The problem of stuttering has received much attention in the world of verbal communication. Yet no single theory has been propounded to explain the etiology of its occurrence. This continues to be a riddle. The etiological ambiguity of stuttering is similar to many problems in the field of mental health, medicine and social science in which genetic, environmental, psychological and social factors are all relevant but causes and effects are difficult to disentangle.

Researchers in speech pathology, psychology and related fields have unanimously agreed that the onset of stuttering occurs between the ages of 2-4 years. Although many varying possibilities have been suggested no one seems certain why it occurs.

Causes of stuttering have been explained by various professionals in different ways. Psychiatrists suggest that the problem generally result out of a neurotic or a psychotic conflict. Psychologists infer that the cause may be due to an emotional conflict and an inability to respond adequately because of a neurosis, where as speech pathologist stated that the problem is due to the attempt made by the child to speak in sentences before he is ready for such behaviour. Other scientists have suggested that the outbreak of nonfluency is neurologically based and may be due to such cases as cerebral dominance, confusion, metabolic imbalance or delayed auditory feedback. There have been a limited number of individuals who have related the cause of the problem to one or more symptoms of stuttering such as a breathing problem or rapidity in speech.

There have been few generally accepted facts known about stuttering which helps to elucidate some of its causes. Researchers say that stuttering can be transmitted through generations within a relatively small proportion of families in the community. Whether this transmission reflects genetic or environmental factors is not fully clear, although many works consider that heredity contributes to causation to some extent.

Many authorities in the field of speech related therapy attributed the cause of
stuttering to physiology but some others believe that the cause is purely psychological. Still others believe that the cause is the result of a combination of the two.

Stuttering appears to be relatively common among children with cerebral diplegia, and other forms of brain damage. Hippocrates in the fifth century B.C. explained the causes of stuttering as being a disturbance in the harmonious mingling of the four humours, blood, black bile, yellow bile and phlegm. A few others believe that stuttering is precipitated directly by some sort of breakdown in physiological functioning. It is a joint product of some sort of abnormality in physiological functioning and as environmental conditions producing stress (Silverman, 1992).

West (1958) suggests that a person can begin to stutter because of the biochemical imbalance or differences that makes speech mechanism in a more vulnerable than normal to the fluency disruptive effects of emotional stress. This explanation views the moment of stuttering as a kind of miniature seizure, somewhat similar to that evinced by those who have a childhood form of epilepsy known as pyknolepsy. Such seizure affects mainly the speech mechanism and is precipitated by emotional stress. Those person who have the symptom of disorder have a biochemical imbalance. Studies have showed that person who stutters have relatively high blood sugar levels than the person who do not stutter (West, 1958, Silverman, 1992). It is also widely accepted that emotional disturbances and familial settings are likely to play some part either as cause or as effect in the problem of stuttering.

The role of socio-cultural factors is uncertain although same clinicians believe that stuttering is fostered in some cultures and suppressed in some others. During the first half of this century many people believed that forcing a left handed child to write with his or her right hand could precipitate stuttering. But, today authorities do not believe that switching handedness by itself can precipitate stuttering, because the evidence in this is inconclusive and conflicting (Silverman, 1992).

Repetition of a sound or syllable is the earliest and most fundamental symptom of stuttering and is present in almost all cases from the beginning of the disorder. These
repetitions will be identified as stuttering by observers, either if they occur regularly in speech, or if there are episodes when there is more than a single repetition on any one sound. They are thus distinct from the common inaccuracies of speech. The association of tension with such repetition is diagnostic of stuttering. Phrases and word repetitions, hesitations, interjections and corrections without tension are often present in normal speech and are not regarded as stuttering.

Prolongation of sound occurs rarely in normal speech, whereas in stuttering they often form a characteristic part of the abnormality. Prolongation tends to occur on the vowels and continuance consonants when the stutterer is unable to end the extension of the sound.

A number of associated body symptoms, such as irregularities of breathing, abnormal movements of the tongue and jaws, facial tics and movements of the trunk and limbs, frequently occur concurrently with the prolongation and blocking. These appear to be outside the voluntary control of the stutterer and end only with the cessation of the particular interruption of speech. Some stutterers can remember first using them voluntarily as a means of release from blocking and later finding them to have become a part of the involuntary patterns.

