Is My Child's Speech or Language Delayed?

Carolyn A. Weiner, M.A., C.C.C.

Parents are often the first adults to notice a possible delay in their child's speech or language development. Your child's speech may not be clear. Or, your child may use shorter sentences than other children the same age. This observation generally leads to three questions:

Is my child's speech or language delayed?

Speech skills are different from language skills. Language refers to the use of words and sentences to convey ideas. Speech is the production of sounds that make up the words and sentences.

Using developmental milestones, such as those listed below, you can compare your child's development with that of other children the same age. Read the description and ask yourself the questions listed. You can get an idea if your child's communication skills are about the same, higher than, or lower than expected.

Use caution when applying any measure of development to your child. Individual differences or special circumstances need to be accounted for. This can be done by consulting with your school's *speech and language clinician* or by checking with your local speech and hearing clinic.

Milestones of Speech and Language Development

- One-year-old children should be able to understand a variety of words and should be using a few single words.
- By age two, words should be combined into two-and three-word phrases and sentences.
- Between the ages of three and five, children learn to carry on a conversation, ask and answer questions, follow and give directions, and speak alone in the presence of a group. These skills are important to success in kindergarten.
- After age five, sentences become increasingly complex. Children begin using words like "when," "while," and "since" to relate two or more ideas in a single sentence. The language level used by teachers and textbooks assumes that children have this skill by the age of seven or eight.
- As a rule, children use understandable speech by age four and use all speech sounds correctly by age five to seven.

At what point should I be concerned about my child's development?

Both social and academic success depend on well-developed speech and language skills. Your child may be having difficulty developing these skills if:

1. Your child has experienced ear infections or an unusually long stay (six months or more) in the hospital.
2. The child is not understood by playmates or others outside the immediate family.
3. The child is frustrated when trying to communicate and the situation does not improve over a one- or two-month period.
4. There is a delay of one year or more in developing speech and language skills. For example, here is a sample of abnormal language development (compiled by Beth Witt):

Three-year-old:

- Says only one or two words at a time.
- Cannot answer "what" or "who" questions.
- Speech is not comprehensible except in context.
- Does not seem to hear or understand all that is said; seems to "tune out" what others say.
- Does not start conversations. Speaks only when spoken to.
- Does not understand spoken directions without visual assistance from pointing and other gestures.
- Repeats what others say rather than responding.

Four-year-old:

- Talks in only two- or three-word phrases. Word order is poor.
- Cannot answer simple "what," "where," or "why" questions.

- Sentences or words are jumbled and disordered—hard to understand.
- Does not talk to peers or adults unless prodded, and then talks as little as possible.
- Does not respond to simple two-step directions: "Go to the kitchen. Bring me a spoon."
- Cannot listen to two or three lines of a story and answer simple questions about what was read.

Five-year-old:

- Talks in only three- or four-word sentences about present events.
- Cannot answer questions about "yesterday" or "tomorrow." Cannot answer "how" questions.
- Poor articulation is still a problem. Child's speech is unclear.
- Talks a great deal, but remarks may not be relevant to the situation.
- Has trouble sitting and listening to story of more than four or five sentences without "tuning out."

If any of these problems exist, it is recommended that you have your child's speech and language skills evaluated or tested.

What can I do about my child's speech and language problem?

Check with your local school district to see what evaluation and therapy services are available for your child. Many districts offer programs for preschool children. Some districts even extend services to infants. If your local district does not have a program for your child, call the Department of Education in your state and ask what services are available on a state-wide basis. If you live in a larger town, you may have the services of a speech and language clinician in a hospital, clinic, or private practice available to you. (For information, call the American Speech-Language-Hearing Association at 301-897-5700.)

After you have located a source of professional assistance, schedule an appointment for an evaluation. Then allow yourself a couple of days to think of, and write down, all the things about your child's communication that concern you. By writing them down, you relieve yourself of the burden of trying to remember them on the day of the appointment.

Vocabulary

Articulation—The production of speech sounds.

Evaluation—Tests used to measure a person's level of development, or to identify a possible disease or disorder.

Speech and language clinician—A person who is qualified to diagnose and treat speech, language, and voice disorders.

Refer to:

1.2 The Speech and Language Evaluation
1.3 Disorders of Speech and Language
1.4 The Speech and Language Glossary
2.1 Language Development
2.2 Speech Development
2.4 Development of the Preschool Child
10.2.4 Otitis Media

Disfluent Speech Behavior in Children

by Daniel DeJoy, Ph.D.

Introduction

When we say that someone speaks "fluently," we mean that the person's speech flows easily. Sounds combine into syllables, syllables blend into words, and words link into sentences with little effort. When someone's speech is "disfluent," it is uneven and does not flow smoothly. A **disfluency** is a break in the smooth, meaningful flow of speech.

It is understandable that all of us have occasional interruptions in our speech. Talking is not automatic. To communicate new thoughts and feelings, we create sentences we have never spoken before. Thus, speaking is a creative, decision-making process.

Children who are still learning language and communication skills are developing *coordination* of the muscles used for talking. They are learning new words and new sentence structures at a rapid rate. Also, children must discover how to inform, persuade, and question their listeners. Is it any wonder that children may speak disfluently from time to time?

What speech behaviors are disfluencies?

1. Repetition
Children may repeat individual sounds or syllables, usually at the beginning of words ("The baby ate the s-soup" or "The ba-ba-by ate the soup"). Also, children may repeat whole words ("The-The baby ate the soup"). Finally, youngsters may repeat more than one word in a phrase or sentence ("The baby—The baby ate the soup").

2. Interjection
Interjections are extra sounds, syllables, or words that add no meaning to the message. Probably the most common interjections are "uh" and "um" ("The uh baby ate the soup" or "The baby um ate the soup"). Words or phrases such as "well," "like," and "you know" are considered to be interjections.

3. Pauses
Pauses or silent intervals between words may be considered a type of disfluency, depending upon when they occur and how long they last. Pauses are often needed to separate phrases or thought units ("The baby ate the soup [pause] and then went to sleep"). However, speakers sometimes pause within a phrase or thought unit ("The [pause] baby ate the soup" or "The baby ate the [pause] soup"). These interruptions can be considered disfluencies, especially if they last over two seconds.

4. Revision
Children frequently revise what they have just said. They may stop in midstream and start over in a new direction. Revisions may be in pronunciation ("The bady—baby ate the soup"); grammar ("The baby eated—ate the soup"); or word choice ("The daddy—The baby ate the soup"). A child also may go back to add a word ("The baby—The hungry baby ate the soup").

5. Mis-timing.
Words can be mis-timed when spoken. Sounds or syllables may be *prolonged* ("The baby ate the s-s-soup" or "The baaaby ate the soup"). There could also be a break in the word ("The ba–by ate the soup"). Varying amounts of tension in the speech muscles (lips, tongue, vocal cords, etc.) may accompany these mis-timed words. Sometimes, the voice sounds strained or the coordination of breathing and speaking breaks down.

What causes disfluencies?

