Stuttering: A Neurotic Phenomenon

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Stuttering speech, or stammering, as it is sometimes called, has baffled learned men through the ages. Theories as to its causation have run the gamut from demonic influence to an organic disorder of neuromuscular origin to personality disturbance. Yet in isolating the actual moment of the dysfluent utterance, a somewhat "basic" definition is, "stuttering stands for labored, difficult, hesitant speech, with resultant defective conversation."¹ In view of the many different hypotheses regarding the nature of stuttering, this paper will examine the phenomenon from the viewpoint that dysfluencies are the outward manifestation of an inward neurosis. Before we begin our discussion of the stuttering symptom, a synopsis of research findings shall be examined based on incidence in the population and the basic characteristics of stuttering behavior. Next will follow the psychoanalytic theory regarding personality development and therapy. The final section will incorporate previous information along with the personal feelings of the writer. Let us now begin our discussion with an overview of research gathered on stutterlike speech.

As we begin our analysis of the characteristics of stuttering, a description of the actual mechanics of this behavior is in order. Stuttering is said to be "a disturbance in the smooth flow of speech, due to tonic and clonic spasms involving functions of respiration, phonation, and articulation tics and spasms near to or remote from the speech mechanism."² The speech therapist Johnson defines it as "an anticipatory, apprehensive, hypertonic, avoidance reaction."³ Stuttering is what a speaker does when he expects the dysfluency to occur, and as a result fears its occurrence. Therefore he becomes tense in anticipation of it, resulting in the attempt to avoid its happening. The endproduct is the complete or partial stopping of speech. Stuttering, or dysphemia ("wrong speech") as it is technically termed, can be divided into situational stuttering and ritual stuttering. Situational stuttering is "the manif-
estion of the speech difficulty which certain persons present in certain speaking situations only. An example would be that some children stutter only in school situations. In ritual stuttering, which is present more in adults, "the habit of speaking correctly only occurs if the speaker assumes a certain position or performs a certain action." These secondary characteristics include eye blinks or the pressing on a part of the body with the hand. If such actions do not take place, stuttering occurs. For therapeutic purposes two other phases of stuttering are described. The primary phase is the initial phase of the disorder—the child is not aware of the effect, and thus has no symptoms of anxiety or any other personality change. However, the secondary phase is what is generally termed stuttering, as anxiety is associated with the speaking situation, and personality changes are evident. Yet there is a specific type of stuttering that cannot be categorized in either of these two phases. Stuttering as the result of "acute manifestations secondary to specific traumatic shocks must be differentiated from chronic or confirmed forms associated with faulty character development." This type of stuttering is typical in soldiers' combat fatigue and responds to treatment quicker than other forms of stuttering.

In examining possible etiologies for stuttering, the number and variety of theories is exhaustive and will not be discussed here. However, to answer the question of any possible genetic influence in the occurrence of stuttering, it has been established that there is no direct correlation between stuttering and heredity. "Though many physiological, neurological, biochemical, and anatomical studies have been made comparing stutterers and nonstutterers, the net result, according to Johnson is that no organic or physical cause of stuttering has been demonstrated." This paper then shall discuss the psychoanalytic theory as a possible answer to why stuttering occurs. In examining population figures, "the incidence of stuttering in the general population is one percent, and one-half of these are children." Stuttering is no respector of social or economic status, religion, race, or intelligence. The Intelligence Quotient (I.Q.) of the
average stutterer is normal, and even above normal in significant instances. Yet there is a relatively high incidence of stuttering in mentally retarded children. No direct correlation exists, however, between stuttering and intelligence. "The age of onset in ninety percent of stutterers is under ten, while the majority of children begin to stutter during their first five years. The psychoanalyst Glauber (whose theory we will discuss later) states this is when the first major social adjustments begin. In stuttering, due to its early onset and the continuation of the syndrome, there is an arrest of emotional development, and a disturbance in interpersonal relationships." In examining the sex distribution of stuttering, it is found that dysfluency is "four to eight times more frequent in males. This is hypothesized to be due to the fact that earlier environmental stress is harder on boys than girls as boys are thrust into more rigorous group competition." While no direct hereditary link has been established, there is a tendency for these children not to be the only stutterer in the family. It was found that in "thirty-three percent of the stuttering children there was another stutterer in the immediate family. In the nonstuttering children's group, nine percent of these had stuttering relatives outside the immediate family." Such information suggests the presence of constitutional factors that would predispose the individual to emotional disturbances on the whole and stuttering speech specifically. There seems also to be some link in stuttering children to "original motor disorganization. Stuttering children in one study were found to be more awkward and less adept at acquiring motor skills than nonstuttering children." It is also suggested that such stuttering children come from a family environment where anxious parents place a great deal of importance on correct speech, resulting in pressure on a normally dysfluent three year old, inexperienced with language rules. Such anxiety in the child may later lead to a habitual stuttering pattern. Keeping this in mind, let us turn now to the discussion of an expanded view of the young stutterer's environment, as offered by psychoanalytic theory.