As the disorder becomes more severe, stutterers begin to avoid words that they feel to be difficult for them, and on which they have often stuttered in the past. The avoidance is usually achieved by finding synonyms, which can often be said without difficulty. Such circumstances may be effective temporarily but when precise and accurate speech particularly of a technical nature is required and if the synonyms fail to express the meanings, then the stutterer is in greater difficulty.

A severe stutterer frequently avoids particular speech situations that he finds difficult, he also develops a range of devices to cope with the situations, when he finds it difficult to avoid them. Embarrassment and frustration are experienced by the stutterer when the disorder interfere with his ability to communicate his needs and wants. Confronted by the stutterer, the listener too becomes embarrassed. In an
attempt to help, he commonly supplies words or finishes sentences. The listener's obvious embarrassment and anxiety is a further goal to the speaker's anxiety, self-consciousness and frustration.

The hallmark of stuttering would appear to be the unpleasant sense of tension and physical effort directly associated with an interruption in the normal flow of speech. The normal speaker is often unaware of the inaccuracies and repetitions in his speech and if the need arises can eliminate them easily. The stutterer is aware of his speech faults, anticipating their occurrence with anxiety, greeting their arrival with tension and effort, and failing to avoid them.

The disorder seems to develop on predictable lines regarding both the complexity and severity of its manifestation. Bloodstein (1975) has given excellent description of the symptoms of stuttering with particular references to their chronological development.

He describes the symptomatology of stuttering under the following headings:

a. Repetition

Repetition occurs at every age level in his/her life but is the dominant feature until six or seven years. They were more frequent and more prolonged than normal non-fluencies and were often associated with a degree of stress. Repeated difficulty with specific sounds were evident even in the young children.

b. Hard contacts & Prolongation

Hard contacts and prolongation are the characteristic symptoms of stuttering. They appear associate with considerable strain, even in the young children. In few cases, it seems that they are the first symptom of stuttering, although it was possible that the repetition had been overlooked and the stutterer diagnosed only when the more markedly abnormal symptoms became prominent.
These symptoms, that is repetition, hard contacts and prolongation form the primary speech disturbances in stuttering. The secondary symptoms can be grouped into the following categories.

a. Associated motor symptoms

Associated motor symptoms appear concomitantly with the speech difficulty. The percentage manifesting these rose steadily with age, reaching 70% in the oldest group of stutterers. Breathing irregularities and head and facial movements were common whereas movement of the hands and feet or total body movements are unusual. Some stutterers interject extraneous sounds, words or phrases.

Associated motor symptoms function initially as devices to start a difficult word, to delay having to say it or as a release when the stutterer is caught in a difficult word.

b. Fluent period

In pre-school children remission of good quality and length appeared to be quite common, but with increasing age such fluent periods diminished until, in the adolescent group, they are completely absent. Some of these remissions might well have been permanent, so that cases of established stuttering could stem from a much larger reservoir of transient stuttering in early childhood.

c. Anticipation and consistency

Anticipation refers to the stutterer’s ability to foretell difficulty with a word before he/she reaches it, that is he expects to stutter on it before actually attempting it.

The consistency effect refers to a tendency for stuttering to occur as the same word in successive readings of the same passage. In other words, stuttering seems to be a response to certain features of the speech sequence.
d. Word substitution

The avoidance of a difficult word by circumlocution and substitution of synonyms is more frequent in older children becoming one of the principle secondary feature of the disorder. In young children avoidance was rare.

Theories of Stuttering

Although none of the theories have ever satisfied the criteria of adequacy, various attempts have been made to summarize the theories in a variety of ways. Some of the theories of stuttering are mentioned below.

CEREBRAL DOMINANCE THEORY

An early explanation of stuttering was given by one of the first American Speech Pathologist, Travis (1931). This explanation caught the attention of many, including the non-speech specialists, and was termed the cerebral dominance theory. The two hemispheres of the brain behave somewhat differently from each other. The left hemisphere dominates in speech and motor functioning, because most of the anatomy of the speech system is approximately along the middle lines, one side of this neurologic system is the leader. The cerebral dominance theory suggests that in stutterers neither hemisphere of the brain takes the lead. The effect is that the muscles receive somewhat conflicting input, and the result is fragmented speech. The person develops unfortunate tactics both physiologic and psychologic to handle this neurologic conflict and stuttering develops (Ham, 1986).