Children may be disfluent for a number of reasons. Rapid growth in language during the early preschool years is a frequent explanation. Preschool children begin to talk about more complicated ideas. Since there are several different ways to express those ideas, decisions about what to say and how to say it become more difficult. For example, when your child uses a newly learned sentence form, such as a question, the ordering of words may be confusing at first. Early questions may sound like "what he doing?" When the child begins to use "is," there may be some disfluency focused around that particular word: "What um is he doing?" or "What—What—What is he doing?" or "What he—What is he doing?"

Children must also decide what word to use to communicate their meaning most accurately. We all have had tip-of-the-tongue experiences. We knew exactly what we wanted to say but could not think of the specific word to use. We paused, said "uh," or held off the listener with "you know what I mean" until we remembered the word. Similarly, children may pause silently, interject "um" or other sounds, or repeat a word or phrase as they search for a word.

Another possible explanation for some disfluency is an occasional lack of coordinated movement among the lips, tongue, and jaw. You have probably heard your child mispronounce certain sounds in words (wabbit/rabbit, pease/please, pence/fence). Sometimes, children mis-time the rapid movements for speech, confuse sequences of sounds, or simply mispronounce a word. The result may be disfluencies such as word repetitions, prolongations, broken words, and revisions.

If a child feels pressure to perform, finding the right word, constructing sentences, and/or coordinating the speech muscles may not be accomplished smoothly. A child who is nervous—or becomes excited and must say a million things all at once—may become quite disfluent.

What disfluencies are common or "normal" ?

Children seem to be most disfluent during the preschool years. Generally, revisions, interjections, and word and phrase repetitions are very common in children's speech. Sound and syllable repetition, sound prolongation, and broken words are less common. As children reach school age, certain types of disfluencies, such as repetitions, become less evident in their speech. However, there is a wide range of behavior considered to be normal. Most children show each type of disfluency from time to time. This is considered to be "normal disfluency."

While disfluency is common in most children, certain patterns of disfluent speech are not quite as typical. First, if your child is very disfluent in most speaking situations, it may signal a problem in putting thoughts into words. If a child's sentence structures or pronunciation skills appear immature, then finding the right word or blending sounds into words may be more difficult. Also, it is not as common for a child to show a great many interruptions in the smooth flow of individual words (sound or syllable repetitions, broken words or prolongations).

What is the relationship between stuttering and normal disfluency?

Many experts have studied the relationship between childhood disfluency and "stuttering." Stuttered speech contains a number of disfluencies that interrupt the smooth flow of individual words. Some authorities have emphasized the similarities between stuttering and normal disfluency. One reason for this view is that almost all children show breaks in the smooth flow of individual words from time to time. Also, many children who begin to stutter seem to do so during the preschool years when normal disfluency is quite frequent. Thus, it is logical to think of stuttering as an outgrowth of normal disfluency.

Other speech clinicians have viewed stuttering as quite different from normal disfluency. They have emphasized the greater frequency of mis-timed words, often more than five instances per 100 words spoken. In addition, disfluencies may last longer than two seconds due to the duration of prolongations (The s-s-s-s-soup); more repetitions of a speech unit (The ba-ba-ba-baby); or tensing and struggle involving the disfluency. Through facial expression and tension, the child may show that the disfluency is a frustrating problem.

The Speech Foundation of America has published a list of "Warning Signs" related to disfluency. The presence of some of these behaviors may indicate that the child is having disfluency and beginning to react to the interruptions:

1. Frequent sound and syllable repetition
2. Syllable repetition in which an "uh" vowel replaces the correct vowel in the word ("puh-puh-peach" rather than "pe-pe-peach")
3. Frequent prolongations of sounds that become longer in duration
4. *Tremors* (trembling of muscles) around the mouth and jaw during speech
5. Rises in the pitch or loudness of the voice during the prolongation of sounds
6. Tension and struggle behavior while saying certain words
7. A look of fear in the child's face while saying a word
8. Avoidance of or delay in saying certain words

Should parents respond in any special way to their child's disfluency? First, view most disfluency as a natural part of the speaking process. Fluency—just like vocabulary, sentence structure, and pronunciation—develops gradually. It takes time and practice for most children to acquire the speaking skills that probably will lead to reduced disfluency.

Second, try to observe your own behavior as you talk with your child. If you speak at a rapid rate or find yourself interrupting, try to slow down a bit. Let your child have as much time as needed. Also, your eye contact, facial expressions, and vocal tone can be important signs to your child that you are interested in what the child is saying. If a child understands that you are interested and patient, then feelings of time pressure may be minimized.

The cooperation of other family members is also important. For example, households with several children may want to establish certain rules for turn-taking in conversations. At the dinner table, one person at a time gets to talk without interruption from others. This reduces the time pressure placed on your child and makes conversation more fun.

Summary

If your child's speech is characterized by a number of the "Warning Signs" described by the Speech Foundation of America, then you may want to contact a certified *speech and language clinician* for an *evaluation*. Seeking professional advice would be especially appropriate if your child's disfluency has been of concern for six months or more. It is important for you to understand that you are not at fault. No one is to blame. Some children, for reasons still not well understood, begin to show disfluency patterns. Many children are very disfluent for a period of time and then "grow out of it."

Vocabulary

Coordination—Muscles working together harmoniously to perform movements.

Disfluency—A break in the smooth, meaningful flow of speech.

Evaluation—Tests used to measure a person's level of development, or to identify a possible disease or disorder.

Interjection—A meaningless sound or word which breaks the smooth flow of speech.

Prolong—To lengthen or stretch out in time.

Speech and language clinician—A person who is qualified to diagnose and treat speech, language, and voice disorders.

Stuttering—Disturbance of the normal fluency and timing of speech.

Tremor—The trembling or shaking of a muscle group.

Refer to:
6.4.2 Talking With a Child Who Stutters
6.4.3. Stuttering: Early Intervention Therapy
6.4.4 Stuttering Therapy for School-Age Children
6.4.5 The Confirmed Stutterer

Reasons for Delayed Speech Development

by Elizabeth M. Prather, Ph.D.

What is the cause of your child's speech problem?

Finding the exact cause or causes of your child's speech problem can be difficult. Each child's speech is influenced by many factors, including the ability to hear, the physical development of the mouth and throat, and the abilities the child inherits. The most common causes of delayed speech development are:

1. **Hearing Loss**

One major cause of delayed speech is hearing loss. Even mild and temporary losses, caused by ear infections or *allergies*, can slow a child's development. Children learn to speak by hearing others speak. When they do not hear speech correctly, they cannot learn to talk correctly. For example, the words "cat," "hat," "sat," "fat," "that," "pat," "bat," and "chat" may all sound the same to a hearing impaired child. If your child's speech is delayed, see an *audiologist* (a specialist in testing hearing).

2. **Mouth Deformities**

Deformities, or physical defects, in the mouth can cause speech problems. Children born with *cleft palates* or other mouth deformities need special help and medical attention. Fortunately, structural problems bad enough to affect a child's speech are very rare.