In examining stuttering as a symptom of underlying neurotic conflict, a basic definition of neurosis is offered. We will then
look at the psychoanalytic view of Glauber; in light of this information, the neoanalytic view of Barbara, which incorporates a less strict adherence to psychoanalytic thought into stuttering therapy, will be presented in discussing the stutterer's childhood and adult personality development.

To begin, "the stuttering symptom is classified as part of a narcissistic neurosis, in which the executive part of the personality, the ego, is defective. This behavior is not differentiated sharply from classical neuroses, which include hysteria or obsessions where the ego is more highly developed." In classical neuroses, symptoms appear in adolescence and continue into adulthood. However, stuttering has its origin shortly after the onset of speech or when formal schooling is begun, and continues through the latency period and beyond. Its frequency is consistently presented, making it a monosymptomatic disorder. The stutterer himself actually has many inhibitions beside the symptom, but they are mostly unknown to him. It is this "inhibition which invades the speech function itself, for the stuttering is in essence an unsuccessful attempt at inhibition." While the stuttering serves as a defense against inward vulnerabilities, other common tactics used are phobias for speech situations. "Inasmuch as the inhibitions and phobias are out in the open only as far as speech is concerned, but hidden, as far as they affect parallel adjustment in social, sexual, and occupational spheres, we term the stutter an overdetermined symptom." It is these defenses which result in personality difficulties. Social interaction is impaired resulting in a distorted concept of self. As the stutterer hides behind this one symptom, stating this problem in speaking is his only obstacle in life which prevents him from attaining personal goals, it results in a total blindness to underlying conflicts that serve to perpetuate the stuttering symptom. A vicious circle is established. These inhibitions in social, sexual, and occupational matters are not specific to stuttering but their expression through speech are unique. With this information as a foundation, Glauber gives a theory based on psychoanalytic thought as to how these traits evolved.

In the writings of Glauber it states, "from our studies of stutterers and their family background we have been impressed with the fact that significant and direct causative influences began
to operate during the first year of life, particularly in relation to the feeding experience." It is believed that an erratic stutter-like feeding pattern of the mother towards her child precipitated later stuttering speech. The mother is said to be the determining force in the child's neurosis. The mother possesses an "anxious incapacity to separate from the child, who was unconsciously felt to be an integral part of the mother's body image— an organ as it were." The stuttering response in the child (usually a boy) does not "stem merely and primarily from such strong feelings as rejection, a mixture of love and hate, and so on." Genuine affection also takes place, yet the mother struggles with her own personality conflicts. She is torn between wishing to shower the child with affection, but she also desires to develop a sense of independence from him. The mother's unique attitude toward speech is the determining factor in the child's inhibitions surfacing in the symptom of stuttering. "A boy stutters primarily because he is the spokesman for his mother." It is said that the male child is one with her because "she stutters in her own way." The father is also important to the emotional wellbeing of the child, yet the mother holds the key to child's development due to her amount of influence.