BIOCHEMICAL THEORY

Biochemical theory was brought out by West in 1958. According to this theory the source of stuttering is to be found in a basic difference between stutterers and nonstutterers in metabolic factors and tissue chemistry. The speech interruptions are triggered by social and emotional pressures, but the stutterer's neurophysiological
mechanism for speech is rendered vulnerable to the disruptive effects of such pressures by a biochemical imbalance.

West formulated the concept of stuttering as a convulsive disorder related to epilepsy and particularly akin to an epileptiform disorder of childhood known as pyknolepsy (West, 1958). According to this concept, the stutterer is a basically seizure-prone person in whom outright convulsions are held in check by a number of observations purporting to show an elevated blood sugar in stutterers, a high incidence of stuttering among epileptics, and a rareness of stuttering among diabetics.

AUDITORY MONITORING THEORY

The variations of auditory monitoring theory approach are several but essentially it suggests that stutterers hear themselves as they talk. Hearing oneself is auditory feedback. Generally, the child learns and the adult continues to use auditory feedback to check speech output against what he/she intended to say. The stutterer, according to this idea, has self-hearing that is out-of-phase or delayed from motor functioning. There is some conflict between input and output. This kind of conflict can result in hesitation, repetition or other stuttering like behaviour (Palmer & Yantis, 1990).

PSYCHO ANALYTIC THEORY

In the first forty years of this century, psychoanalytic theories of stuttering were prevalent, but in more recent times, interest in and acceptance of such orientations has reduced sharply. However, there are studies in psychoanalytic concept of stuttering.

Travis (1931) theorized that desire and repression surrounding eating, elimination, sexual behaviour, and feeding create a conflict that can paralyze behaviour and can cause stuttering. Coriat (1943) is famous for identifying stuttering as a perservation of pregenital drives to oral nursing. Oral gratification in nursing is disrupted by weaning, and the stuttering tongue, lip and jaw movements are symbolic of nursing movements. Fenichel (1945) felt that stuttering was a conversion of neurosis, not an
oral perservation, in which unacceptable anal sadism is transfered to oral messing in disfluencies. As toilet training and social demands constrain the young child’s bowel elimination behaviour, a conversion to verbal soiling provides a more acceptable social form of aggression. Glauber (1958) argued that stuttering is the result of id, ego and super ego conflict. The presumably unspeakable feelings and thoughts of the id are suppressed or rechanneled by the superego, under normal conditions. When the control balance of superego break down over id, the conflict may be expressed in the ego-based function of speech. Id’s effort to break through, and superego’s effort to suppress, result in the jerking, interrupted patterns of stuttering.

Barbara (1965) described that stuttering in children occurs as a result of inconsistent, perfectionistic, rigid, demanding parents. The result conflicts in the child’s feelings are expressed in speech behaviour.

But current theories do not agree that stuttering is a symptom of a clinical emotional disorder or as a communication disorder resulting from internal emotional etiologies. Curlee (1985) rejects psychogenesis as a cause in most stuttering, Wall & Meyers (1984) do not accept the idea that emotional disturbance is a valid stuttering etiology.

It would be in appropriate to conclude that many stutterers do not have conflicts, anxiety level and behaviour patterns associated with their communication difficulties. Andrews et.al. (1983) noted that stutterers have more social adjustment procedures, alone often do not address or ameliorate adequately the disfluencies and disfluency behaviours of stutterers. However, evaluations and management procedures for stuttering ought to provide for the feeling, attitudes and adjustment behaviours, the stutterers may have developed overtime (Ham, 1990).

CONFLICT THEORY OF STUTTERING

Conflict theory of stuttering explained by Sheehan (1958) represents major ideas about the origin of stuttering. This theory reflects the common belief that stuttering is
imposed on essentially normal organisms by intolerable environmental stresses. Sheehan (1958) has utilized four kinds of conflicts - approach-approach, approach-avoidance, avoidance-avoidance, and double approach-avoidance conflict - to explain early as well as advanced forms of stuttering. The early signs are presumed to represent simple approach-avoidance conflicts. The approach aspect is need or desire to speak, while the avoidance is a counter-pressure involving fear of consequences. The approach-avoidance conflict created by these opposing needs leads to oscillation and fixations in behaviour, which at the speech level are the repetition and prolongation so noticeable in stuttering. Sheehan thus considers stuttering as the symptomatic expression of the innerself as it struggles with conflicting impulses. Various classes of symptoms may result from a state of conflict and are expressed through speech and take the specific form of rhythm breaks or interruptions in the forward flow of speech. These speeches related conflict states are word, situation, emotional content, relationship conflict and ego-protective. But the reasons why the conflict is expressed through speech and why the specific symptoms choice is stuttering are unknown.

