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Research Report

Unhelpful thoughts and beliefs linked to social anxiety in stuttering: development of a measure

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Abstract

Background: Those who stutter have a proclivity to social anxiety. Yet, to date, there is no comprehensive measure of thoughts and beliefs about stuttering that represent the cognitions associated with that anxiety.

Aims: The present paper describes the development of a measure to assess unhelpful thoughts and beliefs about stuttering.

Methods & Procedures: The Unhelpful Thoughts and Beliefs about Stuttering (UTBAS) self-report measure contains 66 items that assess the frequency of unhelpful thoughts and beliefs. Items were constructed from a comprehensive file audit of all stuttering cases seen in a cognitive–behavior therapy based treatment programme over a ten-year period.

Outcomes & Results: Preliminary investigations indicate that the UTBAS has high levels of test–retest reliability ($r=0.89$) and internal consistency (Chronbach's $\alpha=0.98$). It has good known-groups validity, being able to discriminate between stuttering and non-stuttering participants on items that contain no reference to stuttering [$t(38)=8.06$, $p<0.0001$], with a large effect size ($d=2.3$). It has good convergent validity ($r=0.53$ – 0.72) and discriminant validity ($r=0.24$ – 0.27). The UTBAS sensitivity to change was supported by improvements in thoughts and beliefs related to social anxiety following cognitive–behavioural treatment for anxiety in stuttering [$t(25)=10.13$, $p<0.0001$]. The effect size was large ($d=2.5$).

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Conclusions & Implications: Implications for the use of the UTBAS as an outcome measure and a clinical tool are discussed, along with the potential value of the UTBAS to explore the well-documented social anxiety experienced by those who stutter.

Keywords: Stuttering, social anxiety, measurement, cognitive behaviour therapy.

What this paper adds

It is known that people who stutter commonly experience social anxiety. Yet, to date, there is no comprehensive measure of thoughts and beliefs about stuttering that are linked to social anxiety which can be used in clinical assessment.

This study begins development of a 66-item scale of Unhelpful Thoughts and Beliefs About Stuttering (UTBAS). Preliminary results suggest the scale is stable and reliable, it can discriminate between stuttering and non-stuttering participants on items that contain no reference to stuttering, and has convergent and discriminant validity. Further, the UTBAS is sensitive to improvements in thoughts and beliefs related to social anxiety that follow cognitive-behavioural treatment for anxiety in stuttering.

Introduction

Development of a measure to assess social anxiety in stuttering

Anxiety appears to figure prominently in the disorder of stuttering. Early case history data and clinical observations suggested a connection between stuttering and a personality trait of anxiety (Despert 1943, Meyer 1945, Honig 1947), and the classic texts on stuttering invariably dealt with anxiety (e.g., Johnson 1955, Van Riper 1982, Ingham 1984, Bloodstein 1995, Guitar 2006). These beliefs appear to have affected clinical practices. Nearly all Australian clinicians in one survey reported believing anxiety to be part of the disorder, and the majority of them attempted anxiolytic procedures with adult clients (Lincoln *et al.* 1996). In the case of American clinicians, Yaruss *et al.* (2002) reported that 56% of their sample of clients reported that their treatments involved 'reducing the fear of stuttering or of speaking situations' (p. 120). In the UK, a survey by Hayhow *et al.* (2002) asked those who stutter to nominate treatments that they had found helpful. Of seven specific treatments nominated, two anxiolytic procedures were included: 'Avoidance reduction/facing fear', and 'Relaxation/anxiety control' (p. 8).

A subsequent body of evidence has confirmed a link between stuttering and trait anxiety with a range of self report assessments with adults and adolescents (Peters and Hulstijn 1984, Craig 1990, Mahr and Torosian 1999, Kraaimaat *et al.* 2002, DiLollo *et al.* 2003, Ezrati-Vinacour and Levin 2004, Messenger *et al.* 2004, Treon *et al.* 2006). These findings have been replicated in a large, non-clinic cohort (Craig *et al.* 2003b). Negative findings of such a general relationship appear to be much fewer in number (Molt and Guilford 1979, Janssen and Kraaimaat 1980, Cox *et al.* 1984, Miller and Watson 1992), but nonetheless constitute some ambiguity in this literature. One explanation of such contradictory findings may relate to the reliance in this literature on unidimensional measures of trait anxiety (Menzies *et al.* 1999).