3. **Mouth Movements**

Many children with delayed speech development have trouble learning to move their lips, tongue, and jaws properly. Just as some children walk, run, and play ball awkwardly, some children cannot control their mouth movements as well as others. A few of these children may not chew their food well, and may sometimes choke when they swallow. Some children drool because they have trouble swallowing. Your *speech and language clinician* can help you learn more about your child's mouth movements during speech.

4. **Language Delay**

Children may have difficulty learning the meaning of words and how to use words in sentences. This language delay will cause speech problems as well. Learning to talk is very complicated. It includes learning:

- The meaning and use of words
- How to combine words into phrases and sentences
- How to produce the speech sounds
- Combining sounds to say words and sentences

Some children have difficulty learning the rules for combining speech sounds. Errors like "pasghetti" for "spaghetti" are made by a child who knows how to say sounds, but does not know where the sounds belong in words.

Have you ever tried to learn a foreign language? It is very difficult to master a new language. Yet, we expect children to learn our language in an incredibly short period of time! It is not surprising that some children need extra time or special help.

5. **Language Disorders**

Sometimes speech problems are part of a more serious language disorder. The speech problem is considered less important than the language problem. First, the child needs help to understand and express ideas. Later the child can learn to say sounds correctly. Usually, as the child learns language, speech also becomes clearer. Speech and language clinicians can help these children improve both language and speech skills.

6. **Genetic Inheritance**

It is common for late speech development to run in families. One or both parents, or any number of aunts and uncles, may have had speech problems when they were young. But children with slow speech development do not always have parents who had the same problem. And parents who had speech problems will not necessarily "pass them on" to all of their children. *Genetic inheritance* is a strong, but not inevitable, factor in late speech development.

7. **Bad Speech Habits**

Many actions, including walking and talking, become automatic with time and practice. Sometimes when children are beginning to speak, they say sounds incorrectly. If a child

repeats an incorrect pattern long enough, it may become automatic—a bad habit! A child may say the word "school" correctly. Then, a few minutes later, the child will say "tool" in a spontaneous remark. You may also find that your child repeats your speech incorrectly, but does not realize it. These are all examples of bad speech habits.

Summary

These factors are the most common causes of delayed speech development. Usually a child's speech has been affected by a combination of these problems, not just one. The earlier a problem is detected, the earlier it can be treated and the less effect it will have on your child.

If you have any questions about your child's speech or language development, ask a speech and language clinician. The clinician will help you identify the factors that may be causing your child's problems. Early detection and treatment will save time and money. But, more important, your child will be saved from years of possible frustration, learning difficulties, and emotional problems.

Vocabulary

Allergy—An extreme sensitivity to a normally harmless substance, causing physical discomfort.

Audiologist—A specialist in testing hearing.

Cleft palate—An opening or split in the roof of the mouth.

Deformity—A physical abnormality or defect.

Genetic inheritance—A trait passed on from parent to child.

Language disorder—Any difficulty in understanding and using language.

Speech and language clinician—A person who is qualified to diagnose and treat speech, language, and voice disorders.

Refer to:

6.5.1 Developmental Dysarthria
6.5.2 Developmental Apraxia
6.5.4 Help Your Child Develop Feeding Skills
10.2.4 Otitis Media and Speech and Language Development
10.3.6 Cleft Lip and Palate: Effects on Speech, Language and Development

Disorders of Speech and Language

by Leslie S. McColgin

If your child has been scheduled for a speech and language evaluation, the child may have a speech and language *disorder* or delay. This article will describe some of the types of disorders. When your child has a speech and language *evaluation*, the evaluator will look for these signs of a particular problem:

1. Disorders of Language Form

A child may fall behind other children in phonological (speech sound) development or understanding and use of *grammar*. These two problems—*phonology* and grammar—often occur together, since they are both aspects of language form. Children with these problems frequently omit word endings. They often do not develop forms such as plurals, past tense verbs, complex verb forms, or other grammar forms at the age that most other children do.

The child with phonological problems often shows some kind of speech pattern. Some of the most common are omitting the last sound in a word (as in "how" for "house"), substituting one sound for another (as in "pork" for "fork" or "toup" for "soup") and omitting one sound from a *consonant blend* (as in "nake" for "snake"). The evaluator tries to discover the child's patterns so that therapy can correct the whole pattern, rather than just a few individual sounds that are in error.

The evaluator is also concerned with whether the child's speech is clear or *intelligible*. How well is the child's speech understood by others? Often the child's speech is more understandable to the family than to friends or strangers. Sometimes it's hard to tell. Many people often act as if they understand a young child, even when they don't. Notice how often your child has to repeat words or phrases when talking with a person outside the family. A child's speech is described as unintelligible when other people almost always misunderstand the child.

2. Disorders of Language Content

A child who has difficulty understanding words or choosing words to express ideas usually has a content problem. The young toddler who is still not talking is one example. This child may even show the ability to understand words and sentences as well as other children the same age. But the child is not using words to express meaning. Some children who do talk may substitute one word for another word with a similar meaning, or for a word that sounds similar. They may use vocabulary more typical of a younger child. They may repeat words or syllables. A common problem is found in children who have difficulty understanding or using *concept* words. These are words that describe:

- Position (such as in, at, under)
- Time (when, first, before, later)
- Quality (big, hot, pretty)
- Quantity (more, some, none, one, two, etc.)

These children often have difficulty with both language form and content, since they are struggling to chose the right words to express their meaning. These children may also be unsuccessful in the area of language use. They may have difficulty understanding questions or conversation directed toward them, and may respond incorrectly or inappropriately.

3. Disorders of Language Use

The child with disordered language use does not use language for the variety of purposes and in the variety of situations available. The child may rely on non-verbal or limited means of communicating. A child who is developmentally delayed, physically handicapped, or mentally retarded may not be given as many opportunities to develop language as other children. The family may not expect the child to use words to ask questions or to express thoughts and feelings.

In fact, one of the most striking features of many language delayed children—not just those with mental retardation—is that they rarely ask questions. In their conversations with adults and other children, they generally answer questions. They do not seem to take turns in a conversation. They let the adults do most of the talking. In contrast, children without language problems show much more balance in answering and asking questions. They are able to take turns in a conversation more easily.

4. Articulation Disorders

Sometimes a child does not make speech sounds correctly due to incorrect placement or movement

of the articulator muscles (lips, tongue, velum, pharynx). This may be caused by a physical problem interfering with speech production, such as impaired muscle ability, a short tongue length or cleft palate. An oral examination should tell the evaluator if the child's errors on speech sounds are due to a muscular or structural problem.

The evaluator assesses the strength and use of the muscles in the lips, tongue and jaw, and observes the child's swallowing pattern. If the child has an immature swallowing pattern, it can interfere with the normal alignment of the teeth. The child might have an overbite ("buck teeth") or an open bite (a space between the upper and lower front teeth). Children with these problems are sometimes referred to an orthodontist (dentist who straightens teeth).