Since stuttering is explained as the result of conflict its termination depends on the resolution of it. The conflict can be resolved either by increasing the approach drive for speaking until it exceeds the avoidance drive or by reducing the fear-based avoidance until it no longer interferes with the approach drive.

Sheehan also believes that guilt feelings have an important role in the onset of stuttering. Sheehan assumes that the central basis for stuttering is the behavioural fluctuations that occur in an approach-avoidance conflict situation, he also assumes that both the cause and intensification of the conflict lie in guilt feelings and he sees the particular behavioural pattern that develops more as a defence system than as a set of responses reinforced by drive reduction.

LEARNING THEORIES OF STUTTERING

Wischner (1950) hypothesizes that the presence of learned anxiety is fundamental to the onset of stuttering. This motive force of anxiety or anxiety drive can
result from the punishment of any behavioural pattern that is in the person's response repertoire, but the development is most clearly understandable if the punishment is associated with speech activity. The adult's noxious reaction to the disfluencies lead to 'painful' responses in the child. If these conditions are repeated often enough, speech under certain circumstances become a response-produced case for eliciting anxiety in the child and this state drives the child to avoid the noxious stimulations.

According to Wischner, anxiety may lead to the development and perpetuation of behaviour other than stuttering. Anxiety may lead to stuttering if it serves as a drive to avoid the painful stimulation that is associated with normal disfluency. This drive to avoid the noxiousness of adult disapproval might result in the absence of all language were it not for the fact that the drive to communicate is in conflict with it. This conflict between the desire to speak and the fear of speaking generate random speech behaviour. The particular random speech responses that are learned are those that lead most consistently and successfully to the avoidance of punishment. This is reinforcement. But this reinforcement of anxiety reduction leads further to the learning of speech responses that are not only different from the normal disfluent behaviour but may also result in a generally faulty use of speech organs. The learning of these different from normal avoidant speech responses signifies the existence of stuttering behaviour.

Wischner (1950) holds that there are two types of anxiety evoking stimuli found among stutterers. These two types are general situational anxiety, which is elicited by essentially nonverbal stimuli, and specific word anxiety, which is elicited by verbal stimuli. These anxiety evoking stimuli will differ among stutterers because of the individual differences in the situational and word anxieties that are associated with noxious stimulation. Stuttering behaviour also varies from individual to individual because stutterers employ different behaviours to overcome the anticipated speech difficulty. Those behaviours which are instrumental in avoiding the expected punishment are reinforced by a reduction in the anxiety drive and become an integral part of stuttering pattern.
THE SELF-PROCESS THEORY

A closely related concept of stuttering is presented by Murphy and Fitzsimons (1960). They claim that the early stuttering behaviour arises from anxiety. Impaired interpersonal relationships are presumed to be the sources of conflicts that create the anxiety.

Stuttering to them is a learned, non-integrative, self-defensive reaction to anxiety or fear of threatening circumstances with which the person feels incapable of coping. They suggested five sources of the underlying anxieties. They are suppression or domination sufficient to threaten self autonomy, extreme and chronic inconsistency of adult handling, too many experiences characterized by derogation, belittling and rejection, complete lack of external controls and fears and guilt feelings, generated by a child's reaction to the foregoing experiences.

The result is a child who is confused and chronically concerned about adult evaluation of his behaviour. The anxiety initially need not be directly associated with speech. It can be related to the skills or self image of the child. Thus, the beginning of stuttering in same instances may reflect anxiety about such various things as appearance muscular strengths or language skills. Pronounced apprehension about any felt inadequacy can cause a child to be generally hesitant in his behaviour. And when he speaks, hesitancy may be manifested in broken fluency. This is the explanation for many cases of early stuttering in which the behaviour disappears before developing into a serious communication problem. As adequate skills and satisfactory self images are acquired, the hesitate disappears. This is a time when most children are troubled by a host of adjustment problems which they feel must be solved in a short time and without the help of parents whenever possible.

