Communication is the greatest gift that has been bestowed on all living beings. Though human beings and animals have their own communicative means, ‘Speech’ is that inborn feature which distinguishes man from animal. From the time an infant is born, it acquires the tendency to utter sounds and words, mainly monosyllables. In the course of time, these sounds are transformed into speech.

Speech is a form of communication, which a man uses most effectively, in interpersonal relationships. It is one of the most effective means of self-expression and communication. It is the way through which one makes oneself known and felt by others. Through speech one expresses his innermost thoughts, needs, ambitions, sorrows, and joys. Most of our social contacts are made through the sole medium of speech. When we are awake, most of the time is spend in speaking to others. An individual’s acceptance into the social organisation depends on how compatible the individual is, how clearly he can express his opinion, how well he gets along with people in his daily activities.

Speech requires at least two persons – the speaker and the listener. It reflects the feelings of the speaker, what he feels about himself and about others, to signal needs, intentions, feelings and thoughts. Speech is used for self-talking and for controlling and directing one’s own behaviour and that of others. Speech is used to deceive by saying many things to avoid a vacuous existence and also to become an accepted socialized and civilized human being. Speech is used to delay non-verbal hostility and for engaging and instigating hostility.

From childhood to adolescence, a person develops the power of speech from parents, relatives, friends etc. If the child does not attain the professed standard, depending on his age, it will be considered as a disability, which affects the individual’s personal adjustment in his later years.

Speech cannot thrive in a vacuum, it needs the stimulation to speak which may come partly from home atmosphere and partly from experiences that provoke linguistic activities. Some environment provides more stimulation to speak and good models to initiate than others. When a mother talks to her child simply and frequently and when her own speech is clear and intelligible, the child is likely to speak quickly. As the
child grows older, he lives with parents who share and enjoy interesting experience with him, and he tends to speak more fully and with longer sentences than the child who has fewer experiences.

A normal Indian child starts to speak meaningful words like 'Acha', 'Amma' around thirteen months. Around the age of one and a half-year he can put two or three simple words together and express his needs. As he grows older he adds more words into his vocabulary and improves his speech. He learns to combine words into sentences and can express his wishes and experiences meaningfully.

However, inspite of the best of circumstances in which the child is brought up, there could be chances that he may have problems in his speech. Strong emotions like fear, anger, and tension do affect the smooth flow of the speech. Repetition, hesitation and interruption that occur so often in his speech will also disturb the communication process. The speed and voices of the speaker are also very important factors. Some children speak too slowly while others are in a hurry to get their words into conversation. The latter need to realise that their listeners miss part of what they are saying because of their speed. Another problem that may arise is the inability to adjust the pitch of one's voice, whether too loud or too low, according to environmental demands. The meaning and emotions and factors like age, sex and physical maturity should be reflected in speech.

Thus speech being the most important form of human communication, it is only natural that various disorders connected with the same might arise. Of all the various types of communication disorders, stuttering has probably received the most attention because of the way in which it dramatically exposes many of the unpleasant sides of social living. No speech problem has received so much attention over such an extended period of time as stuttering. It is one of the most serious clinical problems, which has existed for thousands of years, affecting many people for centuries and refusing to yield fully to scrutiny. It is one of the oldest speech problems noted in the history of speech and language.

The term stuttering refers to abnormal speaking behaviour exhibited by persons whose undesirable attitudes and feelings impede when they attempt to speak with
The disorder is characterised by an interruption in the forward flow of speech in the form of a pause, a repetition or a prolongation of sound or word, a number of times without the ability to control this in any way.

Dorland’s Medical Dictionary (1962) states that stuttering is “a variety of faltering and interruptive speech characterised by difficulty in enunciating and joining together syllables”. The dictionary also has a definition for stammering. Stammering is a “faulty and interrupted manner of speech due to defects of articulation”.

Van Riper (1982) who is an internationally accepted authority in this field states “Stuttering occurs when the forward flow of speech is interrupted by a motorically disrupted sound, syllable or word or by the speakers reaction there to....”.