5. Voice Disorders

The most common voice problem in children is *vocal nodules*. These are hard calluses that develop on the *vocal cords*. They cause the child's voice to be hoarse or sometimes weak and breathy if they are very large. They are sometimes called "screamer's nodules" since they are caused by vocal abuse such as screaming, talking at the wrong *pitch*, frequent coughing or throat clearing, or even constant loud talking. This kind of abuse of the vocal cords can also lead to *polyps* (soft, fluid-filled growths) or *contact ulcers* (ulcers on the vocal cords).

The child with a voice problem should always be seen by an ear, nose, and throat doctor. Any hoarseness or vocal strain that lasts for more than two weeks should be investigated by an ear, nose, and throat doctor. The ear, nose, and throat doctor may suggest a speech evaluation by a *speech and language clinician*. The evaluation will consist of:

- Listening to the child talk.
- Seeing how long the child can make a sound (say "ah-h-h-h-h" as long as you can).
- Determining the child's pitch range and typical pitch.
- Exploring what kinds of vocal abuse the child is engaging in and how frequently.

6. Rhythm or Fluency Disorders

Children who have difficulty saying sounds, words, and phrases in a smooth flow may have a *fluency* disorder. One such disorder is stuttering. A child of any age can be brought in for a speech evaluation if the parents think the child is stuttering. It is true that many children outgrow stuttering. But it is also true that the most effective time to help children with a stuttering problem is in the preschool years.

In the evaluation, the speech and language clinician will want to observe whether the following behaviors occur in the child's speech:

- *Repetitions:* The child may repeat a syllable ("bu-bu-butter"), a word ("I-I-I-I want to go"), a phrase or a whole sentence. In general, the more times the child repeats a syllable or word, the more serious the problem is. Similarly, the child who repeats syllables and words is considered to have a more severe problem than a child who only repeats phrases or sentences.

- *Prolongations:* The child may prolong a sound such as "s" or "f," as in saying "s-s-s-s-sock." In general, the longer the prolongation lasts, the more serious the problem is.

- *Use of the schwa:* Most of us say "uh" while searching for a word or phrase to express our thoughts. The young child learning to talk may also use "uh," which is called the "schwa" sound. However, if this occurs often, along with repetitions or prolongations, it usually indicates a fluency problem.

- *Signs of tension:* The evaluator looks for signs of tension in the face or body when the child speaks. The child may blink or squeeze the eyes shut while trying to say a word. The voice of the child may sound tense, indicating tension in the vocal cords.

The evaluator also needs to know if there is a family history of stuttering, since this problem seems to be hereditary in some cases. The evaluator will explore what situations make the child stutter more, and which situations help the child be more fluent. The evaluator will try different activities to get the child to speak fluently. The evaluator will also want to thoroughly evaluate the child's language skills.

Some stuttering problems seem to be related to delayed vocabulary development. Some language problems, such as a word-finding problem, may make the child sound like a stutterer.

Vocabulary

Articulation—The production of speech sounds.

Concept—A general idea or characteristic applicable to several objects or events, which helps to organize knowledge about the world.

Consonants—The sounds made by stopping or restricting the outgoing breath.

Consonant blend—Two or more consonant sounds spoken together, such as "sn," "tr" and "ch."

Developmentally delayed—A child who acquires specific skills after the expected age.

Fluency—The smooth flow of speech.

Grammar—Rules governing how words are combined in sentences.

Impairment—Physical weakness or damage, or a functional problem.

Intelligible—Clear, understandable speech.

Language disorder—Any difficulty in understanding and using language.

Language form—The ways in which language units of sound and meaning are combined with one another.

Phonology—The study of speech sounds and the rules governing how they are combined to convey meaning.

Pitch—The sound quality associated with high or low frequency of vibration, like high or low musical notes.

Schwa—The "uh" sound.

Vocal cords—Muscles in the larynx which produce speech sounds by vibrating.

Vocal nodules, polyps or ulcers—Various growths on the vocal cords usually caused by abuse or misuse of the voice.

Refer to:

1.2 The Speech and Language Evaluation
2.1 Language Development
2.2 Speech Development
2.3 Cognitive Development
4.7 Turn-taking and Conversation
6.1.3 How You Talk With Your Child is Important!
6.1.4 Simplify Your Language to Help Your Child Understand
6.3.1 Protecting Your Child's Voice
6.4.1 - 6.4.5 Articles on Fluency

The Speech and Language Evaluation

by Leslie S. McColgin

What is a speech and language evaluation?

A speech and language *evaluation* is the measurement of a person's communication skills. It is done to find out if a person has communication problems. The evaluation is done by a *speech and language clinician.* An evaluation may be at a school, hospital, clinic, private office, or your home.

The speech and language clinician gathers information by asking questions about your child and testing the child. Depending upon the age and attention span of the child, the evaluation may be completed in one day. Or, it may be spread over several sessions. The length of the evaluation will vary with the amount of testing that needs to be done.

Before your child is seen for an evaluation, you may be asked to answer questions or complete written forms about your child. You may be asked for a description of your child's:

Health history –
including any serious illnesses, operations, accidents, or recurring health problems.

Developmental history –
including the ages at which your child started doing certain activities like sitting, walking, making speech sounds, etc.

Family –
including names and ages of brothers and sisters, discussion of family members who may have speech or hearing problems, etc.

Speech and language behaviors –
including your comments about your child's speech and language skills and any causes of concern.

School history –
what schools your child has attended.

What kind of tests will my child be given?

During your child's evaluation, the clinician observes the child doing different tasks. Judgments are made about how your child performs compared with other children the same age. The clinician will evaluate your child's:

- Understanding and use of different words
- Correct use of words in correctly formed sentences
- Use of language for different purposes
- Pronunciation of speech sounds
- Physical ability to produce speech
- Voice quality
- Fluency or smooth flow of speech

The clinician also briefly checks the child's *motor* skills, which involve *coordinating* muscle movements. Large motor abilities like walking and running are checked. Fine motor activities like writing or drawing are also checked. A hearing test is part of any speech and language evaluation. There may be a hearing problem that may affect speech and language development. The clinician also checks the child's mouth, looking for any structural problems with the tongue, lips, teeth, or roof of the mouth. The clinician uses formal tests and informal observations of the child's communication abilities. The clinician also notes such things as the child's attention span, activity level, play skills, or any unusual behavior.

What are formal tests?

Formal tests are a way of comparing your child with other children of the same age. There are many tests available. The clinician tries to choose those that will give the information needed about a child's problem. In a formal test, the child is asked to cooperate on certain tasks. The child's ability to perform these tasks is compared to the ability of other children. The clinician is looking for an overall age level at which your child performs. The clinician also notes the kinds of tasks that give the child trouble. Later, if the child is enrolled in therapy, the clinician will do more tests to determine which specific skills to teach. Formal tests are designed to get a sample of the child's skills on various kinds of tasks, including:

1. Receptive vocabulary
What words does the child understand? The child is asked to point to pictures or objects named.

2. Expressive vocabulary
What words does the child use? The child is asked to name objects and/or pictures. At older age levels (over four years), the child may be asked to explain what a word means, or to complete a sentence such as "Fire is hot, ice is _____."