PSYCHOLOGICAL LEARNING THEORIES

Stuttering in any form is clearly obvious and highly disturbing, both to the stutterer and the listener. As a result, speech pathologists, physicians and
psychologists have been intensely interested in stuttering and its treatment for many years. This interest has produced a multitude of ideas, theories and procedures, but only a limited amount of hard data. However, although the specific theoretical approaches to stuttering have differed, one underlying viewpoint has appeared consistently throughout the years. Theoreticians have generally taken the position that the repetition, prolongation, hesitation, posturing and other such behaviours usually described as stuttering are the observable manifestation on an as yet unobservable disorder in the physiological, neurological or psychological functioning of the organism.

In modern psychological learning theory, the basic concept is quite different from those of most personality theories. Personality theorists discuss behaviour in terms of highly abstract concepts such as personality types, traits or generalized motive patterns. Learning theorists discuss behaviours in terms of less abstract units such as responses, or response-chains. Learning theorists divide the psychological world into stimuli, responses and the relationship between these two classes of phenomena that develop from experiences. The relationships include habit strength, stimuli generalization, response extinction and response contingent reinforcement.

More recent theories can be classified under learning based theories that the stutterer has learned to stutter. Learning theories deal with the conditioning of responses. In stuttering of speech disfluencies become associated with anxiety responses, then speech and anxiety can become associated through learning (Ham, 1990). Van Riper (1982) states that stuttering is a learned behaviour, and he rejects Freudian and other analytical theories, which regard stuttering as a neurosis.

Perkins (1982) shows three aspects of stuttering that cast stuttering as a learned behaviour. They are (i) adaptation-unreinforced repetition of a responses leading to a reduction of response (ii) consistency - when a response is associated with a particular stimulus, the reoccurrence of that stimulus tends to precipitate the same response stutterers tend to stutter on the same or similar words, in the same or similar situation (iii) spontaneous recovery – after adaptation of latency period of nonstimulation results in the recovery of original response, that is, stuttering reappears.
OPERANT THEORIES

Operant formulation today stems primarily from the early work of B.F. Skinner. The various operant applications of stuttering relate to a basic construct to explain simultaneously the occurrence of stuttering and the development of stuttering behaviour. This construct suggests that disfluencies increase if their consequences are rewarding to the speaker and that disfluency struggles and avoidance increases if the consequences are punishing to the speaker. Therefore, a child's disfluencies that gain attention concern and response from parents will be reinforced and will tend to reoccur. However, if and when that attention becomes punitive, then the child will indulge in behaviours designed to avoid or suppress the disfluency (Ham 1990).

The Development of Stuttering

Stuttering begins to show itself between the years two to four. In some children the onset comes later, about the time they enter school, and there are a few persons whose stuttering begins after they become adults. Clinicians have often been able to arrest the disorder in its early phases, in other cases, they have seen it grow in complexity and abnormality as the years pass by.

Different stutterers show different courses of development. The majority seems to run a course in which the initial, effortless syllabic repetitions and sound prolongation becomes full of tension and struggle and then in turn the interruption or avoidance reaction begins to develop. Some stuttering begins suddenly with complete blockages and immediate struggle, and the fear and shame develop swiftly. In other stutterers the growth is very gradual and no struggle symptoms appear.

It would be interesting to observe how stuttering develops in a growing child. On the basis of the growth Bloodstein (1975) has divided development of stuttering into four phases.

Phase I

Phase I is particularly important as it is during this time that stuttering makes
small beginning. It occurs mostly between 2-6 years. The prominent speech defects seen at this phase are repetition of sound and syllable and of small words initiating phrases. Prolongation and blocking are seen, and although they may be quite severe in some, they are not common. The essential feature of this phase is that the disorder is episodic with long periods of complete remissions. The speech is worse when the child is in institution of communicative stress. At times the child may not stutter at all. Rarely secondary bodily symptoms are seen.

Phase II

Phase II usually appears during primary and middle school years. By this time the speech difficulties remain very much the same with repetition, prolongation and blocking. The hard contacts and blocking become more prominent and the associated body symptoms begin to appear. The child realises that there is something definitely wrong in his speech by the remarks made by others. He accepts himself as a stutterer and although he may substitute for difficult words neither there is no actual avoidance of speech nor is he embarrassed about his difficulty. He does not try to avoid speaking situation.

Phase III

In phase III the speech difficulties continue to develop. Repetition of sound and syllables present are not prominent. Hard contacts and blocking increases and becomes the significant part of the disability. Associated with these, this phase is characterised by the elaboration of the secondary symptom such as word and sound difficulties, word substitution and situational difficulties. Great difficulty may be experienced in speaking certain words. Inspite of all these difficulties the child does not voluntarily try to avoid the speaking situation.