Trait anxiety is currently thought of not as a single construct but being composed of various constructs such as physical and social anxiety and anxiety about novel situations (Endler *et al.* 1976, 1991a, 1991b).

Indeed, in literature that takes account of this issue, when stuttering participants and controls are compared for social anxiety, a far less ambiguous picture appears to be emerging. Schneier *et al.* (1997), using a measure of social anxiety, reported that a group of 22 stuttering participants scored at equivalent levels to those with social phobia. More recently, there has been a report that around half of the scores of social discomfort for 89 stuttering participants were 'within the range of a group of highly socially anxious psychiatric patients' (Kraaimaat *et al.* 2002). Kraaimaat and colleagues have also shown that 110 stuttering participants score significantly higher than controls on a social anxiety scale, albeit significantly lower than participant with social phobia (Kraaimaat *et al.* 1991). Messenger *et al.* (2004) reported that 32 adults who stutter differed from non-stuttering control participants only on measures of social anxiety and not on more general anxiety scales. The work by Maher and Torosian (1999) contained data indicating that 22 stuttering participants scored higher on social anxiety than controls. These findings are supplemented by recurring reports of stuttering being associated with an extreme form of social anxiety: social phobia. There have been case reports of this occurrence (de Carle and Pato 1996, Paprocki and Rocha 1999), and one report of seven of 16 stuttering clients being given a diagnosis of social phobia (Stein *et al.* 1996). In a recent report from the present group (Menzies *et al.* 2007), 18 of 30 stuttering participants were diagnosed with social phobia with a blinded psychological assessment.

Arguably, these findings are not surprising considering the disfiguring effects of stuttering on verbal communication (Poulton and Andrews 1994). Such findings are also consistent with some findings of aberrant listener responses to stuttering. McDonald and Frick (1954) documented subjective, negative listener responses to stuttering, and Rosenberg and Curtis (1954) documented behavioural listener responses to stuttering. An early study documented physiological respiratory listener response to stuttering (Ainsworth 1939), which was recently replicated by Guntupalli *et al.* (2007) with findings of heart rate and skin conductance changes while watching stuttered speech. Additionally, these findings are consistent with two reports that found that the attentional bias of listeners could not be shifted from stuttered speech to the actual content of the speech (Bar 1967, 1969). They are also consistent with the many reports that listeners harbour negative stereotypes of those who stutter (e.g., Turnbaugh *et al.* 1979, Doody *et al.* 1993, Ruscello *et al.* 1994, Lass *et al.* 1995, Dorsey and Guenther 2000, Klassen 2001, Craig *et al.* 2003b).

In short, it appears that those who stutter have a proclivity towards social anxiety, and that in many cases the anxiety may constitute a prominent and disabling feature of their presentation. From a research perspective, it is imperative to further the understanding of the way in which social anxiety is related to stuttering, the impact that it may have on presentation and prognosis, and whether interventions targeting social anxiety adds to the effectiveness of standard speech restructuring treatments (those based on prolonged speech). From a clinical perspective it is important for speech language pathologists (SLPs) to assess for social anxiety, as the presence of social anxiety may interfere with treatment compliance and early detection may impact significantly on treatment planning (O'Brian *et al.*, in press). Both aims are dependent on accurate and comprehensive measurement of the social anxiety construct.

In clinical psychology, anxiety is viewed as a complex construct that consists of three components: cognitive, behavioural, and physiological (Barlow 2002). The cognitive component refers to unhelpful thoughts and beliefs relating to the anxiety-provoking stimulus. In the case of social anxiety, cognitions generally concern the threat of negative evaluation by others; beliefs that others will judge a person negatively for stuttering and that the opinions of others are important (Wells and Clark 1997, Hofman and Barlow 2002). The behavioural component refers to the degree to which an individual avoids or escapes from an anxiety-provoking situation. The physiological component refers to the changes that occur within the body during the anxiety response, such as increased heart rate, blushing and sweating. There is little debate among contemporary anxiety researchers that individuals may differ markedly in the specific signs of their anxiety response (for example, Menzies and Clarke 1995).