3. **Receptive grammar**
How well does the child understand different language forms? The child might be asked to find a picture that "goes with" a sentence said by the evaluator. Or, the child might be asked to follow a request using some objects, such as "Put the car in the box. Now put both cars in the box." This checks the child's understanding of plurals.

4. **Expressive grammar**
What language forms can the child use? The child might be asked to imitate various types and lengths of sentences. The child might be asked to complete a sentence with a particular form, such as plurals. "Mary has a dress and Joan has a dress. So they have two_____."

5. **Auditory memory**
How well does the child remember what is heard? The child might be asked to follow a series of directions that gradually increase in length, such as "Put the cup in your lap and open the book" or "Touch the dog, the book, the cup, and the spoon." The child might be asked to repeat a series of unrelated words or a series of numbers. The child might also be asked to repeat a series of related words, such as dog, cow, and horse. The child's ability on each task would be compared.

6. **Auditory discrimination**
Can your child hear small differences between words? The child might be asked to tell whether two words sound the "same" or if they sound "different." For example, are "sing" and "ring" the same or different? The child might also be asked to point to a picture in a book. Pictures of words that sound similar would be on the same page.

7. **Word-finding**
How well does the child think of words to use? The child might be asked to rapidly name a series of common objects, or a series of pictures of common objects. The child might be asked to name as many words as possible in a limited amount of time.

8. **Articulation**
What speech sounds can the child make? How clear is the child's speech? The child's pronunciation of vowels and consonant sounds is recorded. The child is usually asked to name a picture. The names of the pictures contain each of the sounds of English at the beginning, middle, or end of the word. The clinician notes any mispronunciations. Sometimes, a picture story is used. This shows the clinician if your child makes more errors in saying sentences than in saying single words. The clinician also has the child imitate some of the error sounds. This shows if the child can imitate the sound all by itself (in "isolation"), in a syllable, in a word, or in a sentence.

What are informal tasks?

Informal tasks include talking with the child, having the child discuss pictures, answer questions, and tell simple stories. If the child is an infant or toddler, the clinician observes how the child plays, how the child uses objects and toys, and how well the child understands words and requests. The clinician also looks at how the child expresses wants and needs and obtains information and objects. The clinician looks to see if these functions are expressed nonverbally (with gestures, eye contact, tugging, and pointing) or with words.

What other measurements are taken during the evaluation?

1. **Oral peripheral examination**
The clinician conducts what is called an "oral peripheral examination." This includes observing the child's face, lips, teeth, tongue, palate, and throat. It also includes observing how well they work in such activities as feeding, moving the tongue, moving the lips, or making alternating lip and tongue movements rapidly. The clinician might ask questions about the child's feeding skills. The muscles of the mouth are first developed in feeding activities such as sucking, swallowing, and chewing before the muscles are used for speech.

2. **Voice**
If there is a voice problem, the evaluator will be concerned with how long the child can hold a tone on one breath, what the child's pitch range is (how low and how high the child can sing), and the pitch that the child usually uses to talk. The clinician might also ask questions about how the child uses the voice. For example: Does the child talk loudly? Does the child yell a lot?

3. **Fluency**
The clinician also tries to find out if there is a fluency problem. As the child speaks, the clinician listens for sounds and words that are repeated or prolonged, hesitations, and fillers such as "um" and "uh." The clinician might ask you to describe how your child talks and whether or not the child avoids talking.

What should be the result of the speech and language evaluation?

A written report of a thorough speech and language evaluation will include the following:

1. Information about the child's history and home environment that may be helpful in understanding the communication problem.
2. A description of the child's abilities in the areas of making speech sounds, language use, voice, and fluency of speech.
3. A description of the child's physical structures for speech (lips, tongue, palate, etc.) and how well the muscles work compared to other children of that age.
4. The results of a hearing test to rule out the possibility of a hearing problem.
5. A description of special problems such as physical limitations, behavior problems, emotional problems, short attention span, overactivity, or poor motor skills.
6. Recommendations for future action which might include:
   - Referral to another professional such as a medical doctor
   - Additional testing
   - Re-evaluation at a later date
   - Participation in a speech therapy program, including suggestions for:
     type of therapy
     frequency of therapy
     length of sessions
     goals for therapy
     parent participation
   - No need for therapy

Summary

The speech and language clinician is interested in finding out your child's strengths and weaknesses in communication. Then the clinician can make the best decisions about treatment or referral to another professional. The clinician will also explain the meaning of your child's test scores. It is often difficult to do all of the activities listed above in the time allowed. But the clinician will try to obtain all the necessary information and share the results, interpretation, and recommendations with you.

If you have specific questions about the evaluation, be sure to ask the clinician. The clinician will be glad to go over specific questions, more than once if necessary. You may want to schedule more than one visit with the clinician. During the second visit you can further discuss the evaluation and clear up any questions you may have.

Vocabulary

Articulation—The production of speech sounds.

Auditory—Involving the sense of hearing.

Consonants—The sounds made by stopping or restricting the outgoing breath.

Coordination—Several muscles or muscle groups working together harmoniously to perform movements.

Evaluation—Tests used to measure a person's level of development, or to identify a possible disease or disorder.

Expressive language—Includes the skills involved in communicating one's thoughts and feelings to others.

Fluency—The smooth, meaningful flow of speech.

Motor—Relating to muscular movements.

Pitch—Sound quality associated with low or high frequency of vibrations, like low or high musical notes.

Prolong—To lengthen or stretch out in time.

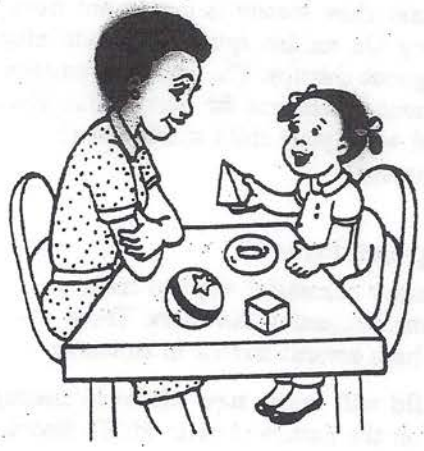
Receptive language—Includes the skills involved in understanding language.

Speech and language clinician—A person who is qualified to diagnose and treat speech, language, and voice disorders.

Vowels—The sounds associated with the letters "a," "e," "i," "o," "u," and "y"; made by allowing air to pass through the nose or mouth without friction or stoppage.

Refer to:

1.1 Is My Child's Speech or Language Delayed?
1.5 What is Speech and Language Therapy?



What Is Speech and Language Therapy?

by Anthony B. DeFeo, Ph.D.

Introduction

Your child will be enrolled in speech and language therapy. This article will help you answer questions like: What is therapy? How can therapy help your child? How can you choose the best therapy setting for your child?