Phase IV

The last phase stands for the fully developed stuttering pattern seen among adolescents and adults. Word fears and situation fears become more common. Hard contacts and prolongation along with repetition occurs in full force. The stutterer tries to
avoid the speaking situations voluntarily. At this phase there is a definite interference in
the day to day activities of the stutterer. The unpleasant emotions of worry, anxiety,
shame and embarrassment is experienced.

Stutterers are not known to stutter while alone or while talking to children and
others. Nor would they stutter while they sing or recode a passage from memory.
Stuttering invariably shows itself in the interpersonal communicating situations,
particularly while talking to authority figures or while addressing a group of persons.
Stuttering is greatly reduced when the speaker is in a relaxed state of mind. Treatment
of stutterers by medication particularly sedation has given little relief. All these
observations substantiate the psychological nature of stuttering.

Factors That Influence the Frequency of Stuttering

The frequency of stuttering varies when it is affected by the situation in which the
stutterer is speaking, by the listener and by the nature of the social interaction. Complex
linguistic interaction and the amount of information conveyed during fluency tasks
involving description, narration and conversation tend to influence the frequency of
stuttering. The greater the meaningfullness of speech, the greater the frequency of
stuttering. Increased sentence length and grammatical complexity as well as less
frequently used words have all been found to increase the frequency of stuttering.
Stuttering is more often linked with stressed words and with words appearing in the first
part of the sentences.

The frequency of stuttering is influenced by communicative pressure, such as
time pressures, the number of listeners and their reactions and social approval.
Communicative pressure may be imposed, internally as well as externally. If the
stutterer is excited or feels hurries these factors will tend to increase stuttering whether
the pressure is self imposed or imposed by someone else.

Behaviour Occurring During the Period of Stuttering

Although it is not always easy to differentiate on which behaviours would begin
prior to or during the moment of stuttering, it is generally believed that the earlier
behaviours intensify instead of totally new behaviours being generated. Stutterers continue to behave as they did before they get closer and closer to the stuttering moment.

The ongoing flow of speech may be characterized by increased tension, resulting in various degree and types of disfluency. Since stuttering behaviour vary greatly from stutterer to stutterer, clinicians wants to device their own chart for recording and classifying the behaviours observed for each stutterer.

Equally important to the actual occurrence of stuttering are the struggle and release devices employed by the stutterers. To identify precisely the specific behaviours involved, a clinician must make thorough analysis of each stutterer, identify and differentiate between avoidance and release behaviours because they may demand different relearning procedures. It will be good to use video-audio methods inorder to avoid missing any of the behaviours that occur in various communicative situations.

**Overt Behaviour in a Stutterer**

Stuttering encountered in older children and adults are revealed by an ever greater variety of behaviour patterns. Stuttering does not remain static. As it grows the disruptions in fluency tend to become more noticeable as well as more frequent.

Many other overt visible patterns may be noticed among adult cases. Some include pronounced tremors of the lips, jaws or tongue. Sometimes the tongue is literally protruded during the moment of stuttering. Rigid postures of head may occur. Facial grimaces and pronounced tension, postures of lips and tongue are quite common. Extraneous convulsive movements of the head or limb may be observed.

Overt pattern in the advanced stages of stuttering also may include various audible elements – finger snapping, gasping or choking sounds, and exaggerated series of ‘Uhs’ etc. are among those found in the stuttering patterns of people who stutter. Sometimes odd noises accompany the head postures or extraneous
movements. Another audible pattern found among older stutterers involves excessive prolonging of sounds.

**Covert Behaviour in a Stutterer**

There are many forms of covert behaviours associated with stuttering disorder. Some stutterers seldom exhibit behaviour that directly or obviously indicate their stuttering problem. They hide it. They detour around expected trouble. They filibuster with words they can say fluently. They work to avoid situations in which stuttering is anticipated. As long as they succeed in the avoiding or in the disguising of behaviour, stuttering may not be observable.

**Consistency of Stuttering Behaviour**

Variability in frequency and severity as well as puzzling inconsistencies, also characterize stuttering in each individual. Every stutterer experiences preplexing fluctuation in difficulty from week to week, day to day, from situation to situation. Predicted trouble may not materialize. Anticipated freedom from stuttering in a particular situation may turn into a nightmare of broken speech.