Stuttering and stammering are synonymous terms for the same speech disorder. Stuttering is used as the proper terminology for the problem in most professional areas. Characteristics of stuttering includes repetition of sound and syllables such as ba---------ba...ball, often with the correct vowel perceived as a sound, unusual pauses between sound and syllables, typically associated with prolongation or repetition of articulatory gesture, more commonly referred to as “blocks”. A block typically involves obstruction of airflow, usually accompanied by abnormal increase in tension or lack of coordination in the articulatory or laryngeal muscles.

Historically, the problem of stuttering had occupied the minds of intellectuals dating back to the period before Christ. During the era before Christ, Herodotus (464-424 B.C), Hippocrates (450-375 B.C), and Aristotle (384-322 B.C) were noted to have mentioned the problem and in some instances have suggested remedies. In Biblical times, Moses complained to the Lord that he could not lead the children of Israel because he was slow of speech and of a slow tongue stuttering. The problem apparently was known during the existence of the kingdom of the divine Pharaohs, Egypt (3200 B.C to 300 A.D). It has been a problem that has brought disgrace and internal turmoil to those who have been affected (Ham, 1986).

In Roman times, stutterers were viewed as being possessed by evil spirits. But later during the Middle Ages, it was commonly thought that stutterer’s tongues were
somehow inadequate for the fluency demand of speech.

Historical accounts showed that stuttering were due to some central nervous problem and were caused by faulty action of the respiratory muscles, or that it was a bad habit. Some began to view stuttering as a neurosis and Psychoanalysts even declared it as a form of hysteria, with its neurotic core in traumatic early childhood experiences.

Throughout the history of mankind, innumerable men and women have not been able to achieve their potentials and live peaceful lives because of stuttering problems and the same is the case in the present modern era. This disorder has always had a very demeaning and demoralising effect on those who suffered from it, often making them shun social contacts to a large extent. It appears that ever since the onset of the problem there have been those who have searched in vain for a remedy or therapeutic procedure to eliminate the repetition, hesitation, prolongation, and stoppages that occur while speaking. To this date no one has completely solved this problem that plagues so many human beings.

Speech, as mentioned earlier is the highest form of integrated response of a human being. Speaking in a formal situation is a strain than speaking in an informal situation. A child stutterer feels being trapped in social speaking situations. During such situations there is an increase in tension and anxiety in the child. As the child becomes a teenager speech becomes more demanding. Stutterers are capable of clear thinking and formulation of ideas, but when these ideas have to be translated into speech they become a prey to undesirable emotions like anxiety, fear etc... At this stage stutterer's speech becomes disorganised whenever he attempts to speak. He feels tensed and anxious which lead to interruption of his speech. With repeated frustrating experiences, stuttering behaviour gets strengthened.

During the teenage period, these individual stutterers develop adjustment problems because of their speech problems. During such times they are more likely to develop certain deviant behavioural patterns, which may serve as impediment in their progress. The nature of the problem they face may result in social isolation, anxious and apprehensive responses, feeling of inferiority etc.. During social interaction
situations it may leave him in dilemma. He may adopt avoidance, that is, giving up an attempt to speak, postponement, pausing, repetition preceding words etc. Shame, guilt, embarrassment are the consequences of such episodes. They become highly sensitive when they anticipate similar speaking situations. When a person begins to stutter, it affects his personal happiness. Stuttering thus seriously interferes with one's success in life, imposing limitations in interpersonal relationships.

The beginning signs of stuttering tend to be mild and transient. They appear only in the form of repetition or prolongation. Even when the earliest signs are severe, they still come and go. Many parents hesitate to make their children available for professional observation and evaluation until long after the first signs are noted. By this time, the underlying cause may be obscured by the factors that operated to precipitate the changes that motivated the parents to seek advice.

Stuttering usually has its onset during the pre-school years, frequently between the ages of two and four. It rarely occurs in later life, and particularly in the adult years, and when it does, it may be because of some other reasons like emotional traumas or damages in central nervous system. The nature of stuttering at the onset is usually simple repetitions, pauses or blocks and is associated with some secondary characteristics such as increased muscle tensions and facial expressions. As years go, the problem becomes complex and abnormal. In coping with these breaks in speech so as to hide or escape his difficulties, the stutterer habituates much coping behaviour, which complicate his problem. These coping behaviour soon become automatized components of the stuttering and stutterers feel that these are involuntary and they cannot keep them out.