Accurate assessment of the cognitive component of social anxiety in stuttering requires the development of a comprehensive measure of cognitions — thoughts and beliefs — that relate directly to stuttering. To date, research into the role of social anxiety in stuttering has relied on measures of social anxiety that were developed to assess social phobia, and that therefore contain no references to stuttering. Social phobia is not necessarily related to speech or communication. Some sufferers of social phobia may, for example, experience anxiety about other people watching them eat, or listening to them playing an instrument, but not experience anxiety about speaking to others. Existing social anxiety assessment measures include items to assess non-speech anxiety, and because of this they may not be particularly sensitive to the speech-related social anxiety that typifies adults who stutter.

The current paper describes the development and initial validation of a measure of unhelpful thoughts and beliefs relating to stuttering. The aims were: (1) to develop a comprehensive measure of cognitions to assess speech-related social anxiety in adults who stutter; (2) to determine whether scores on the measure were higher for a stuttering group than for a non-stuttering control group; (3) to determine the reliability, known-groups validity, convergent validity and discriminant validity of the measure; and (4) to determine the measure's 'sensitivity to change' by exploring whether scores on the measure decrease following treatment with cognitive behaviour therapy, which known to be effective in reducing social anxiety.

Method

Phase 1: Initial development of the measure

The items were developed by recording unhelpful thoughts and beliefs reported by stuttering patients treated with cognitive-behaviour therapy (CBT) for social anxiety. Because CBT involves the identification and modification of unhelpful cognitions, CBT practitioners assess cognitions thoroughly and retain detailed records of the thoughts and beliefs reported by their clients during treatment. Hence, the investigators had access to many thoughts and beliefs reported by stuttering clients who presented to a Sydney anxiety disorders clinic during a ten-year period. The unhelpful thoughts and beliefs were sourced with a retrospective file audit of all clients who stuttered. Seventy-nine thoughts and beliefs were sourced from these client files. The first two investigators independently reduced the scale by eliminating overlapping items. Where there was disagreement about the independence of items, discussion between these two investigators either produced

a consensus view (i.e. agreement) or prompted an item to be discarded. Thirteen items were discarded in this process, leaving 66 items in the final Unhelpful Thoughts and Beliefs About Stuttering (UTBAS) scale. Thirty-nine of the 66 UTBAS scale items (59%) contain no reference to stuttering (items 8, 9, 13, 16–18, 20–24, 27–29, 31, 33, 35–37, 41–44, 46–60, and 63). The UTBAS scale is presented in the appendix. Each item is rated on a five-point Likert scale according to the frequency with which that thought is experienced (1='never have the thought' and 5='always have the thought'). Possible scores are in the range of 66 to 330.

Phase 2: Construct validity and sensitivity of the UTBAS

Fifty-seven participants took part in Phase 2 of this research. Phase 2 was designed to compare UTBAS scores between PWS and non-stuttering controls, and to assess the sensitivity of the measure to clinical improvements associated with CBT for social anxiety. The control group comprised 31 non-stuttering volunteers (16 men and 15 women) recruited from general staff at The University of Sydney, Australia. The average age of the control participants was 29.5 years (standard deviation (SD)=10.9, range=19–56 years). The stuttering group comprised 26 adult stuttering participants (21 men and five women) taking part in a randomized controlled trial at La Trobe University, Melbourne, Australia. The average age of the stuttering participants was 27.0 years (SD=14.5, range=16–65). The purpose of that trial was to compare the efficacy of speech restructuring treatment alone and speech restructuring treatment plus CBT for social anxiety in alleviating stuttering and speech-related anxiety. Each of the participants in the present study had been randomly assigned to the CBT condition. Exclusion criteria for the CBT trial were: (1) CBT received during the previous six months, (2) intellectual disability, (3) stuttering at less than 2% syllables stuttered during baseline testing, and (4) current use of benzodiazapines. Inclusion criteria for the trial were: (1) 16 years or older, (2) proficiency in English, and (3) psychotropic medication was kept at a stable dose throughout the duration of the trial. Control participants met these inclusion and exclusion criteria also.

Phase 3: Reliability of the UTBAS

Phase 3 of the research was designed to establish the test–retest reliability and internal consistency of the UTBAS. A convenience sample comprising 18 adult stuttering participants (15 men and three women) who were clients of the Australian Stuttering Research Centre was used. All but two had completed treatment programmes for stuttering in the past. Completion of treatment, prior to taking part in the present research, ranged from nine months to 30 years previously. Eight participants were currently on a waitlist for further treatment. Others were taking part in maintenance programmes. The average age of the group was 39.7 years (SD=14.4, range=21–61 years).