Such inconsistencies are universal with stutterers but are not the same for every individual. It is generally believed that all are fluent when singing and it does seem to be true for the majority. Reading aloud causes some stutterers to have great trouble, more than they usually have when they just talk. Some stutterers stutter more when talking to people within their own general age or of the same sex. Others have little or no trouble in such circumstances but stutter around older people or those of the opposite sex. Many stutterers claim that a few drinks will free their tongue as it does for most non-stutterers. Yet others report that alcohol causes them to stutter more (Silverman, 1992).

**Personality Characteristics of Stutterers**

The study of personality characteristics of stutterers has occupied the interest of many clinicians. No typical personality pattern that is unique to stutterers has yet
been found. But studies have pointed out certain characteristics that are common among them. They often need understanding friends to cheer them up, find it very bad to take no for answers, feel just miserable for no good reason, suddenly feel shy when they want to talk to an attractive stranger. Their feelings are rather easily hurt. They daydream a lot, feel tense and highly strung. Ideas run through their heads so that they cannot sleep. They get palpitations of the heart, get attacks of shaking and trembling, feel irritable, worry about awful things that might happen, feel nervous, feel easily hurt when others find fault with them. And they are troubled with feelings of inferiority. Most of these characteristics find a close parallel with the commonly known clinical condition psycho-neurosis.

While there are considerable speculation about the personality traits common to persons who stutter, their presence has not been established empirically. While there is no personality trait common to persons who stutter, there are some common traits that many appears to possess. The reason may be that they have been reacted to negatively by their normal speaking peers like being teased, mocked or laughed and treated as intellectually inferior by them (Silverman 1992).

Many persons who stutter used to avoid social situations in which they expect people to react negatively to them because they stutter. When they enter such situations, they tend to talk very little, even if they do not stutter. These people also avoid interactions involving talking on telephone, because in this situation most stutterers tend to stutter relatively severely. Because of this problem many people restrict their social relationships including romantic relationships because they do not know how their partners would take the problem.

There are yet other personality traits shared by stutterers. A prominent one among them is unwillingness to express anger openly (Barbara, 1982). This trait which appears to result from living with stuttering can influence its severity. The more anger they feel, they are less willing to express it openly. Hence they are likely to stutter more severely.

Depression is another personality trait that is shared by many persons who stutter (Johnson, 1946, Silverman, 1992). Stutterers are depressed because they
experience the loss of ability to speak normally. According to Johnson (1946) the first stage of the loss is denial, the second is the anger, the third is bargaining, the fourth is depression and the fifth is acceptance. Another reason why stutterer's become depressed is because they believe that the failure to overcome stuttering is their fault. They believe that it is possible to overcome their problem and their failure to do so means that they have not tried hard enough. The belief that it should be possible to cure their stuttering could have been based on the information from the sources like books or journals about the disorder, and the statements made by speech pathologists (Silverman, 1992).

Another personality trait that is shared by many persons who stutter is guilt about stuttering (Van Riper, 1982). A person who stutter believes that they are somehow responsible for beginning to stutter because they did not do what was necessary to talk correctly. They also feel guilty because they feel that they have not taken the advice they had received during childhood from their parents and others to talk slowly, or take deep breath before beginning to talk or think of what they were going to say. They feel that they are responsible for their failure to maintain the fluency they gained while they were in therapy. The guilt may result when the clinician make comments suggesting that if they had been doing what they should have been doing to maintain their fluency, they would not have relapsed.

Another belief that may contribute to guilt is that when people stutter, they take too much of other people's time. This belief is likely to put them under time pressure to speak fluently, which tend to increase stuttering severity and motivates them to avoid saying words on which they expect to stutter. Feelings of guilt about stuttering can lead to feelings of shame and embarrassment about it (Van Riper, 1982).

Anxiety is another important personality trait which is being shared commonly by many persons who stutter (Craig, 1990). Such anxiety results from anticipating stuttering in a speaking situation and desiring to avoid it. Some persons whose stuttering is relatively mild tend to experience a higher level of such anxiety than some of those whose stuttering is relatively severe, particularly if they try to conceal the fact
they stutter (Silverman, 1992). The longer stutterers have tried to conceal their stuttering and the more they value a personal relationship, the more intense this anxiety is likely to be.