Evaluation: The basis of therapy

The evaluation your child received or is currently completing is the first step of therapy. Evaluation includes careful observation and measurement of your child's speech and language abilities. From these observations and measurements, the clinician develops a treatment plan to meet your child's special needs. Measurement does not end here, however. Throughout therapy, the clinician will measure your child's progress to set new goals for learning. Precise evaluation is an important part of therapy.

Therapy as a process

Speech and language therapy involves a series of activities to meet specific goals. These goals are usually accomplished over time. Only rarely can a child's communication skills be changed in one or two sessions.

The length of therapy cannot really be predicted. But usually the more serious the disorder, the longer the period of therapy. This is not to suggest that your child will fail to improve right away. You may see immediate improvement. Then a period of gradual progress may begin. Or, your child may show steady improvement from the beginning. Or, sudden spurts of growth may occur throughout therapy. The rate and pattern of improvement is different for every child. Keep this in mind when your child starts speech-language therapy.

Therapy procedures

There are many successful ways to treat children's communication disorders. These procedures have several factors in common:

1. **Your child will learn new skills in therapy**
Depending on the nature of your child's disorder, the child may be asked:

- To learn new behaviors (such as pronouncing a certain speech sound).
- To modify behavior that interferes with adequate communication (such as reducing speech rate or the loudness of voice).
- To relearn skills that were lost due to an acquired disability.
- To improve speech through muscle stimulation and by combining motor-speech practice with medical procedures such as surgery or dental appliances.
- To augment oral communication with a variety of alternative, non-vocal communication devices (gestures, *sign language, communication boards,* or electronic instruments that produce synthesized speech).

2. **Speech and language therapy proceeds in small steps**
Therapy is based on a carefully designed sequence of practice. The clinician selects key communication skills that are taught in several ways—drill and practice, play interactions, or conversations.

The difficulty of the response required from your child is gradually increased over time. Thus, your child may be asked to practice using single words before using phrases and sentences. The clinician is careful to *reinforce* or reward desired responses. Your child is clearly told which responses are correct and which are not correct. This is called *feedback* and it helps your child in the learning process. The therapy is programmed in small steps so that your child receives much success and reward, especially early in therapy. Gradually, your child is challenged to improve or expand speech and language skills.

3. **The clinician will try to develop a good interpersonal relationship with your child**
Your child will learn best in a warm and supportive environment. The clinician also uses games, rewards, and play activities to maintain your child's interest and stimulate the child to learn.

4. **Parents play a key role in the therapy process**
You will probably be asked to help by observing your child outside of therapy and helping your

child practice at home. Sometimes you will need to learn how to respond to your child's communication difficulties. Or, you may learn how to *model* certain speech and language forms as an example for your child. The clinician will prepare you for these activities by providing information, general counsel, or specific skill training. You can also help by assuring your child's steady attendance at therapy sessions. Most important, you can model for your child a positive attitude about the therapy process.

Frequency and length of therapy sessions

How often your child attends therapy depends upon the child's age, the nature and severity of the communication disorder, and practical considerations of the cost and availability of services. Clinicians agree that one session per week is usually not enough, because it is difficult for the child to remember what has been learned. Most commonly, children are seen for two to three sessions per week. For some speech disorders, such as stuttering and certain *articulation* problems, daily treatment is often most successful. More rapid and permanent progress will occur than when therapy is spread out over time. Such intensive programs are rarely available except in public school settings.

The length of sessions also varies. If your child is a preschooler, it is probable that individual therapy sessions will be thirty minutes. Sessions are often one hour if treatment is in a group. Typically, sessions for older children are forty-five to sixty minutes.

Therapy settings

Often parents have a choice about where to seek speech and language therapy services. Public schools provide speech and language therapy for school-age children in every state. Some states extend services to preschool children. Most major hospitals have outpatient programs that serve children with speech and language handicaps. A number of state health agencies sponsor community clinics. Other options are a university speech and language clinic and services provided by professionals in private practice. In some cases, speech and language therapy may be carried out in the home environment.

As you explore these options, you should know that fees vary. You may want to check with your insurance company to find out which services they will fund.

Clinician qualifications

The recommended minimum qualifications of a speech-language clinician are a Master's Degree plus national certification from the American Speech-Language-Hearing Association. This certification is signified by the letters C.C.C., which stand for Certificate of Clinicial Competence. Some states require a license for individuals in private practice. You should be comfortable in asking a clinician whether he or she has these credentials. One exception to this rule would be in university clinics, where graduate students carry out treatment. In this instance, you would want to be sure that students are supervised by instructors with an M.S. or M.A. degree and C.C.C. certification. In addition to these minimum qualifications, you should only seek and stay with those clinicians who have scientific knowledge plus a caring approach to the therapy process.

Vocabulary

Articulation—The production of speech sounds.

Communication board—An aid for people with speech difficulties. The board contains pictures or representations of numbers, the alphabet, and commonly used words. The person uses the board to communicate by pointing to the pictures which express the desired message.

Evaluation—Careful observation and measurement of a person's speech and language abilities.

Feedback—Information provided on the correctness of the learner's responses.

Model—To provide a correct example for the learner to follow and imitate.

Reinforce—To reward desired behavior.

Sign language—Communication using a system of gestures rather than spoken words.

Refer to:
1.2 The Speech and Language Evaluation

The Speech and Language Glossary

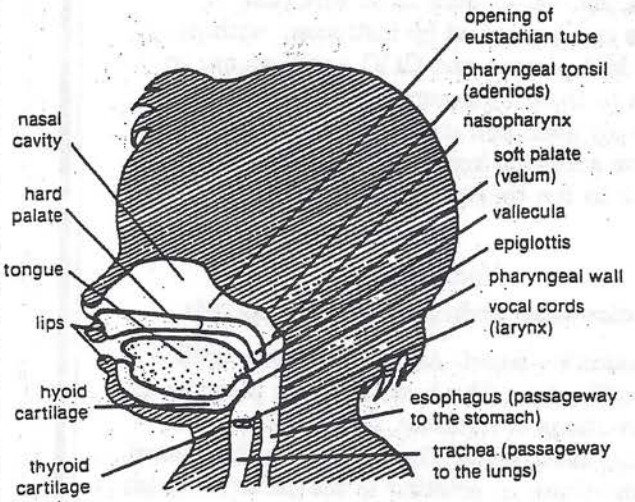
by Leslie S. McColgin

What is Speech?

The term "speech" is used to refer to the actual physical aspects of communicating a message. There are three major aspects of speech:

1. Articulation

Articulation refers to the actual physical production of sounds in speech. Speech requires air to pass from the lungs through the *larynx* or voice box, causing the *vocal cords* to vibrate. The sound is then altered by the *palate*, tongue, lips, and teeth.



These structures can:

- Block and then "explode" the air stream, as in "p"
- Make the air stream be narrowed and directed against the teeth or palate, but not completely blocked off, as in "s" or "f"
- Allow part of the air stream to flow through the nose, as in "m"
- Alter the air stream by the size and shape of the oral cavity, depending on the exact position of the tongue, as in vowel sounds. These structures which can interrupt the flow of air, or change the oral cavity are called *articulators* (lips, jaw, soft palate, tongue, and pharynx).