Phase 2 procedure

Stuttering participants completed a battery of questionnaires (see below) on two occasions: prior to receiving CBT and immediately after completing CBT. Both

questionnaire batteries were administered prior to the participants receiving any prolonged speech treatment. The CBT was presented in an intensive, group format over five days. The CBT package was developed specifically for adults who stutter (McColl *et al.* 2001), and was focused on speech-related social anxiety. The CBT was administered by the first and second authors, both of whom have a minimum of seven years experience in cognitive-behavioural treatment of anxiety. In summary, the CBT treatment package adapted for stuttering clients incorporates procedures from the four usual domains of CBT. Cognitive Restructuring, as described for social phobia by Mattick *et al.* (1989), is a procedure where clients are trained to systematically identify and modify their irrational thoughts related to anxiety. Graded Exposure, described for social phobia by Mattick *et al.* (1989), requires clients to gradually and progressively confront anxiety-provoking situations, and to repeat that exposure until anxiety decreases to levels that are not regarded as excessively distressing. Behavioral Experiments, as described by Butler (1996), are conducted in conjunction with graded exposure. Predicted negative outcomes are compared with actual outcomes of the exposure exercises. Finally, Attention Training, as described by Clarke and Wardman (1985), involves a focusing task intended to reduce the frequency of threat-related intrusive thoughts by increasing capacity to attend to alternative cognitive targets during a rhythmic breathing exercise.

Phase 2 measures

The test battery completed by participants included the UTBAS scale (see above and Appendix), and the following tests. The Social Phobia Anxiety Inventory (SPAI) (Turner *et al.* 1996) is a comprehensive and widely used measure of social anxiety. Both reliability and validity appear to be excellent (e.g., Ries *et al.* 1998, Peters 2000). The SPAI yields a total score and a difference score, which controls for the presence of agoraphobia symptoms. The difference score was used in our analyses, as it is generally considered a more pure measure of social anxiety. The Fear of Negative Evaluation Scale (FNE) (Watson and Friend 1969) is a 30-item, self-report questionnaire that assesses the extent of concerns about scrutiny and evaluation in social encounters. It is widely used in the assessment of social anxiety, and its psychometric properties are well established (e.g., Oei *et al.* 1991). The Social Avoidance and Distress Scale (SADS) (Watson and Friend 1969) is a 28-item questionnaire designed to assess self-reported avoidance of, and distress associated with, social encounters. It is considered to have adequate psychometric properties (e.g., Ries *et al.* 2001), and is amongst the most commonly used outcome measures for social anxiety. The Beck Anxiety Inventory (BAI) (Beck *et al.* 1988) is a popular measure of general anxiety symptoms. It has several factors; subjective, neurophysiological, panic, and autonomic symptoms. Psychometric studies generally support the factor structure, reliability and validity of this instrument (e.g., Osman *et al.* 1993, Steer *et al.* 1993). The Beck Depression Inventory-II (BDI-II) (Beck 1996) is a widely used measure of depressive symptomatology. It is a 21-item, self-report questionnaire designed to measure the frequency of depressive symptoms. The reliability and validity of the BDI-II are well established (e.g., Osman *et al.* 1997, Dozois *et al.* 1998).

Phase 2 data analysis

Known-groups validity was assessed with a *t*-test to compare scores obtained by the non-stuttering control group on the 39 non-stuttering related UTBAS items with pre-treatment scores obtained on the same 39 items by the stuttering group. Within the stuttering group, pre-treatment UTBAS scores were correlated with pre-treatment scores on the other scales to determine convergent and discriminant validity of the UTBAS. Convergent validity was assessed by measuring the correlations between the UTBAS and other measures of social anxiety. Discriminant validity was assessed by determining whether the correlations between the UTBAS and social anxiety measures were significantly greater than correlations between the UTBAS and measures of unrelated constructs, such as depression. Pre-treatment UTBAS scores were compared with post-treatment UTBAS scores in the stuttering group to determine the sensitivity to change of the UTBAS following CBT, a treatment known to reduce social anxiety successfully.

