

CHILDHOOD-ONSET FLUENCY DISORDER (STUTTERING): AN INTERRUPTION IN THE FLOW OF SPEAKING

Abstract: The Childhood-Onset Fluency Disorder (stuttering) reflects a marked impairment in speech fluency that is not attributable to stroke or another medical condition, and developmental or mental disorder (Birstein. 2015). This article examines Childhood-Onset Fluency Disorder (Stuttering): An interruption in the flow of speaking. The focus is on the Diagnostic Criteria in DSM-5 Diagnostic Criteria, Diagnostic Features, Prevalence and Risk Factors are discussed.

Keywords: Childhood-Onset Fluency Disorder, stuttering, interruption, DSM-5 diagnostic criteria, flow of speaking.

Mourad Ali Eissa Saad, PhD
Full Professor of Special Education
Vice President of KIE University
KIE University
Egypt
Contact:
E-mail: profmouradali@gmail.com
ORCID: 0000-0002-1520-4482

Omaima Mostafa Kamel, PhD
Full Professor of Educational Psychology
Cairo University
Egypt
Contact:
E-mail: omaima.gomma@gmail.com
ORCID: 0000-0001-7990-9628

INTRODUCTION

Stuttering is a multifactorial disorder in which genetic, neurophysiological, psychological and environmental factors have an influence (Sadock, Pedro & Sadock, 2015). There is evidence that stuttering is more common in children who also have concurrent speech, language, learning or motor difficulties (Ward, 2006).

Although the etiology of stuttering is not fully understood, there is strong evidence to suggest that it emerges from a combination of con situational 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 (Barry & Edward, 2007).

DEFINITION

Developmental stuttering is a disorder that disrupts speech fluency (Kraft, , Lowther and Beilby, 2019). It is a speech event and a disorder (Yairi & Seery, 2015). Childhood-Onset Fluency Disorder (Stuttering) is a condition characterized by disturbances in the normal fluency and time patterning of speech that are inappropriate for the individual's age and language skills, and persist over time (American Psychiatric Association, 2013; Birstein. 2015).

AETIOLOGY

The aetiology of stuttering is still unknown. No single, exclusive cause of developmental stuttering is known. Psycholinguistics theories and several other theories attempt to explain causes of stuttering, but no single approach, theory, or model is able to explain all cases of stuttering (Birstein. 2015). Research found that stuttering appears to be a disorder that has high heritability and little shared environment effect in early childhood. In stuttering, both early recovery and persistence are heritable (Birstein. 2015).

DIAGNOSTIC CRITERIA IN DSM-5

To be diagnosed with childhood-onset fluency disorder, a person needs to fulfil the following criteria (American Psychiatric Association 2013):

A. Disturbances in the normal fluency and time patterning of speech that are inappropriate for the individual's age and language skills, persist over time, and are characterized by frequent and marked occurrences of one (or more) of the following:

1. Sound and syllable repetitions.
2. Sound prolongations of consonants as well as vowels.
3. Broken words (e.g., pauses within a word).
4. Audible or silent blocking (filled or unfilled pauses in speech).
5. Circumlocutions (word substitutions to avoid problematic words).
6. Words produced with an excess of physical tension.
7. Monosyllabic whole-word repetitions (e.g., "I-I-I see him").

B. The disturbance causes anxiety about speaking or limitations in effective communication, social participation, or academic or occupational performance, individually or in any combination.

C. The onset of symptoms is in the early developmental period.

D. The disturbance is not attributable to a speech-motor or sensory deficit, dysfluency associated with neurological insult (e.g., stroke, tumour, trauma), or another medical condition and is not better explained by another mental disorder.

DIAGNOSTIC FEATURES

The essential feature of childhood-onset fluency disorder (stuttering) is a disturbance in the normal fluency. This disturbance is characterized by frequent repetitions or prolongations of sounds or syllables and by other types of speech dysfluencies, including broken words (e.g., pauses within a word), audible or silent block (i.e., filled or unfilled pauses in speech), circumlocutions (i.e., word substitutions to avoid problematic words), words produced with an excess of physical tension, and monosyllabic whole-word repetitions (e.g., "I-I-I see him") (American Psychiatric Association, 2013, P. 47).

COURSE

Developmental stuttering usually starts at the age of 2–6 years, and exhibit an overt speech profile that includes repetitions, sound distortions, and/or blocking (Kraft, et al., 2019). Persons who stutter

recover spontaneously in 70–80% of cases. (Katrin et al., 2017). The onset can be insidious or more sudden. Typically, dysfluencies start gradually, with repetition of initial consonants, first words of a phrase, or long words. (American Psychiatric Association 2013). Approximately 5% of preschool children are affected, but by the end of junior high school this percentage drops to 1% and remains at this level throughout life (Birstein, 2015).

PREVALENCE AND RISK FACTORS

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 (Barry & Edward, 2007). Risk factors for persistent stuttering include male sex, familial stuttering (especially persistent familial stuttering), onset of the dysfluencies more than 6–12 months ago, age at onset of stuttering >3–4 years, no reduction in stuttering severity within the initial 7–12 months (Katrin et al., 2017)

STUTTERING TREATMENT

There are two methods used for stuttering treatment (Gluck, 2014).

- *Indirect treatment* – this method seeks to teach parents how to provide a relaxing environment so that the child's speech improves on its own. The therapist will encourage parents to exhibit positive speech modelling and to support their child by patiently listening until he gets the entire thought out without trying to finish his sentence or having another negative reaction.
- *Direct treatment* – this method involves face-to-face therapy sessions between the child and the speech pathologist. The therapist will teach the child to slowly form sounds and words, to speak slowly, and to relax even when struggling to speak. The child will learn how to refrain from the physical symptoms of stuttering like eye blinking and head jerks.

CONCLUSION

Stuttering is a speech disorder in which the flow of speech is disrupted by involuntary repetitions and prolongations of sounds, syllables, words or phrases as well as involuntary silent pauses or blocks in which the person who stutters is unable to produce sounds. No single, exclusive cause of developmental stuttering is known. Research found that stuttering appears to be a disorder that has high heritability and little shared environment effect in early childhood. In stuttering, both early recovery and persistence are heritable. Indirect treatment seeks to teach parents how to provide a relaxing environment so that the child's speech improves on its own. While direct treatment involves face-to-face therapy sessions between the child and the speech pathologist. Stuttering is most amenable to treatment during the preschool years when neuronal plasticity is greatest.

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