parents should also be advised to slow their own speech rates to a moderate and calm pace, espe-

cially when the child is going through a period of increased stuttering.

It is often difficult for busy, concerned parents to provide models of slow speech for the child to emulate. Therefore they are likely to

need encouragement for continuing this practice after an initial trial. Most children, whether they stutter or not, will benefit from adults' speech that is close to their own natural rate. Children who stutter may feel less need to hurry their speech if their parents speak slowly.

While parents may provide models of a slower, more relaxed way of speaking, they should refrain from criticizing, showing annoyance, or telling the child to "slow down." This may create a power struggle that makes it more difficult for the child to slow his rate.

It is also important for parents to provide daily opportunities for one-on-one conversations with the child in a quiet setting, as frequently as possible.

These are times when the child has chosen the activity and can experience the feeling it's a time to talk about anything he or she wants.

If the child asks about the problem, parents should talk about it matter of factly: "Everyone has difficulty learning to talk. It takes time, and lots of people get stuck. It's okay; it's a lot like learning to ride a bike. It's a little bit tricky at first."

The parent may mention casually that going slow can sometimes help or that the child need not hurry, if the child seems to be asking for help.

If the child's stuttering persists for four to six weeks or more despite these efforts on the parents' part, or if the parents are unable to follow these suggestions, the child should be referred to a

speech-language pathologist (see later section on referral).

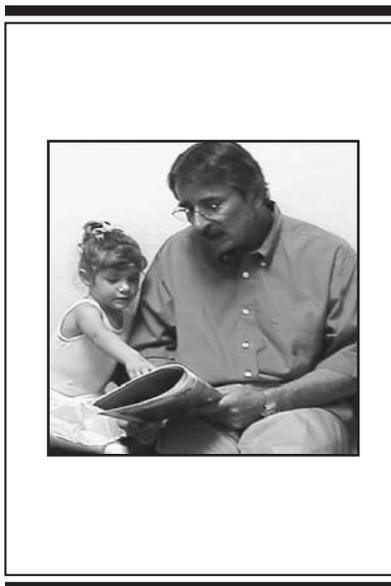
Treatment of the child with mild stuttering may be indirect and focused on creating an environment in which the child feels fairly relaxed about speaking, both at home and in the treatment setting.

If more direct treatment is needed, the speech-language pathologist may show the child how to produce speech more easily, without increased physical tension and struggle, so that stuttering gradually diminishes into something more like normal speech.^{10,11} Some speech-language pathologists may choose to train the parents to work more directly with the child.¹⁰

Counseling Parents of a Child with Severe Stuttering

The child with severe stuttering should be referred immediately to a qualified speech-language pathologist for an evaluation, further counseling, and direct treatment of the child if appropriate. Because severe stuttering frequently seems to develop when a child struggles or becomes afraid of or concerned with speaking in response to his milder stuttering, anything that helps the child relax and take his or her disfluencies in stride will be of benefit.

Parents should model a slower rate of speaking. They should try to convey acceptance of the child regardless of the stuttering, by paying attention to what the child is saying rather than to the stuttering. The speech-language pathologist working with the



child might also encourage the parents to nod or comment on the child's courage for "hanging in there," when the child has a particularly hard time on a word. In addition, the child with severe stuttering would probably benefit from being able to share his or her frustration with his or her parents. This may be difficult in many families, and may be best handled with the help of a speech-language pathologist experienced with the management of stuttering.

Professional treatment of severe stuttering often consists of helping the child overcome the fear of stuttering and, at the same time, teaching the child to speak, regardless of stuttering, in a slower, more relaxed fashion. In addition, treatment is focused on helping the child's family create an atmosphere of acceptance of stuttering and conducive to ease in speaking.^{7,10}

As mentioned earlier, some speech-language pathologists may choose to train the parents to provide some aspects of therapy in the home. The clinician will ask the parents to keep careful records of the child's responses to treatment and will closely monitor the therapy.⁷

During a period of a year or more, the child's stuttering will often gradually decrease in frequency and duration. In some cases, the child may recover completely. Treatment results depend on the nature of the child's problem, the presence of other strengths, the skills of the therapist, and the ability of the family to provide support.

