LETTERS TO THE EDITOR

Episodic Hysterical Stuttering

Although Van Biper (1971) stated that “one of the few solid bits of evidence we have about stuttering is that it usually begins in childhood” (p. 62), he also noted that stuttering may begin in adulthood. Adult onset of stuttering may be the direct sequella of neurological insult (Canter, 1971; Helm, Butler, & Benson, 1978; Rosenbek et al., 1978; Rosenfield, 1972). Adult onset of stuttering also may be of functional origin (Deal, 1982; Dempsey & Granich, 1978; Freund, 1966; Wallen, 1961).

We have recently had occasion to see a patient who seems to fall into the latter category, adult onset of functional stuttering. This patient is remarkable for the nature, not for the fact, of his stuttering.

CASE HISTORY

This 54-year-old man’s medical history is long and complex. We know little of his medical history prior to the age of 18 years, when he was healthy enough to join the Air Force. Three years later, he suffered a head injury when he fell from the wing of an aircraft on which he was working. He was hospitalized and several days later developed grand mal seizures. He was eventually discharged from the service with a medical disability. During the subsequent 32 years, the patient has been in and out of hospitals, locked facilities, and city-county jails. His medical records contain the following diagnoses and opinions:

- schizophrenia
- emotional problems
- epileptic seizures: grand mal
- sociopathic: somatic form
- hysterical personality, chronic
- inappropriate behavior
- violent personality
- impotence
- chronic organic brain syndrome
- belligerent
- personality disorder
- emotional instability
- impulsive
- conversion reaction
- epilepsy, hypothalamic with psychomotor component

Beginning in 1982, he began to experience spells, during which he would lose consciousness for 2–30 min. Sometimes when he woke up he would be “normal.” On other occasions, he
would awaken with hemiplegia or monoplegia (lower extremity), usually on the right. The weakness persisted for varying lengths of time, sometimes for days, but always resolved completely.

Speech changes, as best we could determine from the patient's medical records, began in early 1984, following a seizure and loss of consciousness. When the patient awoke, he had right hemiparesis and did not speak. He was hospitalized and seen by multiple disciplines including neurology, speech pathology, and psychiatry. None of the disciplines felt that the symptoms were organically based. He had no auditory comprehension difficulty and communicated by writing (records do not indicate with which hand). He wrote that he was unable to speak. When evaluated by speech pathology, he did produce some laryngeal noise and automatic words such as yes. He was hospitalized for about 1 month, and his speech suddenly returned to normal the day prior to his discharge.

During 1984 and 1986, the patient was seen in different hospitals and clinics. The medical records available to us are filled with references to the patient's speech:

- episodic dysarthria
- speech is gibberish
- speech impairment
- garbled speech
- aphasia
- dramatic stammer

The records also reflect the intermittent nature of the speech problem. It came and went. The patient not only had speech problems, he also had atypical chest pains, headaches, sore throats, bouts of hemi- and monoparesis, and difficulty sleeping.

The patient was first seen in our medical center in 1985, as an outpatient. The patient was also being followed in our mental health clinic. When seen by a neurologist (JMD), the patient was exhibiting what was described as stuttering. A speech pathology evaluation was requested, but the patient refused to keep several appointments. The reason given was that his speech had returned to normal, and he had no need or wish to see a speech-language pathologist. On February 6, 1986, the patient was again seen by the neurologist because of a recurrence of stuttering. He was seen the following day by the speech-language pathologist (JLD).

**DESCRIPTION OF STUTTERING**

The patient was seen for 1 hr on Friday, February 7, 1986. He was exhibiting severe repetitions of initial syllables and, at times, whole words. Some of the repetitions listed for more than 30 s. It was difficult to transcribe the tape-recorded interview because the speech was so rapid, with so many repetitions, as to be unintelligible at times. When asked to prolong a vowel, the patient could do so only after what appeared to be considerable struggle. Throughout the interview the patient maintained good eye contact and did not exhibit secondary characteristics. There was no change in speech when he read aloud, and there was no adaptation during reading aloud. When the patient was asked to mime words, without producing voice, he exhibited what appeared to be the same pattern of repetition as when talking.

When the patient returned to the speech pathology clinic on Monday, February 10, 1986, he was fluent. There was no indication of the severe stuttering noted on the previous Thursday and Friday, and a second recording was made. He did not exhibit initial-syllable or whole-word repetitions, and his rate of speech was slower. He had no apparent difficulty initiating speech or prolonging vowels. The patient stated that his speech had suddenly returned to normal while fishing on Saturday. On Friday, the patient had been walking with no difficulty but could hardly speak. On Monday, the patient was speaking without difficulty but was in a wheelchair, complaining of inability to walk. The patient promised to contact us "when" (his word) stuttering returned.

Throughout our contact with this patient, he never seemed concerned about his speech. If he was not demonstrating "a belle indifference," he was certainly close. He denied any history of stuttering prior to 1984, and his wife supported this claim. We have continued to see this patient from time to time. He comes in with a variety of complaints. He is walking without difficulty. The stuttering behavior has returned and resolved at least one more time since February 1986, and we have recorded it.