Statistics show that male stutterers are many more in number when compared to female stutterers at any age level (VanRiper, 1982). Some speech pathologists speculates that excessive disfluency may be due to sex linked genetic trait, where as others favour environmental interpretations such as male children being held up to higher standards and expectations, are likely to face more social stress than females resulting in such a complex behaviour. Other explanations have focussed on learning theory and suggested that female children were more sheltered, were subjected to
lower parental expectations, met less peer pressure. Moreover, generally it is observed that males are more vulnerable to all types of disorders than females (Silverman, F.H, 1992). It has also been observed that as age advances, the female stutterers gain better fluency. It is also believed that a change of handedness may bring about stuttering. But experimental evidence so far has proved otherwise.

Case histories of the clients often reveal that stuttering runs in the family of the stutterers. Ordinarily, the concept of family includes mother, father, grandparents (both maternal and paternal), aunts, uncles, cousins and siblings. Although the study of genetics has made rapid progress in recent years, there is nothing known as to whether such reactions as anxiety and fear, which plays a large role in stuttering can be transmitted from parents to child through genes. The explanation that stuttering tend to run in the family appears to be a matter of tradition rather than genes. Parents who stutter, or had stuttering brothers and sisters are likely to develop some beliefs, attitudes and reactions to stuttering.

It is believed that stutterers in many cases are made and not born. Most parents treat these initial deficiencies in their child's speech by ignoring them. Parents often feel that their love, understanding and care of the child's emotional well being would be sufficient to make him feel secure. On the other hand, there are parents who unknowingly make the problem more serious and worse. Due to their love and affection for the child, they develop anxiety and tend to overprotect the child.

Prevalence of stuttering in any country is conveyed by the information as to how many persons continue to stutter, either in general or within a particular age range. Nobody seems to have conducted extensive surveys covering the entire population of a country in an effort to count the number of stutterers. Study of larger groups of stutterers in America show that nearly 50% of them began to stutter before their age of five years, 90% of them before they were eight years and nearly 99% of them before the age of thirteen years. In general the prevalence rate of stutterers of America was slightly over 1% of total population. Some questionnaire studies conducted at different countries also show that the prevalence rate of stutterers is slightly above 1% (VanRiper, 1982). But no study has been conducted in India to indicate the prevalence rate of stutterers here. The importance attributed to this problem of communication by
the authorities concerned is in fact negligible. Even the awareness of the public as to the seriousness of the problem, significance of its early identification and treatment is found to be very poor. They believe that the problem has no treatment as such and the stutterer automatically becomes all right, as he grows older. The number of speech correction centers functioning in western countries are innumerable when compared to India. They believe that stuttering is a childhood disorder and should be nipped in the bud itself.

The development of acceptable and normal speaking behaviour in individuals with speech and language defects has received abundant attention in western countries. Today there are overwhelming types of therapeutic procedures being offered by those in the field of speech and hearing in the hope of eliminating problems and improving speaking behaviour. Much emphasis is being placed on behaviour modification as a newer entity in controlling human behaviour and bringing about desired changes in speech.

As there exists a definite lack of agreement as to the cause of stuttering and its continuation throughout the years, adequate therapeutic procedures or remedies have not been developed for its correction. Most therapies used are based on the philosophy held by different speech pathologists and the treatment programmes directed toward the alleviation of non-fluent speech are quite diversified and numerous depending upon the mode selected by each of them.

The background of stuttering therapy is ancient. Eldridge and Rank (1970) states that the earliest known reference to stuttering therapy dates back to about 2000 B.C during the middle Egyptian dynasty. Many of them blamed malfunctioning of tongue for the halt and distortion of production of sound. In the eighteenth century, Mandelssohn recommended slow rate of speech, Erasmus Darwin proposed a system of easy attacks on articulated sounds, and a number of authorities introduced various rhythm techniques. Arnot, in the nineteenth century advocated using “e” sound between each word, and Hagerman suggested producing a continued “n” sound before each syllable (Klingbeil, 1939).
For a period of time, intervention included surgery, popularised by the great German surgeon, Dieffenbach, and many European surgeons busily transacted muscles removed wedges of lingual tissues, and severed nerves. The popularity of these techniques waned rapidly, as the post operation results failed to justify the pain and danger of the procedure (Ham, 1986). Rieber (1977) describes a number of unusual devices used in the past, including one designed to keep the airway open even when the teeth were clenched and the tongue pressed against the roof of the mouth.

