

Comparison of Cases Presenting Late Onset Stuttering

Rachel Karker, Erina Kuleta, Kristin Perkl

Faculty Advisor Lisa R. LaSalle, Ph.D., CCC-SLP



University of Wisconsin-Eau Claire

Abstract

Two separate cases involving late onset of stuttering were compared. Both were the only cases of late onset stuttering evaluated in the past 15 years at the University of Wisconsin Eau Claire Center for Communication Disorders, where only six to eight cases of childhood stuttering are evaluated each year (i.e., n=90-120). A male and a female client were selected on the basis of being the only individuals of a similar age (11-12 years old) when evaluated, whose parents reported a late onset of stuttering (9-11 years old). A clinical retrospective design was used to evaluate diagnostic and observation data from case files in order to contrast the cases. Results indicate similar characteristics between Case 1 and Case 2, and are compared to available literature on psychogenic and late onset cases.

Introduction

- ❖ Psychogenic stuttering is a late-onset stuttering disorder and the two terms may be used interchangeably.
- ❖ The major identifying characteristics of late-onset stuttering are prolonged stress or traumatic events (Guitar, 2006).
- ❖ According to the American Psychiatric Association's DSM-III-R (1987), 98% of stuttering cases begin before age 10 (Mahr and Leith, 1992, p.283).
- ❖ The present study is important because late-onset cases are rare (2%), and thus it is crucial to gather as much relevant data as possible to help understand the possible underlying factors or etiology. By doing so, findings may lead to possible preventative measures.

Methods

- ❖ The study was conducted by comparing two selected files of UWEC CCD clients presenting late-onset stuttering (clinical retrospective design).
- ❖ Signs and symptom charting was based on clinical observation notes, parental reports and parental completion of case history forms.

Results

- ❖ Case 1, a female, averaged 17.5 stutters (range: 17-18) and 4 nonstutters (range: 1-7) per 100 words, based on a 300-word sample taken at baseline (6/29/99). The most prevalent stutter type was sound-syllable repetitions of ~ 2-7 iterations, and the most prevalent nonstutter type was interjections.
- ❖ Case 2, a male, averaged 14.5 stutters (range: 11-18) per 100 words, mostly sound-syllable repetitions, with noticeable physical tension, at baseline. Nonstutter data was not available at baseline, but data collected at a re-evaluation confirmed that stutters comprised more of the total disfluencies (6/9 = 67%) than did nonstutters (3/9 = 33%) (mostly interjections).
- ❖ In both cases, self-awareness, frustration, and/or avoidances of stuttering were observed. (e.g., Case 2 reported, "if I think I will stutter on 'big,' I will say 'large' instead.")
- ❖ Table 1 shows data collected on case history information and temperament.

Table 1

	Case 1	Case 2
Gender	• Female	• Male
Speech and Language History	• Began stuttering at age 11;7 • First noticed after a psychosocially traumatic event (performance/audience in nature) and peer difficulties • Early behavior was struggle with first words of utterance • Parents believe busy schedule to be a causal factor	• Began stuttering around age 9;9 • First noticed during the time of parents' divorce and changes of residence • Early behavior was repeating syllables • Parents believe general stressors to be a causal factor
Medical History	• Jaundice at birth; no other birth complications • Chicken Pox; Earaches • Mildly lactose intolerant • Lyme's disease at age 4	• Jaundice at birth; In Vitro Insem.; Premature(5 wks) • Swallowing difficulties – past and current sensitive gag reflex • Startled easily to loud noises as an infant • Head injury at 15 mos of age • Adverse reaction to MMR resulting in high fever and rash • Two surgeries (cyst at 9 mos of age; appendectomy at 10 yrs of age)
Family History of S/L Disorders	• No known history	• Mom stuttered for about 6 mos in 9 th grade, and recovered with no treatment • Uncle has Down Syndrome
Temperament	• Shy around new people • Desires attention from parents ; Very compliant and likes to please others • Prefers "down-time" to process daily information; Becomes confused when working with more than one person • Not eager to engage in social situations	• Shy; low self-esteem • Becomes emotionally upset easily • Social with familiar individuals; Gets along well with peers and adults • High expectations for himself • Gifted and talented / ACT testing; challenges himself at school

Discussion

- ❖ Case 1 and Case 2 present many similarities with each other and with the literature.
- ❖ Individuals with late-onset stuttering typically show stuttering behaviors associated with stressful times or events (Guitar, 2006), as was found with both of these cases.
- ❖ Roth, Aronson and Davis (1989) found that psychological stress was associated with stuttering onset in 10/12 patients with adult-onset stuttering, acute (n=6) and chronic (n=4). In accordance with Roth et al., stuttering onset in Case 1 was sudden and acute (i.e., an event), whereas Case 2 presented with more gradual onset around the time of stressful changes in residences and family structure, considered more chronic in nature.
- ❖ Emotional sensitivity and shyness were reported in both cases. Auditory sensitivity was indicated in Case 2. Kagan, Reznick and Snidman (1987) found that children born with sensitive or inhibited temperaments are more likely to react with muscle tension and physiological stress indicators when interacting with new people.
- ❖ Differences across the cases were also apparent: Case 1 did not have a family history of stuttering; Case 2 did. Furthermore, Case 1 had a milder medical history than Case 2. Future researchers should investigate the possibility that acute stressors could be more influential than chronic ones in tipping the scale towards stuttering onset when there is little or no known genetic predisposition or organic causes of the onset.
- ❖ Each had different tolerance and reactions to social situations. Case 1 was more intolerant with negative reactions to socialization; Case 2 was more tolerant/positive. Perhaps these temperamental features are part of exacerbating and/or coping strategies for individuals who begin stuttering after age 9 yrs of age.
- ❖ Our results suggest that when a sensitive temperament and/or genetic predisposition is the backdrop: (a) social intolerance plus a socially traumatic event, or (b) social tolerance/enjoyment plus unwanted changes to one's social environment (new family structure; new residence) is enough to yield a stuttering onset.
- ❖ Our findings stress the importance of more research on cases with stuttering onset in late childhood versus adult onset.

References

- ❖ Guitar, B. (2006). *Stuttering: An integrated approach to its nature and treatment*. (3/e). Baltimore, MD: Lippincott/Williams & Wilkins.
- ❖ Kagan, J., Reznick, J.S., and Snidman, N. (1987). The physiology and psychology of behavioral inhibition in children. *Child Development*, 58: 1459-1473.
- ❖ Mahr, G., & Leith, W. (1992). Psychogenic stuttering of adult onset. *Journal of Speech and Hearing Research*, 35, 283-286.
- ❖ Roth, C., Aronson, A., & Davis, L. (1989). Clinical studies of psychogenic stuttering of adult onset. *Journal of Speech and Hearing Disorders*, 4 (4): 634-646.