WHEN TO REFER TO A SPEECH-LANGUAGE PATHOLOGIST

Children with severe stuttering problems should be referred immediately. Children who have mild stuttering problems that have not shown marked improvement within six to eight weeks, depending on the child, should also be referred. These children should be given direct treatment if it is warranted, and their parents will receive support and guidance, and they will be followed carefully.

Some children with mild problems may receive direct treatment, but it should be carefully planned so as not to make the child feel apprehensive or self-conscious about the problem. As Table 1 suggests, children with normal disfluency do not need to be referred unless the parents are

The charts on the following three pages may be photocopied and distributed without permission of the publisher. 

so concerned that they need reassurance about the normalcy of their child's speech. They may also be followed by the speech clinician to provide additional guidance if needed.

The speech-language pathologist should have a Certificate of Clinical Competence (CCC-SP) from the American Speech-Language-Hearing Association, and should also be licensed by the state in which he or she practices. Certification requires a master's degree from an accredited university, a national examination, and a year of supervised internship. In addition, the speech-language pathologist to whom a child is referred for stuttering should be experienced with the disorder. Many hospital and university speech and language clinics will have such persons on their staff or can suggest one. Most school systems also employ speech-language pathologists. The Stuttering Foundation of America provides referrals to qualified therapists in most areas of the country. Their toll-free telephone number is 800-992-9392, and their web site is www.stutteringhelp.org. They also provide books and DVDs for parents: *Stuttering and Your Child: Help for Parents*, a 30 minute DVD; *Stuttering and Your Child: Questions and Answers*, a 64 page book; *If Your Child Stutters: A Guide for Parents*, 7th edition, a 64 page book; *Stuttering: For Kids By Kids*, a 12 minute DVD for children; and for teenagers *Do You Stutter: A Guide for Teens*, all for a nominal cost.

CONCLUSION

Pediatricians, family physicians, and other healthcare providers are often the first professionals to whom parents turn for advice about their child's disfluencies.

These professionals can help in the prevention of stuttering. Early identification of children at risk for chronic stuttering and appropriate referral is critical. Moreover, effective parent counseling can often create an environment conducive for children to outgrow their disfluencies.

The authors of this booklet too often meet severe adult stutterers whose parents were told "Don't worry, he'll outgrow it" so that the opportunity for therapy when the disorder is most treatable has been missed. We have repeatedly found that when children are referred early, treatment is most effective, even in cases of severe stuttering. Early intervention prevents the development of lifelong habits that interfere with social, academic, and occupational success.

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Table 1: PHYSICIAN'S CHECKLIST FOR REFERRAL

	The Child With NORMAL DISFLUENCIES Age of Onset: 1½ to 7 years of age	The Child With MILD STUTTERING Age of Onset: 1½ to 7 years of age	The Child With SEVERE STUTTERING Age of Onset: 1½ to 7 years of age
Speech behavior you may see or hear:	<input type="checkbox"/> Occasional (not more than once in every 10 sentences), brief, (typical ½ second or shorter) repetitions of sounds, syllables or short words, e.g., li-li-like this.	<input type="checkbox"/> Frequent (3% or more of speech), long (½ to 1 second) repetitions of sounds, syllables, or short words, e.g., li-li-like this. Occasional prolongations of sounds.	<input type="checkbox"/> Very frequent (10% or more of speech), and often very long (1 second or longer) repetitions of sounds, syllables or short words. Frequent sound prolongations and blockages.
Other behavior you may see or hear:	<input type="checkbox"/> Occasional pauses, hesitations in speech or fillers such as "uh," "er," or "um," changing of words or thoughts.	<input type="checkbox"/> Repetitions and prolongations begin to be associated with eyelid closing and blinking, looking to the side, and some physical tension in and around the lips.	<input type="checkbox"/> Similar to mild stutterers only more frequent and noticeable; some rise in pitch of voice during stuttering. Extra sounds or words used as "starters."
When problems most noticeable:	<input type="checkbox"/> Tends to come and go when child is: tired, excited, talking about complex/new topics, asking or answering questions or talking to unresponsive listeners.	<input type="checkbox"/> Tends to come and go in similar situations, but is more often present than absent.	<input type="checkbox"/> Tends to be present in most speaking situations; far more consistent and non-fluctuating.
Child reaction:	<input type="checkbox"/> None apparent	<input type="checkbox"/> Some show little concern, some will be frustrated and embarrassed.	<input type="checkbox"/> Most are embarrassed and some are also fearful of speaking.
Parent reaction:	<input type="checkbox"/> None to a great deal	<input type="checkbox"/> Most concerned, but concern may be minimal.	<input type="checkbox"/> All have some degree of concern.
Referral decision:	<input type="checkbox"/> Refer only if parents moderately to overly concerned.	<input type="checkbox"/> Refer if continues for 6 to 8 weeks or if parental concern justifies it.	<input type="checkbox"/> Refer as soon as possible.