2. Voice

As mentioned above, the air stream passes through the larynx or voice box, causing the vocal cords to vibrate. The size and shape of a person's vocal cords, along with the size and shape of the mouth influence a person's voice. Voice is the sound produced by the vibration of the vocal folds. There are several aspects of voice:

- **Loudness**
- **Quality** (hoarse, weak, strident, husky, breathy)
- **Resonance** (vibration of air in the throat and nasal cavities during speech)

3. Fluency or rhythm

Language generally flows out in speech in an appropriate rhythm, with pauses and stress in the right places to express meaning. Fluency is how smoothly sounds, words, and phrases flow together during speaking.

What is Language?

Language is an organized set of *symbols* that are used to communicate thoughts and feelings. A symbol is a sign that stands for or represents something else. For example, the word "dog" is a symbol used to represent a specific kind of animal. These symbols are combined according to the rules that govern language. Symbols can be gestures, as in sign language. Or they can be written, as in use of the alphabet for writing words and reading. Sounds can also be used as symbols. This article will be concerned with oral, or spoken, language.

Language always has some kind of *form*. Language also has *content* and *use*. **Form** refers to **how we say something**, or our choice of symbols. **Content** refers to **what we say**, or the meaning of our message. **Use** refers to **why we say something**, or the purpose of our message. When a child's language skills are evaluated, the evaluator observes and describes the child's **form**, **content**, and **use** of language.

1. Language form

Language **form** has several levels: the choice of sounds to use; the choice of words and word forms to use; and the choice of word order to use. When evaluating the child's form, the evaluator looks at two aspects:

- **Phonology.** Phonology refers to the sound system of the language. Every language in

the world has its own sound system, although most languages share many of the same sounds.

These sounds make a difference in meaning. For example, "pat" means something different from "bat." In English, "p" and "b" are two different meaningful sounds. Sounds are combined according to rules for any given language, and the sounds are divided into certain classes. For example, the sounds "p," "b," "t," "d," "k," and "g" are called *stops* because the air stream from the lungs is completely stopped by the tongue or lips, and then released. The sounds "m," "n," and "ng" are called *nasals* because the soft palate allows some of the air stream to enter the nose.

- **Morphology.** Morphology refers to the child's choice of word forms and word endings to express a thought. The young child learns to express various morphological forms in speech, such as be verbs (am, is, are, was, and were), negative words (such as can't and don't), prepositions (such as in, on, and at), plurals, past tense verb forms, etc.

- **Syntax.** Syntax refers to the order that words are put in a sentence. For example, if we want to express the thought of a boy who kicked a ball, we don't say, "The ball kicked the boy." Instead, we say, "The boy kicked the ball." The English language has rules for the order we use to express our ideas with words. Of course, a child cannot tell you the rule itself. But the child uses these rules every time words are combined in a sentence to express a thought. The child learns that using correct forms is the most effective way of getting a meaning across.

2. **Language content**

Language content refers to the meaning that the child can understand and express. To the child, meaning is of the utmost importance.

The content that the child expresses may belong to the different categories including:

- Existence—Refers to existence of an object
- Nonexistence–disappearance—Refers to nonexistence or disappearance of an object
- Recurrence—Refers to reappearance of an object or event
- Denial—Refers to negation of identity, state, or event
- Possession—Refers to ownership by different persons
- Action—Refers to movement
- Locative state—Refers to the location of a person or object
- Quantity—Refers to numbers of people or objects
- Time—Refers to the passage of time
- Causality—Refers to cause-and-effect relationships
- Mood—Refers to the attitude of the speaker

The term *semantics* refers to the child's meaning or content. Semantic ability refers to the child's ability to choose words and combine them in such a way as to express the child's intended meaning.

3. **Use**

This refers to the **reason** or **purpose** for talking. The uses of communication are sometimes called language functions. The following is a list of common language functions, or uses:

Function	**Example**
Requesting an object	"Gimme milk."
Requesting an action	"Come here." "Mama!"
Sharing thoughts and feelings	"I love you."
Expressing one's personality or asserting one's self	"I'm a big boy."
Requesting information	"What that?" "Tell me how to fix it."
Exercising the imagination	"You be the daddy and I'll be the mommy."
Relating information to a listener	"Guess what we did at school today? We saw this really neat movie about dinosaurs."

Children are able to do many of these functions without using words. For example, a baby may hold up an empty milk glass and grunt to indicate more milk. However, it is vital that children learn to use words effectively to accomplish these language functions or uses.

What is receptive and expressive language?

Receptive language refers to the skills involved in understanding language. These skills include:

- The ability to hear differences in sounds (phonology), as in understanding that "paw" and "pot" mean two different things.
- Being able to remember what is heard, as in being able to repeat a series of words or follow two-, three-, or four-part directions.
- Understanding vocabulary and concept words (semantics).
- Understanding different grammatical forms (morphology and syntax) such as understanding that "cat" and "cats" mean two different things.

Receptive language also affects language use. For example, the child may have trouble understanding question forms or certain concept words. This causes the child to respond inappropriately to a question, or have trouble staying on the topic of conversation.

Expressive language refers to the skills of being precise, complete and clear when expressing thoughts and feelings, answering questions, relating events, and carrying on a conversation. These skills include:

- Being able to use the sound system (phonology).
- Choosing word forms and word order appropriately (morphology and syntax).
- Choosing the best words to express a thought (semantics).
- Using a wide variety of language functions.

Vocabulary

Articulation—The production of speech sounds.

Articulators—The lips, lower jaw, soft palate, tongue, and larynx which produce meaningful sound by restricting the flow of air.

Consonants—The sounds made by stopping or restricting the outgoing breath.

Content—The aspect of language concerned with meaning.

Expressive language —Includes the skills involved in communicating one's thoughts and feelings to others.

Fluency—The smooth, meaningful flow of speech.

Form—The aspect of language concerned with how we say something; how we choose and combine symbols according to the rules of language.

Morphology—How words are formed and used to convey a message.

Nasals—The sounds "m," "n," and "ng"; made by allowing passage of air through the nose rather than the mouth.

Phonology—How the sounds within a language are combined to convey meaning.

Receptive language—Includes the skills involved in understanding language.

Resonance—The vibration of air in the throat and nasal cavities during speech.

Semantics—The aspect of language concerned with meaning or content.

Stops—The sounds "p," "b," "t," "d," "k," and "g"; made by blocking the air pressure in the mouth and then suddenly releasing it.

Symbol—A sign that represents a person, thing, action, quality, idea, or feeling.

Syntax—How words are put together in a sentence to convey meaning.

Use—The aspect of language concerned with the purpose of our message as we relate to other people.

Vowels—The sounds associated with the letters "a," "e," "i," "o," "u," and "y"; made by allowing air to pass through the nose or mouth without friction or stoppage.