As years passed, the treatment of stuttering also varied in number. The methods adopted included holding pebbles in the mouth, blistering and deadening application to the tongue, clenching teeth, speaking on inhalation, talking out of one side of the mouth, alternating hot and cold bath, eating raw oysters and travelling to religious shrines (Gottlober, 1953).

Review of literature reveals that various treatment modules have been employed as attempts to alleviate the problem of stuttering during the past twenty years. One of the programmes that received immense attention of the public is ‘adaptation’. This procedure is based on the concept that the individual would reduce his tendency to stutter because of increased familiarisation with the words he uses, the person to whom he speaks, and the situation in which he finds himself. He adapts to the speaking situation, thus, his speech becomes more fluent. Another therapy worth mentioning is the auditory or initiation approach in which the person hears fluent speech. He is supposed to initiate the normal fluent speech that he hears and uses it. Some therapists use a reward system for good speech in conjunction with this programme.

Yet another suggestion made by some other speech pathologists involves the process in which the stutterer speaks to the beat of a metronome, which sets a rate of speaking and makes him more fluent. Others recommend finger tapping, or hand movements to achieve some results. A few speech clinics use videotapes and sound tracks in their programmes. The person who stutters is filmed and his speech is recorded is played back for him to see and to hear. He notes his behaviours and with refiliming and recording, he is to correct the problems noted and speak more fluently. In the case of sound tracks the subject’s speech is taped and reproduced to the subject.
He is to listen to how he is talking and the clues help him to perform in certain ways in order to improve his rate of fluent speech output.

Another programme that proclaims the correction of stuttering recommends that the stutterer practices the words on which he stutters until he does not stutter on them anymore. There is a commonly held belief that the stutterer talks too rapidly and feels that if he would slow down, he could talk better.

With the advent of theoretical treatments of stuttering, systematic and logically derived forms of therapy were developed. The most pervasive treatment devised for stuttering was Psychotherapy. The psycho analytically oriented workers saw stuttering as a neurotic symptom. The focus of treatment involved the identification of unconscious conflicts and restructuring of personality. If the person who stutters is a child, it is recommended that the parents receive the treatment. It is usually the mother who is offered the therapy because of her affiliation with the child. The child also may receive some psychological or psychiatric assistance if his problem is severe enough.

Bryngelson's (1943) approach involved stressing the stutterer's acquisition of an objective attitude about his problem, which would enable him to speak freely about it, and talk without inhibitions, without attempting to mark the problem, whereas Brutten and Shoemaker (1967) presented a programme of therapy based on counter conditioning procedures. The initial part consisted of relaxation exercises and the second part of the therapy is aimed at the reduction of instrumental responses associated with stuttering which includes escape and avoidance behaviour, eyblinks, facial expressions, sudden inhalation etc... This type of orientation towards stuttering has become quite popular because of the prominent belief that stuttering is emotional in its origin.

Different types of relaxation therapies have occurred in the treatment of stuttering. Attitude towards its efficacy was mixed. Blumel (1960) stated that relaxation really had no theoretical basis to support it, but empirical evidence was sufficient to recommend its use. Bloodstein (1975) felt that it was used primarily as subprocedure and not as a major therapy. This view was also supported by Gregory (1968) who felt that brief series of relaxation should start early in the therapy and should continue as
part of therapy session and should use other techniques such as the major approaches to rectification.

Popular relaxation techniques used for the treatment of stuttering therapy is deep muscle relaxation (Jacobson, 1938) where the client tenses and then relaxes specific muscle group, progressively learning to relax the whole body from head to feet and Transcendental Meditation, popularly known as TM (Harisinghani, 1990), where clarity of mind leads to freedom from tension, anxiety, stress and improves the health of the individual.

Another technique used for the treatment of stuttering is Systematic Desensitization. This is based on the assumption that a person stutters more than usual in some situations, may be because there is a stimulus associated with them that elicits higher than usual amount of anxiety (Wolpe, 1958). According to Gerstman (1983) stuttering is an anxiety bound neurotic behaviour that causes problem in communication, whenever the person is in the stressful situation. Desensitization therapies attempt to reduce or eliminate these problems. Implosive therapy or emotional flooding therapy is also used for the treatment of stuttering. This, like systematic desensitization, is a behaviour therapy method that involves having clients enter or imagine being in disturbing situations (Stampfl & Lewis, 1967).