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SUGGESTIONS FOR PARENTS OF CHILDREN WHO STUTTER

1. Speak with your child in an unhurried way, pausing frequently. Wait a few seconds after your child finishes speaking before you begin to speak.

Your own slow, relaxed speech will be far more effective than any criticism or advice such as “slow down” or “try it again slowly.”

2. Reduce the number of questions you ask your child.

Children speak more freely if they are expressing their own ideas rather than answering an adult's questions. Instead of asking questions, simply comment on what your child has said, thereby letting him know you heard him.

3. Use your facial expressions and other body language to convey to your child, when she stutters, that you are listening to the content of her message and not to how she's talking.

4. Set aside a few minutes at a regular time each day when you can give your undivided attention to your child.

During this time, let the child choose what he would like to do. Let him direct you in activities and decide himself whether to talk or not. When you talk during this special time, use slow, calm, and relaxed speech, with plenty of pauses. This quiet, calm time can be a confidence-builder for younger children, serving to let them know that a parent enjoys their company. As the child gets older, it can serve as a time when the child feels comfortable talking about his feelings and experiences with a parent.

5. Help all members of the family learn to take turns talking and listening.

Children, especially those who stutter, find it much easier to talk when there are few interruptions and they have the listeners' attention.

6. Observe the way you interact with your child.

Try to increase those times that give your child the message that you are listening to her and she has plenty of time to talk. Try to decrease criticisms, rapid speech patterns, interruptions, and questions..

7. Above all, convey that you accept your child as he is.

Your own slower, more relaxed speech and the things you do to help build his confidence as a speaker are likely to increase his fluency and diminish his stuttering. The most powerful force, however, will be your support of him whether he stutters or not.

For more information on stuttering and ways to help your child, write or call the nonprofit Stuttering Foundation of America
3100 Walnut Grove Rd. Ste. 603
P.O. Box 11749, Memphis, TN 38111-0749
(800) 992-9392 www.stutteringhelp.org

The following books are available from them for a nominal cost:

If Your Child Stutters: A Guide for Parents, 7th edition, Publication No. 0011, 64 pages,
Stuttering and Your Child: Questions and Answers, 3rd edition, Publication No. 0022, 64 pages,
Do You Stutter: A Guide for Teens, 4th edition, Publication No. 0021, 72 pages.

The following DVDs are available at www.stutteringhelp.org:

Stuttering and Your Child: Help for Parents, DVD 0073, 30 minutes
Stuttering: For Kids, By Kids, DVD 0172, 12 minutes
Stuttering: Straight Talk for Teens, DVD 1076, 30 minutes

Please see the Stuttering Foundation's catalog at www.stutteringhelp.org for these and other resources.

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TABLE 2. QUESTIONS THAT MIGHT BE ASKED OF PARENTS

Note: These questions are listed in order of the seriousness of the problem. If a parent answers “yes” to any question other than number 1, it suggests the possibility of stuttering rather than normal disfluency.

1. Does the child repeat parts of words rather than whole words or entire phrases?
(For example, “a-a-a-apple”)
2. Does the child repeat sounds more than once every 8 to 10 sentences?
3. Does the child have more than two repetitions? (“a-a-a-a-apple” instead of “a-a-apple”)
4. Does the child seem frustrated or embarrassed when he has trouble with a word?
5. Has the child been stuttering more than six months?
6. Does the child raise the pitch of his voice, blink his eyes, look to the side, or show physical tension in his face when he stutters?
7. Does the child use extra words or sounds like “uh” or “um” or “well” to get a word started?
8. Does the child sometimes get stuck so badly that no sound at all comes out for several seconds when he’s trying to talk?
9. Does the child sometimes use extra body movements, like tapping his finger, to get sounds out?
10. Does the child avoid talking or use substitute words or quit talking in the middle of a sentence because he might stutter?

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