The mother, outside of her relationship with husband and child, possesses good control of her life. When her child begins to stutter, she is very enthusiastic about seeking help. More concern is lavished on this offspring than any other family member. Regardless of his age, she will fight to remain first in his life. To best explain this neurotic mother-child tie, "there is a high frequency of the mother's discontinuation of treatment of the child after it has gotten well under way, unless in the original treatment plan proper attention is given the mother simultaneously with or prior to the child's treatment." The mother is threatened by therapeutic intervention where independence is encouraged in the child. "The maternal effect most commonly shown is great anxiety centered around the child's speech, his general behavior, masturbation, his school or social life. Below the surface envy, disappointment, and hostility are also found." In most areas the mother is aware of her insecurity, but emotionally, behaviorally, and sexually, she is inhibited and unaware. She is burdened by separation fears, guilt, and aggression. "In her life
history she suffered from a masochistic dependence on her mother. Both Mother and Grandmother idolized active, aggressive types which were personified in a male relative. Later this idealization was referred primarily to an image of their ego-ideal." Psychosexually, the mother has a "poorly differentiated sense of self-part child, part tomboy, part wife-husband. Penis envy or competitiveness with males is frequently a component, as is the history of being in love with a masculine, Oedipal type of man and marrying another, weaker type. The marriage is sado-masochistic; there is the need to control in the woman and a sense of duty, but little in the way of pleasurable pursuits. Lone objects (son and husband) represent to her narcissistic objects—self-images, idealized and/or degraded." Due to the mother's identification with her very strong mother and her disappointment in the weaker father, there is a lack of "that fundamental, steady, affective support essential for the emotional maturation of a child. The mother, as a "stuttering feeder" alternates aggressive feeding gestures with sudden withholding, both accompanied by anxiety." This pattern is then incorporated in the oral musculature which later appears when the same organs are used for speaking. "The mother fluctuates between a wish to feed the child and make it independent and a wish to incorporate the child and thus regain the image of her perfect or ideal self which she had in pregnancy." The young stutterer in some ways attains a "precocious ego development, yet such development often takes place only in intellectual abilities, while the capacity to bear frustrations and attempts at reality testing are areas generally ignored." The father, as a contributing factor to the stuttering also can serve as a major determinant of a positive prognosis. Since he is responsible for the child's faulty ego development in running from his child as he also runs away from a proper relationship with his wife, it is imperative that he take a more active interest in his child and become the stable leader in the marital relationship in order for therapy to be of any substantial impact. "The quiet of mutual parental acceptance was often based on mutual acceptance of each other's neurotic ties." The result is the exchange of normal roles between the parents, but the child suffers from a lack of identity. A mother or father who outwardly protests unmet needs is "more reachable than a frightened, resigned, or guilt-imbued
A healthy parental relationship based on a strong husband-wife bond is the key to effective stuttering therapy. "While there was no doubt that the primary pathogenic relationship was that between mother and child, there was always the possibility that the father could mitigate the mother's infantile traits and assist in the emotional development of his wife." As a result the child would be aided in establishing an identity apart from the mother. In this way the stuttering symptom is the result of a total family problem.

In continuing this view of the early psychological development of the child stutterer and expanding it to include personality conflicts during later childhood and on into adulthood, the work of Barbara will be discussed. In comparing stuttering to other neuroses, a very similar social environment exists. "It differs mainly in regard to the quality and degree of the individual responses and experiences to the particular environmental background." Each child is a unique individual with highly diverse intellectual, emotional, and social needs. When he is presented a healthy family in which there is a genuine warmth, love, and respect, the child then feels wanted and loved and thus is given the foundation for healthy self-realization and individual growth. However, when such love is not present in the environment, or it simply is not conveyed openly, "the child may begin to be rendered weak, insecure, and shaky." This absence of adequate love is due to the parents own personal problems. There may be open hostility toward the unwanted child, or the parent may be detached and reserved. Another way such feelings are camouflaged involves "oversolicitude or the self-sacrificing attitude of an "ideal" mother," as was discussed earlier.

Certain factors in the family relationship, according to Barbara, are often present, predisposing the child to stutter. Usually he is an only child, or he may be the only male child in a family of two or more females, giving him a unique position. Also he may come from a very traditional family, such as found in minority groups—Italians, Jews, and Negroes. As a result of this cultural environment, often an almost sacred preference is given to him as the first son or the first born. "Stress is then placed on the social importance of male superiority to female inferiority." The male is therefore the master, and the female
is submissive as the weaker sex. The boy is then bombarded with a very masculine stereotype of the strong aggressive leader, which is an impossible image to attain.