**DISCUSSION**

Freund (1966, p. 139) described features of hysterical stuttering that we believe fit our patient well. He had demonstrated a variety of nonspeech symptoms as noted earlier. He showed surprising "acceptance and passivity" of his speech. The behavior was "highly stereotyped and consistent" and showed little variation from one situation to another. There was no adaptation. Eye contact was present. We felt that he was "rather detached from his symptoms." The stuttering began suddenly and late in life, and "mutism may be an initial feature." He was "indifferent to his stuttering, even when it is most severe or bizarre." In addition, this patient exhibited the same pattern of stuttering-like movements when miming speech as he did when actually producing speech. Deal (1982) suggested that this last behavior is indicative of psychogenic stuttering, and we would add it to Freund's features.

**CONCLUSION**

We believe that our patient represents an example of hysterical stuttering that is remarkable because of its episodic nature. We would hope that other clinicians might be reminded of patients whom they have seen, and perhaps treated successfully, and that they will provide additional data to help us identify, understand, and treat other patients with similar symptoms.

Jon L. Deal
Joseph M. Doro
Veterans Administration Medical Center
Des Moines, IA

**REFERENCES**


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Are Maltreated Children at Risk for Speech or Language Impairment?: An Unanswered Question

Annually, more than 300,000 children in this country suffer some form of child abuse, with perhaps twice that many suffering neglect (U.S. Department of Health and Human Services, 1981, p. 36). Tragic consequences of such child maltreatment can include physical injury and even death (Elmer & Gregg, 1967; U.S. Department of Health and Human Services, 1981, p. 42). Serious developmental correlates have also been implicated, including impairment in social and emotional development (e.g., Barahal, Waterman, & Martin, 1984; Green, 1978; Reidy, Anderegg, Tracy, & Cotter, 1980), intellectual development (e.g., Appelbaum, 1980; Buchanan & Oliver 1977; Fitch et al., 1976; Perry, Doran, & Wells, 1983; Sandgrund, Gaines, & Green, 1974), language skills, and speech skills. An example of a statement in the literature that links maltreatment and language impairment follows: “There is no doubt whatsoever that mistreated children have lower IQ’s, poorer language [emphasis ours], and show less competent academic progress than children who have been well parented” (Martin, 1990, p. 349).

The tragically high incidence of maltreatment among all categories of children in the United States is coupled with an even higher incidence for several populations frequently served by speech-language pathologists and audiologists (e.g., mentally retarded or certain psychosocially disturbed children) (Diamond, 1983; Sandgrund et al., 1974). What is not known includes whether a specific speech or language impairment affects maltreatment of an otherwise normally developing child, whether maltreatment of a sufficient level or of a certain type can cause a specific speech or language impairment, or whether the speech and language impairments linked to maltreatment are long lasting. In fact, the conclusion that poor speech or language skills are characteristic of randomly selected maltreated children appears unwarranted.

To date, only four studies known to us (Allen & Oliver, 1982; Blager, 1979; Blager & Martin, 1976; Bloom, 1975) have focused directly on the relationship of child maltreatment (abuse or neglect or both) and speech or language development, although a variety of other studies have provided some information on the topic (e.g., Curtiss, 1977; Skuse, 1984). Methodological problems prevent any of these studies from providing a satisfying response to the question of risk for speech and language impairment among abused or neglected children.

Bloom (1975) studied the expressive speech and language skills of three groups of 8-10-year-old subjects: 17 abused children, 17 accident victims, and 25 unabused and uninjured controls. The subjects were matched on age, race, gender, socioeconomic status, and history of hospitalization. Standardized speech and language measures were administered. Clinical judgments regarding presence or absence of voice or fluency disorder, and 5-point ratings of articulation and language adequacy were made.

Despite the lack of overall group differences, comparisons among subgroups of subjects did reveal significant differences. Specifically, Bloom found that “high-certainty” abused children (i.e., those who had been judged to be abused on two evaluations conducted 1 year apart) received poorer expressive language ratings than did the “low-certainty” abused children ($\chi^2 = 6.35, \ p < .01$). Because one would suspect that children who experience more severe abuse are more likely to be identified among the high-certainty group and to be placed outside of the home, these findings suggest that risk for communication problems in abused children may exist primarily for more severely abused children.

Bloom also found a significant relationship between socioeconomic status and expressive language ratings in all groups ($\chi^2 = 8.32, \ p < .01$) and between socioeconomic status and conversational articulation ratings ($\chi^2 = 8.77, \ p < .01$). Both poorer language ratings and poorer articulation ratings were associated with lower socioeconomic status ratings. Based on these findings, Bloom concluded that the presence of poor expressive language and conversational articulation skills may be more closely related to low status than to specific group membership. Problems with this study include the failure to match subjects for nonverbal intelligence and the failure to distinguish between neglect and abuse (i.e., 8 of the 17 abused children were also described as neglected but were treated no differently in the data analysis than the other subjects).