Phase 3 procedure

The UTBAS was completed by participants on two occasions, one month apart. The instrument was mailed to participants on each occasion. To assess the internal consistency of the UTBAS, Cronbach's alpha was calculated for each set of questionnaires. To assess the stability of the UTBAS over time, test-retest reliability was calculated. The correlation between Time 1 and Time 2 total UTBAS scores was calculated. A paired *t*-test was conducted to test whether any difference between UTBAS totals existed between Time 1 and Time 2.

Results

Phase 2

The two groups (i.e. PWS and Control) differed in UTBAS totals, even after excluding all items that contain reference to stuttering. The difference between these two groups is statistically significant [$t(38)=8.06$, $p<0.0001$], indicating that the stuttering group scored significantly higher (mean=101.3, SD=25.0) on this measure than the control group (mean=56.9, SD=14.1). The effect size was large at 2.3, suggesting clinical significance also. This finding supports the known-groups validity of the scale.

Correlations between the UTBAS and other measures in the clinical group are shown in table 1. Scores on the UTBAS were correlated significantly with scores on other measures of social anxiety (SPAI, $r=0.72$, $p<0.0001$; SADS, $r=0.68$, $p<0.0001$; FNE, $r=0.53$, $p<0.006$). This finding supports the convergent validity of the scale. The correlation between the UTBAS and the BAI, a general measure of anxiety, was not significant ($r=0.24$). The correlation between UTBAS scores and BDI-II scores, which measures depressive symptomatology, was also not significant ($r=0.27$). The overall pattern of these correlations supports the discriminant validity of the scale, as UTBAS scores were significantly correlated with measures of social anxiety but not with measures of general anxiety or depression.

As shown in table 2, the mean UTBAS score for the clinical group decreased significantly from pre-treatment to post-treatment [$t(25)=10.13$, $p<0.0001$]. Every

Table 1. Correlations between the Unhelpful Thoughts and Beliefs about Stuttering (UTBAS) and other measures

	Correlation with the UTBAS
SPAI diff	0.72*
SADS	0.68*
FNE	0.53**
BAI	0.24
BDI-II	0.27

* $p < 0.0001$; ** $p < 0.006$.

Table 2. Comparison of pre-treatment and post-treatment total Unhelpful Thoughts and Beliefs about Stuttering (UTBAS) total scores for the stuttering participants

	Pre-treatment ($n=26$)	Post-treatment ($n=26$)
Mean*	172.0	99.9
Standard deviation	38.4	20.6

* $p < 0.0001$.

one of the 26 stuttering participants showed a reduction in scores following treatment. On average, UTBAS scores reduced by more than 40% and the effect size was large at 2.5, suggesting clinical significance. These findings indicate that the UTBAS was sensitive to the changes in social anxiety that resulted from treatment.

Phase 3

Phase 3 of the research sought to establish the reliability of the UTBAS. Cronbach's alpha for Time 1 administration of the UTBAS was an impressive 0.98. Similarly, at Time 2, Cronbach's alpha=0.96. Both findings suggest a very high level of internal consistency for the instrument. The test-retest reliability of the instrument, with one month between administrations of the UTBAS and no intervening treatment, was an impressive $r=0.89$. A paired t -test found no difference ($p=0.99$) between UTBAS total scores at Time 1 (mean=135.6) and Time 2 (mean=135.5).

Discussion

It seems evident from the above data that the Unhelpful Thoughts and Beliefs about Stuttering (UTBAS) is a promising measure of unhelpful thoughts and beliefs concerning speech-related social anxiety in those who stutter. It appears that the UTBAS scale can discriminate between stuttering and control participants' unhelpful cognitions related to social anxiety, with large effect sizes (known-groups validity). Those who stutter are more prone than those who do not stutter to report thoughts such as 'I can't speak to aggressive people', 'people will think that I have no opinions', and 'people will think I'm boring because I have nothing to say' (see the appendix). Having said this, it is worth noting that those who stutter do not experience these thoughts all of the time. On average, individuals in the stuttering

sample, despite having sought treatment, indicated that they had these thoughts no more often than somewhere between 'rarely' and 'sometimes'.

The UTBAS scale appears to have strong internal consistency, test-retest reliability, known groups, convergent and discriminant validity. Further, it appears to be sensitive to changes obtained in treatment with a CBT package designed specifically for social anxiety in stuttering. All clinical participants in Phase 2 had decreased UTBAS scores after this CBT treatment, and a large effect size was obtained. In contrast, the Phase 3 (reliability) sample of PWS did not differ in their total UTBAS scores across two administrations of the measure, with no intervening treatment procedure.