In this type of environment where an overprotective, compulsive mother alternates between hugs and kisses and harsh criticism, it is no wonder the child is "rendered weak, irresponsible, and overdependent. At first he is stilted, awkward, and rebellious, but later as the result of repetitive restrictions and stern measures, the child succumbs to becoming compliant, submissive, and appeasing." The child fears competition, as he is fearful of maternal control. "She dresses and undresses him, abuses his privileges, and causes him to feel helpless and childish." Play time is disciplined and regulated, and the parents usually fight his battles for him. As a result, the child has the need to assert some form of independence as he struggles toward self-realization in a tug-of-war with his parents. Unfortunately, due to forced submission, the child eventually tires and gives up. Maternal dependency becomes paramount. In relinquishing his real self, the child takes pride in being a "good boy", and discovers the benefits of being taken care of. Problems do not have to be dealt with, for Mother will solve them. "She is a magic Mom; as he hides behind her cloak of authority, he feels omnipotent and self-satisfied." However, when Mother does not meet his needs, this is when the screaming occurs as he demands that she be at his beck and call.

As the boy enters school, his parents overemphasize intellectual pursuits and perfect grades. "Due to this rigidity and preoccupation with absolute values, the environment of the child is filled with perfectionistic shoulds and impossible demands—all resulting in perpetual strain and tension." While at first he rebels against such demands, as the parents show their disapproval, he again resigns himself to his fate. The boy is now, as a result of many years of conditioning, "filled with fear, rage, helplessness, and finally hopelessness and insecurity. He withdraws more and more into the unreal, private world he builds for himself exclusively." He is an onlooker, a loner, and takes part in excessive daydreams and feelings of unreality. With the first impact of freedom from parental ties in this school period, there comes the stark realization that the boy "no longer has special
privileges—he now must contend with competitive group situations. An insecure child will have trouble adjusting, will feel unhappy and resentful, and will exhibit behavior disorders."

In tying this personality profile to the stuttering symptom, it is known that "the period of quickest development of speech is generally considered as occurring during the fourth and fifth developmental years of life. It is somewhere in this period of growth that the overabundance of desires and needs to express himself openly, and where the inhibiting influence of neurotic parents can be of significant trauma to the future function of the particular child's speech mechanisms." It is in school where there are no excuses for an inability to speak and do other things well that the child develops habitually dysfluent speech, if he has not done so already. When met with the ridicule of peers concerning his inability to compete and express his needs, he in turn uses his stuttering symptom to shield himself from other people. "His feeling of social inferiority is caught up in a process which will cut him off from the possibility of social success, but also from the possibility of real utter failure. A tentative equilibrium is attained." He can no longer go back to a more dependent time, when Mother met his needs. He must use his own defenses, one of them being his stuttering, to wall himself off from others who wish to see his fragmented self. "The stutterer's neurotic anxiety, taking the form of a fear neurosis, is a creation instituted by his need for the protection of his personality in numerous speech situations." This defense reaction soon generalizes to all social reactions, which then becomes in turn the guiding pattern for all his behavior. It is in this school setting where the child first encounters social disapproval and nonacceptance. He is now labelled as having a "defect", and the more he struggles to speak, the more dysfluent he becomes.

While every child exhibits dysfluencies in learning the rules of language, it is when the parents put a great deal of emphasis on correct speech that problems occur. However, this preoccupation with the child's utterances is only one of many areas that is under such close scrutiny. The stage is now set for the habituation of neurotic conflict in the adult years.

The stuttering adult in many cases has withdrawn from most social situations due to his alienation from himself and the resultant struggle with verbal expression.
"To remedy disorganization, he creates an idealized image of himself through his struggles to avoid awareness of intrapsychic conflicts— he rises above others. In this process of self-idealization, the personal character of the image gives a neurotic sense of identity and unity."44 He then cons himself into self-worship, telling the "hero" that if only he could speak fluently, he would conquer the world. He sees himself as a great orator, as speech dominates his life. All energies are directed toward perfection. A false pride and vanity are assumed so that introspection will not take place. "He uses witty sayings, and deliberate charm. In dealing with people he is always loving and kind. Yet at the same time he is on guard for fear of being wrong. When he is corrected anger erupts, for he hates to feel stupid. Our great orator must be the master of his mind and the speaking situation."45 Often facts and witticisms are memorized to impress his listeners. However, while in practice little or no stuttering occurs, when the hero enters a group, fluency breaks down. The stutterer feels that he is in constant competition with the world. Strong feelings of envy and jealousy ensue. Society is therefore responsible for his humiliation. His ostracization from society is the result of factors outside himself, for the stutterer is blinded to any internal weaknesses. His search for glory goes on as he alternates between his vision of himself as society's cripple versus one endowed with God-like omnipotence. "Most stutterers are highly intelligent, capable, yet blind to their actual capacities and what they expect of themselves. They are driven toward jobs and professions where verbal communication plays a big role. These occupations, which include sales, law, and psychology, indicate this driveness and self-destructiveness. They must compulsively prove themselves by pushing ahead at all costs."46 Because of all his suffering, society "owes" him special privileges. Yes, others have problems, yet few are so crippled as he. "The process of stuttering, with all of its conflicting tendencies is a destructive and progressively unhealthy pattern. It usually tends to lead in a direction toward actualizing the idealized self and away from the real self."47
The stutterer feels others should take over in those speaking situations where he may falter—talking on the telephone, making requests, and in the telling of information. Of course, people should pay absolute attention when he talks, and criticism and questions should not be directed at him since he is very sensitive to such probing. Due to his egocentricity the hero takes what he's entitled to, yet gives little in return. With this in mind, let us now look at the therapeutic process.