Blager and Martin (1976) described a poorly controlled study of two groups of abused children served in the National Center for Child Abuse in Denver: one group consisted of 10 preschool children between 2 years, 6 months and 4 years and the second group consisted of 13 children between 3 years, 9 months and 8 years, 2 months of age. The few standardized speech and language instruments that were used to examine the subjects in this study were supplemented by clinical assessment procedures that were minimally described. The authors concluded that almost all of the abused preschool children in their first group were delayed in the speech and language skills assessed, and that the somewhat older group of subjects were performing adequately except in spontaneous expressive language. However, because of the subjective nature of many of the measures, the use of a more appropriate group of children from a higher socioeconomic population, this study also fails to provide compelling evidence that maltreated children are at risk for a speech or language impairment.

In a later study, Blager (1979) examined the speech and language skills of three groups of maltreated children. No control group was included. Problems with this study include sketchy description of the study design and the use of an apparently inconsistent and insufficiently defined battery of speech and language measures. Thus, although the author provided interesting comments regarding her impressions of overall patterns of speech and language skills and of their underlying causal factors, increased risk was not demonstrated objectively.

The most recent study treating speech and language skills directly is also the most rigorous and consequently most informatively the four. Allen and Oliver (1982) used multiple regression to compare performances on the Preschool Language Scale (Zimmerman, Steinke, & Pond, 1979) for four groups of children: an abused only group ($n = 13$; mean age = 4 years, 2 months), a neglected only group ($n = 7$; mean age = 3 years, 11 months), an abused and neglected group ($n = 31$; mean age = 3 years, 7 months), and a nonmaltreated group ($n = 28$; mean age = 4 years). The investigators found a strong, independent relationship between neglect and receptive language performance as well as between neglect and expressive language development. Abuse did not appear to be correlated with language performance in their study. No attempt was made by these investigators to discuss the clinical significance of their findings. However, their careful documentation of findings regarding poorer performances among some maltreated children relative to nonmaltreated peers is a harbinger of the kind of research needed to examine risk of speech or language disorder among maltreated children.

Aside from the four studies discussed above, information concerning speech and language skills of maltreated children comes from individual case studies (e.g., Curtiss, 1977; Kohutová, 1976; Skuse, 1984) and from studies in which speech and language are not necessarily the major skills assessed (Appelbaum, 1980; Elmer & Gregg, 1967; Fitch et al., 1976; Friederich, Einbender, & Leucue, 1983; Kent, 1980; Lynch & Roberts, 1982; Martin, Beezley, Conway, & Kempe, 1974; Morgan, 1979; Oates, Peacock, & Forrest, 1984a, 1984b; Perry et al., 1983; Smith & Hanson, 1974). Broadly based studies in which speech and language skills are assessed concurrently with other developmental skills are needed to determine whether documented speech or language problems are specific deficits or are indicative of a more pervasive disorder. Unfortunately, in the studies cited, assessments were generally very superficial in all areas and the issue of specificity of deficits was not addressed.
Also not addressed were possible clinical implications of observed differences in performance. Therefore, although several of these studies report findings of poorer performances on language or speech measures by maltreated than by nonmaltreated controls, these findings are difficult to interpret.

In order to provide basic information concerning the possible presence and nature of the risk of maltreated children for specific speech or language disorder, future research designs need to surmount at least four hurdles.

1. Future designs need to control for nonverbal cognitive skills through subject selection criteria or alternatively to evaluate speech and language skills in combination with other, nonverbal cognitive skills. The fact that the development of language skills is so closely tied to overall cognitive development requires one to take nonverbal cognitive skills into account when discussing the possibility of specific impairment (e.g., Benton, 1964).

2. Future designs should address the adequacy of speech and language skills on two levels. On one level, standardized measures of selected speech or language skills can provide very specific information. On another level, clinical diagnoses that are based on both standardized instruments and other sources of clinical information (e.g., case history information, naturalistic observation) can provide a more general indication of the adequacy of a child’s communication skills. With both kinds of information, more valid statements regarding risk for clinically significant delays can be made.

3. Because of suggestions in existing research that speech and language findings may differ depending upon the severity and form (abuse vs. neglect) of maltreatment and the socioeconomic status of the children, future subject groups need to be defined carefully with respect to those variables. Other subject variables that could be expected to be important include the dialect spoken by the children and their examiners.

4. If developmental correlates of maltreatment are identified, longitudinal designs and attempts to control “time since abuse” will be needed in future designs to help determine whether effects of maltreatment persist or are byproducts of short-term interpersonal problems that could adversely affect a child’s ability to participate in testing administered by an unfamiliar adult. Possible reactivity to testing is omnipresent in an unfamiliar adult. Possible reactivity to testing is omnipresent in evaluation, but could be expected to be particularly pronounced in maltreated children. Techniques that could be used to reduce this possibility include a long “warm-up” period of playful interaction with the examiner prior to the beginning of testing.

Rebecca J. McCauley
University of Vermont, Burlington

Linda Swisher
University of Arizona, Tucson

REFERENCES


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