To our knowledge, the UTBAS is the first measure of speech-related social anxiety developed specifically for use with adults who stutter. These results provide preliminary support for the use of the UTBAS as an exploratory tool and an outcome measure in stuttering research trials. There are several immediate applications for such a tool. It could be used to clarify further the role of speech-related anxiety in stuttering, and to determine the degree to which anxiety about speaking may account for poor long-term outcome with standard prolonged-speech interventions for stuttering. Whilst post-treatment outcome for prolonged-speech programmes is generally good, long-term relapse rates are high. Depending on how relapse is defined, estimates of relapse range across studies from 30% to 73% (Howie *et al.* 1981, Martin 1981, Perkins 1981, Boberg and Kully 1994, Craig and Hancock 1995). At this stage it is unclear what variables are related to relapse in adults who stutter. It may be that high levels of speech-related social anxiety influence long-term outcome. In our recent randomized controlled trial evaluating CBT for adults who stutter, participants who received only speech restructuring (without CBT) reported several difficulties during the post-treatment period (Bryant *et al.* 2002). First, they reported concern about, and avoidance of, feared speaking situations. This is likely to have resulted in reduced practice of speech techniques over time, and may therefore have affected their long-term outcome. Second, they reported that they did not always use their PS techniques because they were concerned that their novel speech pattern sounded unnatural, and were uncomfortable having attention drawn to their speech. Both complaints are a result of social anxiety, that is, fear of negative evaluation by others. The development of specific, reliable and valid measures to assess social anxiety in the stuttering population is an essential step towards clarifying poor long term outcomes in treatment for chronic stuttering. The early results suggest that the UTBAS is such a measure.

Whilst the findings from the present study are encouraging, they are clearly preliminary, and are based on quite small samples. Future research should further establish the psychometric properties of the UTBAS by replicating the current study with larger groups of adults who stutter and gender-matched controls, and determining whether those participants with a co-morbid diagnosis of social phobia score higher on the UTBAS than those without. Further work on the factor structure and content validity of the instrument should also be undertaken. To date, on the basis of evidence supporting the internal consistency and convergent validity of the instrument, no items have been cut from the UTBAS. It must be acknowledged that no attempt to exclude items that might be associated with constructs other than social anxiety has occurred in the development of the UTBAS. This might be seen as a weakness of the measure by some. However, in the present authors view, the strong internal consistency of the UTBAS and the need for a

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25. No one would want to have a relationship with a stutterer.
26. I can't think clearly because I stutter.
27. I can't speak to aggressive people.
28. People will think that I have no opinions.
29. People will think I'm boring because I have nothing to say.
30. If I block, people will think I'm retarded.
31. I can't face these people.
32. People will wonder what's wrong with me if I stutter.
33. What will people think of me if they disagree with what I say?
34. Most people view stutterers as less capable.
35. I don't want to go—people won't like me.
36. My pauses are too long—people will think I'm weird.
37. People won't like me because I won't be able to talk.
38. I can't convince people of anything I say because I stutter.
39. People will think I'm retarded if I stutter.
40. I'll block – I know I will.
41. I'll make a fool of myself.
42. People get tired of waiting for me to get my words out.
43. People shouldn't have to wait so long for me to speak.
44. I always embarrass the people I'm speaking to.
45. People think I have something to hide because my stutter sounds suspicious.
46. People will think that I'm worthless
47. I'll embarrass myself.
48. I can't speak to people I find sexually attractive
49. No one will understand what I'm trying to say.
50. What's the point of even trying to speak—it never comes out right.
51. I won't be able to say exactly what I want to say.
52. Everyone will think I'm simple or dumb because I avoid using difficult words.
53. I slow up everyone's conversation.
54. Everyone hates it when I start to speak.
55. I can never speak on the phone.
56. I won't be able to ask for what I want.
57. The person on the other end of the phone will hang up on me.
58. People will laugh at me.
59. People will think I'm mute.
60. I'll never finish explaining my point – they'll misunderstand me.
61. The answering machine will turn off if I block – I won't be able to leave any message.
62. They'll think I'm a prank caller if I block.
63. I won't be able to say 'hello' when I pick up the phone.
64. People who stutter are stupid.
65. People who stutter are incompetent.
66. People who stutter are boring.

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