Before we begin this process of attempting integration, let us look at a summary of the stutterer's characteristics. "It is not the speech situation nor the speech difficulty as such, but his neurotic investment in it that determines the degree and frequency of his stuttering." The stutterer, in blaming society for his halting speech, camouflages his near total neurotic blindness to other neurotic attitudes. "He has repressed impatience, stubbornness, vindictive hostility and dependency." He lets the world pass him by as he wallows in hopelessness. The anxiety in the stutterer is due to disturbances in overall character structure. The stutterer, in expressing his overall dissatisfaction with life and others masks self-hate and rage directed toward his inner shortcomings. Yet as is typical of neurotic behavior, the stutterer says "Forget about your disgraceful self—this is how you should be—always productive and able to endure everything." Thus, he is caught in the "Tyranny of the Should"—our hero should be calm, generous, courageous, et cetera. Therefore, "he will resort to forced hesitations, bugaboo words, various bodily maneuvers, twitches, and contortions to distract his audience from becoming aware of the obvious fact he is stuttering." He should speak in a relaxed state with total spontaneity. The spotlight should fall upon him. "In stuttering, and other forms of neuroses, the person shows a marked disregard for his own personal psychic condition." Such a personality is what the therapist sees. A battle begins to remove the adult stutterer's alienation from his real self.

"The stutterer feels that his presence in therapy is a claim to be cured, as he so rightly deserves. Due to this defect he has been deprived of many things that he would have attained if it were not for his faulty speech musculature. He has
read extensively about stuttering, and due to his pseudo-martyrdom he is a better person for it." 53 To reach the goal of reduced stuttering, the stutterer must give up the mask of his suffering, purified personality, and face his internal shortcomings. In other words, he must first understand himself. To get a deeper understanding of the stutterer's speech, the therapist must gain insight into his language behavior. "As he speaks and stutters, we must be alert enough to attempt to penetrate his inner defenses and approximate some of his hidden feelings and thoughts. When we get behind his reactions internal and external, at the time of high anxiety, we may ascertain hidden confusions and reasons for his stuttering." 54 In therapy, the interpersonal relationship between the therapist and the stutterer is the most important factor in therapeutic success. Therapy in this context involves psychotherapy as the stutterer is provided an environment of acceptance and unconditional positive regard. In this way, past experiences with faulty and painful relationships are replaced with ones in which the client is encouraged to sort out repressed feelings and distorted perceptions of the self. Due to the nature of this paper, detailed therapy techniques will not be included. It will suffice to explain that in the newer schools of psychoanalysis, areas stressed include "new emotional experiences", "benign traumas", "corrective emotional experiences", "emotional re-education", and the "breaking down of inhibitions" to attain "the reversal of the vicious circles of disorder into benign ones". 55 This view is not far removed from those who advocate positive speaking experiences combined with the re-education of the personality. Barbara, in the modification of psychoanalytic principles, "emphasizes Adlerian principles of secondary gain, false life goals, and the refusal to deal with symptoms. He states that in the psychotherapy of the stutterer, there needs to be the working with resistance, overcoming the blockage of stuttering consisting of the stutterer's vanity, egocentricity, and his exaggerated feeling of self-importance and illusional life goals." 56 As the stutterer becomes less inhibited, his blocks and hesitancies will decrease along with an increased growth toward emotional maturity. He will no longer
"need" to stutter. In psychoanalytic theory, the external symptom will be removed only when the internal cause is solved.