Many stutterers exhibit abnormalities in respiratory system during moments of stuttering. Attempts have been made to teach them to breathe more normally. One such approach is known as Regulated Breathing Method, in which the clients are taught to breathe in a smooth manner, to pause at natural juncturing points, to breathe deeply, to plan ahead for the content of speech and to relax chest and neck muscles (Azrin, Nunn & Frantz, 1979). Another method used for breathing irregularities is known as Pranayama (Harisinghani, 1990), in which each deep breathe consists of a very full inhalation through the nose. These will help to avoid breathing irregularities during stuttering.

Other techniques used for the management of stuttering includes choral speaking or unison speech, Rhythm therapy or singing therapy, whisper speech, Role play prolongation, Paradoxical intention, and drugs (Ham, 1986, Silverman 1992).
Even now, there exists a situation in which many different professionals appear to be moving in different directions to solve and to treat the same problem. Because of these diversified approaches for the correction or remediation of this speech disorder, it may be assumed that no one has truly developed an acceptable corrective therapy or treatment for the rehabilitation of stuttering behaviour. The investigator does not imply that these therapeutic methods of the past and present are completely valueless. It is certain that each of them has freed some stutterers from their communicative disabilities and has produced improvement in others.

From the above discussions it evolves that one of the sad things about stuttering, is that the victims far too often find themselves in the hand of a novice rather than at the hands of a competent therapist. It is indeed unfortunate that stuttering can be temporarily ameliorated by different kinds of treatment since the sporadic success seems to generate a host of blind enthusiasts who make vast claims that are disproved eventually. Each new generation of therapists seems to have to rediscover the same old methods alter them slightly, give them a new rationale, and then apply them to a new crop of stutterers. There are many vicious circles in the field of stuttering but certainly this is one of the most tragic ones.

**Need and Significance of the Study**

The discussions made so far clearly indicate that the problems of stuttering is a multifaceted one. The personality profile of the stutterer is more or less complicated. Stuttering is a common disorder being faced by the people all over the world. This is a speech disorder, which got comparatively less importance than any other communication problem. Starting from a small family get together to a crowded social programme, this problem tends to keep the victim aloof. Such situations inspired the investigator to bring forward a solution to this unattended problem.

A number of investigations have been conducted in the Western countries in the area of stuttering. The speech pathologists over there have given appreciable importance to each and every aspect of the problem of stuttering. They have applied a number of management techniques for controlling this problem, but even these
management programmes could not yield any satisfactory results.

In India, nobody seems to have conducted an extensive research programme in this area. Here, National Institute for Speech and Hearing has been provided with a few management programmes to control the problem of stuttering. Comparing the research studies and the management programmes conducted in Western Countries, very few research works have been done in India. Here the speech pathologists in general appear to have given more importance to other communication problems than the specific problem of stuttering. The number of speech correction centers giving treatment for stuttering is also very few when compared to the Western Countries. Awareness of the public regarding the seriousness of the problem and importance of its early identification in the prognosis of the disorder is in fact negligible. People believe that this problem has no treatment as such and the stutterers have a natural cure, as they grow older. In fact, the medical professionals in India also give less importance to the problem of stuttering, they also believe that the problem of stuttering has no treatment that the stutterer becomes all right as years pass by.

A certain amount of attempts have undoubtedly been made to probe into the pros and cons of various causative factors and management techniques. Several such techniques have been tried at various times by different speech pathologists. The results of these techniques being far from satisfactory since no treatment has focussed to the different problems faced by the stutterers at the time of interaction. Most of the management programmes give importance to the conventional treatment methods as prolongation, slow reading, and a few exercises but none stressed the major psychological problems faced by the stutterers.

Keeping all these points in mind, and understanding the nature of the problems faced by the stutterers, the investigator intends to work out a new treatment procedure, to bring out an innovative treatment strategy for the management of stuttering. The treatment programme includes a group of management techniques for the treatment of stuttering and to test the efficacy of the same in a selected population of the stutterers in Kerala. Therefore, the problem of the study is stated as “THE EFFICACY OF A PACKAGE PROGRAMME FOR THE MANAGEMENT OF STUTTERING”.