**Stuttering as a personality disturbance**

In the most widely accepted personality accounts of stuttering, the basic problem is believed to be some hidden emotional conflict, the actual stuttering is viewed as an overt manifestation of a covert conflict, either in representational or symbolic form. If a stutterer admits to, or assessed as having personal problems, it is quickly assumed that his stuttering is a manifestation of these problems. On the other hand, if a stutterer gives all appearance of otherwise being normal and well adjusted, his symptom can be interpreted as representing his solution to his inner conflict.

**Fear and stuttering**

The motivation concepts invoked as a central feature in stuttering reduces to a common denominator namely fear. Negative emotions, punishment, penalty, anticipation, apprehension, dread, anxiety – all represent alternative ways of referring to fear and its presumed influence in stuttering.

The source of the fear has been the continued restatement of its significance. Throughout the recorded history of stuttering, fear has been mentioned frequently as a major force in the development of this disorder. If fluency, normal nonfluency and stuttering all occur in the presence of fear of speaking, there is no special connection between fear of speaking and stuttering. It might well be that stuttering is more likely to occur, or increase, under condition of fear, but the fear is at best of precipitant and the stuttering must be due to something else.

It is said that many stutterers do no stutter whey they speak alone. This claim is invariably presented as indirect evidence of the situation of fears. When a stutterer is isolated from sources, which generate fear, he does not stutter.
Stutterers supposedly fear certain words or certain sounds and it is the fear of these words and sounds, which cause them to stutter. This belief has attained wide acceptance, in fact, certain theoretical formulations have elevated it to the state of a principle, namely "specific word anxiety" (Van Riper, 1982).

Testimony regarding fear of stuttering is supplied by older stutterers, and it is hardly legitimate to presume whatever feelings they report are also to be found in youngsters who stutter. But even if we limit our consideration to evidence regarding older stutterers it is quite impressive to discover that the relevant research provides very little support for belief in the consequence of a fear of stuttering.

**Associated problems**

Often the most handicapping aspect is the response of stutterers to their stuttering behaviours. Young children, unless attention is directed to their speech at an early age, tends merely to be frustrated in their attempts to communicate. However, as children live longer and in social environments outside immediate family, they experience negative feelings, which often extend to their self-image.

Stutterers have reported that listeners think less of them because they stutter and are irritated with the time they have to spend waiting for the stutterer to finish the message. Stutterers also feel that it is something that happens to them, that they have no control over the speech mechanism. Stutterers anticipate the occurrence of stuttering, particularly in stressful or feared situations, and that they tighten up physically in lips, tongue, neck, chest or abdominal areas.

Stutterers often are embarrassed, frustrated and humiliated by their stuttering. They feel angry and frustrated with themselves. It is said that stuttering is a personal problem as well as a speech problem in that person who stutter report fear, frustration and dissatisfaction with themselves. In other words, there is a tendency for personal problems, common to all human beings to become associated with the speech disturbances.
Stuttering as a Psychological Problem

It is reasonable to contend that psychological factors may be involved in stuttering, and certainly any one seriously interested in the disorder should be prepared to give due consideration to the possible psychological elements operative in any particular case.

Psychological interpretation of stuttering is that emotion of a negative character plays a central role in stuttering. It is easy to explain how emotion has attained a prominent role in stuttering. Many stutterers report that their stuttering varies according to circumstances and is related to how they feel, that is, whether they feel threatened, or confident, tense or relaxed, apprehensive or secure. Statements of this kind are corroborated by an association between the occurrence of stuttering and an apparent emotional state of the individual. Normal speakers can recognize that they too tend to be disfluent under conditions similar to those in which some stuttering is observed and reported.

It cannot be denied that there are ample evidences that indicates stuttering is associated with negative emotions. But how relevant such evidences may be it must be tempered by certain considerations, which are typically overlooked. The personal testimony of self-observation is regularly obtained from older stutterers, and their reports are by no means necessarily applicable to the young child who stutters. While emphasis is placed on the concurrence of stuttering and negative emotions (fear, embarrassment, and hostility), stuttering is also associated with positive emotions such as excitement, particularly in youngsters. In stutterers, stuttering occurs in the absence of any observable indications of emotional arousal whether they are old or young. When the fluency of normal speakers is affected by emotional stress it looks as normal disfluencies. Emotional stress disrupt other skilled motor acts too and can accept this without being lead to interpret the disturb performance as an emotional problem. While various kinds of normal functions may be disrupted by emotions, abnormal function is also exacerbated by stress.