The psychoanalytic view of stuttering as a neurotic symptom of underlying neurosis seems to offer a complete explanation of the etiology and treatment of stuttering and the stuttering personality. However, some serious doubts arise as to the efficacy of such a view. If one were to examine cases of stuttering that were treated by psychoanalysis, the findings would be extremely sparse. What is known about the subconscious phenomena in stuttering comes from nonpsychoanalytic sources. The aim of psychoanalytic writers on stuttering in the past was "not so much the study of clinical facts and the clarification of heretofore poorly understood relationships but the adaptation of the known facts to equally known psychoanalytic theories. This resulted in the "translation" of descriptive terms into the language of "organ libido" and "pregenital sexuality"." 57 Such terms have not been used here so as to avoid lengthy definitions of their meaning. "The only fruitful psychoanalytic clinical observations on stuttering have been done by Ruth Usher in her one paper on a single case in 1944, and the very sketchy work of Freud, who described one case of "atypical" stuttering—its tic-like character in a severely hysterical patient. " 58 Nowhere in his writings does Freud discuss treatment of "common" stuttering. Two reasons can be offered as to the lack of research in the area of stuttering. The first is the psychoanalyst's reluctance to study symptoms, preferring to explore underlying "factors". The second is the psychoanalytic therapist's disregard of current fears and conscious experiences due to the fact that they are symptom-centered. The psychoanalyst feels that a preoccupation with the symptom does nothing to alleviate the underlying dynamics and only serves to make matters worse by increasing the anxiety attached to the speech situation. However, research does not bear this out. Symptom analysis in stuttering has been done largely by nonanalysts, especially those termed behavioristic learning theorists. On the contrary, this lack of research by the psychoanalyst creates poor treatment results and weakens the desire in the therapist to treat such
cases. Freud himself was skeptical concerning the effectiveness of such techniques. "To understand stuttering some of the basic tenets of psychoanalytic theory would have to be modified." A problem in the area of etiology is also noted. In a substantial number of cases the stuttering symptom does not surface until later in childhood, such as junior high age, or even as late as adulthood. If the mother-child pathologic relationship is at the core of the neurotic stuttering's origin then why should such symptoms demonstrate a considerable delay in manifesting themselves? "Whatever has been claimed as constituting alleged organ libidinous (oral or displaced anal) conflicts manifesting themselves in "stuttering" could apply only to the preneurotic phase or what is also called "primary" stuttering. The secondary "neurotic" phase of actual "stuttering"—with pathologic system erected against the recurrence of communicative failure is left entirely unexplained and unnoticed by such an approach." The strides made in stuttering therapy are more likely to be due to the accepting atmosphere created by the therapist rather than through the solving of inner conflicts. In addition, the stuttering symptom can be reduced and in some cases removed without a lengthy and expensive period of psychoanalysis. Revisions can be made in psychotherapy that include the personal interworkings of the client, while at the same time eradicates the stuttering and its resultant anxieties related to the specific situation. The area of behavior modification attempts to do just this. "If we accept the behavioral therapist's revised definition of psychotherapy which holds that "neurotic behavior consists of persistent habits of learned (conditioned) behavior acquired in anxiety-generating situations and that therapy depends upon the unlearning of this behavior, then much of what we have always done in stuttering therapy could be viewed as psychotherapy." What must be done then, is to provide new behaviors to be learned to deal with speech situations. Psychotherapy is then performed in reducing anxiety and also in offering the stutterer reachable goals in which the self-concept of the stutterer is enhanced.