Refer to:

2.1 Language Development
2.2 Speech Development

Tips for Parents on Learning at Home

by Margaret Schrader, M.S., C.C.C.

Introduction

Being a parent is a very special role. Parents are responsible for teaching their children about life and how to live it fully. This can be a very big job, especially if your child has communication difficulties. Parents often need information about how to best meet the needs of their child.

Your child's speech and language clinician can give you helpful information about your child's speech and language development. The clinician can also suggest specific activities to help your child learn at home. In addition, there are a few basic guidelines on teaching and learning which can help you and your child succeed:

Tips for Parents

1. **Let your child feel loved.**
Touching, hugs, kisses, gentle words, or an approving smile will help your child feel relaxed and confident about learning. Use a happy tone of voice to convey love and acceptance. When your child feels loved, the child is more likely to be open to learning.

2. **Remember that your child is just a child.**
It's important to keep your expectations appropriate to your child's abilities. Ask your speech clinician about your child's language abilities. That way, you won't expect too much—or too little—from your child.

3. **Give your child approval.**
Appreciate any success in learning your child accomplishes. Compliments will encourage your child to continue to learn. Criticism may discourage your child. Accept that your child can make mistakes. Each child is unique. Let your child know that you accept your child's strengths *and* weaknesses.

4. **Help your child to feel important.**
Take time to do things with your child. Driving in the car, going to the store, and doing family activities are all opportunities for learning. Your child will appreciate your time and attention.

5. **Remember that learning can be fun.**
Have a good time with your child. Play together. Do things that delight both of you. If you do not enjoy what you are doing, neither will your child. Follow your child's lead in finding things that are fun to do.

6. **Talk to your child.**
Even if your child does not seem to understand at first, talk often about what you are doing together. Give your child time to respond.

7. **Really listen to your child.**
Get down to your child's eye level, and look at your child as you are listening. Respond to what your child says. This shows your child that you are sincerely interested in the child's thoughts and feelings. Make sure your child has enough opportunities to be listened to.

8. **Share your ideas and experiences with your child's speech clinician, doctor, or teacher.**
Share information and ask questions about your child's learning needs. Let them know about situations which may affect your child's learning, such as illnesses or problems at home.

9. **Take an interest in your child's schoolwork or therapy.**
Help your child learn to be enthusiastic about learning. Talk about school and therapy in a positive way.

Summary

You are your child's first, and most important, teacher. You set an example for your child of how to listen and talk with others. You can make a big difference in how well your child develops communication skills. It is important to help your child learn and practice communication skills at home. As your child uses these new skills in everyday activities, you can feel proud of your child's success.

Refer to:
4.0 Articles on Learning to Talk and Understand
5.0 Articles on Home Activities for Speech and Language Development

Dealing with Frustration

by Judith M. Creighton, Ph.D.

Introduction

Frustration is the angry feeling that develops when we can't have what we want. Everyone knows what it's like to be frustrated. Children with speech and language problems are often frustrated.

It's not easy to deal with your child's anger and frustration. But your child needs your guidance about what to do with angry feelings. The best time to talk with your child about how to deal with anger is when you are both feeling friendly. Try the following methods to help your child learn to manage anger and frustration.

Share your ways of dealing with anger.

First, your child needs to know that you get angry, too. Explain what you do to keep from showing anger in dangerous or foolish ways. Start by talking about the last time you felt frustrated. Tell what you wanted to have happen, what did (or did NOT) happen, and how you felt. Bring up the issue of your child's anger carefully and matter-of-factly. Ask your child to talk about the last time the child felt angry. What did your child want to have happen? What did happen? How did your child feel? How was the feeling expressed?

Try to help your child identify successful and not-so-successful ways of expressing anger. Be honest about your own anger. It really helps children to know that their parents are not perfect. Also try to help your child recognize the kinds of situations which are likely to cause anger. Point out how you prepare for difficult situations. Talk about the times when your child handled problems without getting angry. What did your child do to "keep cool?"

Help your child learn control words.

A child with speech and language disabilities is often made to feel like a second-class communicator. People may consider your child babyish, stubborn, or stupid for "not getting the idea." Other children can be particularly cruel. They are more likely than adults to deliberately shame or avoid your child.

Your child needs to practice some control words until they are known very well. Some of these are: "Stop!" "Wait!" "My turn!" or "Me, too!" If your child can't form these words, find other ways to express the message. A simple "No" with some gestures may do the trick.

Your child also needs to have some social words ready. In order of importance, these may be: "Thank you." "I like you." "I don't like it." "This is fun."

Provide opportunities for successful play with other children.

Speech and language delayed children need good humor, persistence, AND some play materials which other children enjoy. Show your child and describe in words the meaning of good humor and persistence. Find play materials for your child that don't require a lot of language for successful use. Tell other children that your child is trying very hard to be a friend. Make your house and outdoor play area inviting so children will come into your child's territory. You can be nearby to help resolve problems.

Help your child prepare for possible frustrating interactions.

Adults who interact with your child can create more complicated problems. Few adults would openly admit to negative feelings about a child with a disability. But, many adults are short-tempered with such children. Some adults tend to talk down to a child with any kind of delay. Finally, some adults are cruel but will say, "I didn't mean it" or "I was just kidding" if you challenge their behavior.

Be sure to share and talk about good times, too. It's not necessary to dwell on anger and frustration. (Your child might decide that being angry is the best way to get your attention.)

Help your child learn acceptable ways to deal with frustration:

1. Use words, rather than actions, to express your anger.
2. If one way of doing something doesn't work, think of another. Or, get help with the problem,

rather than hitting the person or object which is making you angry.

3. If you have a problem, it's all right to cry. But it's not all right to give up on trying to reach your goal.

4. If someone won't do what you want, try to persuade that person that it's important to you. If it's not important to them, trade. (Do something in exchange).

5. If you can't solve a problem, leave it for awhile. Do something else. Or, think about it some more. Then, come back to the problem.

All of these techniques may be standard for adults, but children have to learn them by experience. Your language delayed child is not unique. Talk about which ways of dealing with anger work best. Explain the situations where one technique is better than another. Point out how other people deal successfully with their problems. Try to describe what they are doing. Praise your child when the child deals with anger successfully.

Help your child learn what behavior is not allowed.

For your own survival, you have to have some house rules about expressing frustration. There are some ways of expressing anger that are not allowed. People may not hurt other people or animals. People may not destroy other people's property. (Most children break these rules occasionally, or act as if they're trying to.) Your punishments for infractions should be established with your child ahead of time. For hurting people or trying to, brief banishment from people—a time-out—is best. For hurting others' property, a child should be expected to make some repayment. Depending on the age and ability of the child, an apology should be made.

If you are consistent and use the teaching methods suggested here, you can help your child learn to manage frustration. As your child gets older and more experienced, the child will get better at dealing with frustration. There may also be less frustration as your child progresses in speech and language therapy.

Refer to:
9.3 Talking About Your Child's Feelings and Behavior
9.4 Dealing With Negative Behavior