In direct opposition to the psychoanalytic view of stuttering as a neurotic symptom, this writer believes, as do many authorities in the field of speech pathology, that there is no
one "personality" associated with the stutterer or his parents. On the contrary, the stuttering child is essentially normal and dysfluencies are the result of inexperience in speech and the rules of language. It is only when emphasis is placed on fluent speech production that the child is labelled a stutterer, as he attaches anxiety to parental suggestions to "Slow down!" "Don't repeat!" "Spit it out!", et cetera. Early hesitations and repetitions of initial words become habituated avoidance of certain words and the repetition of initial sounds with associated facial grimaces and timing devices (hitting the palm, eye blinks, et cetera), as fear grips the stutterer in specific speaking situations. True, severe cases may develop emotional and behavioral problems; however, it is the conditioned avoidance of speaking situations that is the focus, not an underlying neurotic conflict. Stuttering cannot be explained as the result of fixation in an earlier phase of development according to psychoanalytic theory, since not all stuttering develops at the same maturational stage. Stuttering can also begin suddenly as the result of physical or emotional trauma such as from a dog bite or a death of a family friend. Also, some children stutter in childhood, only to outgrow it as they mature. Has the child achieved integration of his faulty ego? Psychoanalytic theory fails to account for such occurrences. In response to this weakness, learning theory's view of stuttering as a conditioned response to the speaking situation incorporates the psychological needs of the patient, along with the removal of dysfluent speech. At any rate, irregardless of one's personal theory, more research needs to be done in the area of stuttering therapy to meet the needs of the client, not to bolster the clinician's ability to theorize.

Just exactly what is the state of the "art" today? While a permissive, accepting attitude in the clinical setting plus an empirical therapeutic method (such as behavior modification) can quickly eliminate stuttering in the treatment situation, unfortunately there is the problem of little carryover taking place in real life situations. To counteract these lapses into old patterns of dysfluency, graded tasks and the extension of the range of situations the client is able to master will foster increased self-assurance, along with a decrease in anxiety. "By
using a conspicuous manner of stuttering imitation without provoking in the listener those untoward reactions which he dreads, a gradual "weaning" process takes place, rendering the stutterer more independent and self-reliant. However, in the case of severe stuttering with the accompanying grimaces, more psychotherapy than stuttering therapy is needed when emotional and social impairment is evident.

In conclusion, an increased focus on research is needed examining the effects of speech therapy alone, speech and psychotherapy, and psychotherapy alone. Also, the success of such individual methods as delayed auditory feedback, hypnosis, behavior modification therapy, and psychoanalysis need to be documented. While psychotherapy in the form of psychoanalysis presents one etiology of stuttering, it is of greatest importance in probing the psychological needs of man. The emphasis of learning theory, on the other hand, in treating the actual moment of stuttering can be combined with a psychotherapy focus to treat the entire individual. A complete approach is needed to incorporate the total person, as communication is a reflection of the inner man. A blending of both views seems to be the answer.
Endnotes


2 Ibid., p. 3.

3 Ibid., p. 3.

4 Ibid., p. 3.

5 Ibid., p. 3.

6 Ibid., p. 5.

7 Ibid., p. 5.

8 Ibid., p. 11.

9 Ibid., p. 11.

10 "The Stutter-Type Personality and Stuttering". The Medical New York State Journal of Medicine, Vol. 36, 10, May 15, 1936, p. 43.

11 Hahn, p. 8.

12 Ibid., p. 9.


14 Ibid., p. 242.

15 Ibid., p. 242.

16 Ibid., p. 242.

17 Ibid., p. 243.

18 Ibid., p. 243.

19 Ibid., p. 243.

20 Ibid., p. 243.

21 Ibid., p. 244.

22 Ibid., p. 244.

23 Ibid., p. 245.

24 Ibid., p. 244.

25 Ibid., p. 245.

26 Ibid., p. 246.

27 Ibid., p. 246.

28 Ibid., p. 248.

29 Ibid., p. 248.

30 Ibid., p. 249.


32 Ibid., p. 67.

33 Ibid., p. 67.
34 Ibid., p. 71.
35 Ibid., p. 73.
36 Ibid., p. 73.
37 Ibid., p. 75.
38 Ibid., p. 76.
39 Ibid., p. 77.
40 Ibid., p. 78.
41 Ibid., p. 82.
42 Ibid., p. 82.
43 Ibid., p. 84.
44 Ibid., p. 99.
46 Ibid., p. 108.
48 Ibid., p. 123.
49 Ibid., p. 122.
50 Ibid., p. 126.
51 Ibid., p. 127.
52 Ibid., p. 129.
53 Ibid., p. 129.
54 Ibid., p. 160.
56 Ibid., p. 176.
57 Ibid., p. 115.
58 Ibid., p. 116.
59 Ibid., p. 117.
60 Ibid., p. 117.
62 Freund, p. 179.
Bibliography


"The Stutter-Type Personality and Stuttering". The Medical New York State Journal of Medicine, Vol. 38,10, May 15, 1936, p.45.