

LÁSZLÓ VÉKÁSSY

**COMPLEX
TREATMENT
FOR
STUTTERERS**

AKADÉMIAI KIADÓ, BUDAPEST

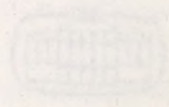
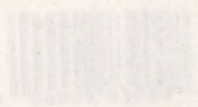
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FOR STUTTERERS

(from the Age of Eight)

László Vékassy



Akadémiai Kiadó, Budapest 1993

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by

László Vékássy



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Akadémiai Kiadó, Budapest 1993

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This book is the enlarged and revised version of the original Hungarian
A dadogók komplex kezelése,
published by Medicina, Budapest 1991

Translated by

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MAGYAR
TUDOMÁNYOS AKADÉMIA
KÖNYVTÁRA

ISBN 963 05 6603 6

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Published by Akadémiai Kiadó és Nyomda Vállalat
Budapest, P.O. Box 245. H-1519, Hungary
Typography by PP Editors, Ltd., Budapest

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Printed in Hungary

M. TUD. AKADÉMIA KÖNYVTÁRA
Könyvtár .G.S. 17 9 .S.3... sz.

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INTRODUCTION

The accumulation of theoretical and practical knowledge in related branches of science have led to a better understanding of stuttering. This process has also led to an increase in the scope of objective information on stutterers. The recognition of the fact that a multitude of causes are responsible for stuttering which is manifested in a multitude of symptoms, has raised the question of the need for a complex method of treatment for differential therapy which combines several professions and approaches, in order to enable therapists to adjust to the nature of the phenomenon. This type of therapeutic approach has the most to offer for stutterers today.

Our procedure is not speech-centered, it does not directly focus on the speech defect itself. In our view, stuttering is not a speech disorder, but a manifestation of interiorized influences and events, of erroneously fixated speech behavior. Consequently, our procedure does not offer to change the cause of symptoms, but the medium responsible for maintaining the symptoms, namely, the speech behavior block (complaints are modes of fixation of symptoms). The procedure for the treatment of the various manifestations of stuttering symptoms, was developed in the course of two decades of psychological and speech therapy work, and each of the procedural steps is backed by theoretical and practical experience.

The present volume is an enlarged edition compiled on the basis of earlier publications by the author.

CHAPTER ONE

COMPLEX TREATMENT FOR STUTTERERS

(FROM THE AGE OF EIGHT)

General goals and conditions for the application of a complex procedure

We have worked out a complex method (combining speech-therapeutic and psychological procedures with medical examination) for the treatment of stutterers of different ages starting from the age of eight. As regards content, structure and concept, the procedure has been adapted to speech-therapeutic and psychological theory and practice, to the specialist areas of speech therapists and psychologists, who are primarily involved in the treatment of stutterers.

Our complex procedure for the treatment of stutterers is one of many. In other words, it is not the only way of treatment, but it comprises the main elements of every complex therapeutic approach (for this reason we shall not discuss other, subordinate elements of speech therapy, such as rhythm, music, puppetry, etc.).

The procedure is recommended in the case of stutterers who exhibit adequate behavior and possess intact intelligence.

Our complex therapy is composed of two large methodological parts: *examination* and *treatment*. In this way the therapist treats what he/she has examined and diagnosed. Treatment must always be based on the results of the examination. That is to say, stutterers should not be treated in general, but according to objectively diagnosed symptoms.

Two decades of experience in applying this method shows our complex procedure to have a beneficial effect in cases when stuttering has *functional causes* and when the stutterer exhibits the secondary symptoms of stuttering. (In cases when stuttering is caused by organic impairment, our method is ineffectual.)

In our opinion, current knowledge shows stuttering to be a psychosomatic phenomenon. Man is a psychosomatic entity in health and in sickness alike, thus a psychosomatic treatment, or view, is not something special; it is not a doctrine of functional illnesses, symptoms, but a general concept valid for every treatment, and one which always considers *man as a whole*. So, instead of focusing on some

illness or symptoms, we must focus our attention on the patient, on the individual, that is, we must treat the stutterer, not stuttering.

In our view, stuttering is linked to certain personality components, the interaction of which promote the appearance, and influence the extent, of stuttering. Naturally, the same mechanisms are also present in illnesses showing other symptoms. What is important is the dominance of one or the other at a given stage of development, on the one hand, and the ratio and extent of linkage of these mechanisms, on the other (so the personality becomes linked up with the symptom). It follows, therefore, that the *stutterer's personality does not differ* fundamentally from that of a non-stutterer, there is no distinguishing subgroup of special, characteristic traits (the results of projective tests are greatly determined by the opinions, the personality of the interpreter). The characteristic, so-called distinctive signs refer to secondary traits, all of which have evolved as a result of stuttering.

In using our complex method we expect to be able to adequately define the stutterer's characteristic symptoms (by which we mean the leading secondary symptoms of the stutterer's speech behavior) in the course of the examinational procedure (series of examinations), and to be able to favorably influence the secondary characteristic symptoms of speech behavior caused by stuttering in the course of the therapeutic procedure (series of treatment measures). According to the literature and our own research, these symptoms are: behavioral, motor, vegetative and speech symptoms.

Our complex procedure represents a methodology constructed on the basis of these four symptoms, which we expect to exert an influence on the whole of personality. Its general result should be a newly learned behavior pattern representing a rise in speech behavior standards (enabling the stutterer to lead a life fulfilling his/her potentials). The procedure should enable us to lead the stutterer with a contact-pathic behavior disorder toward an expression of intention and a courage to speak. The psychological change due to treatment should mean an alleviation of complaints, the results should be resistant to time and to changes, and the internalized method should continuously aid the natural process of self-improvement of the personality even after the treatment is over.

The method is recommended for influencing the secondary symptoms of chronic speech behaviors caused by stuttering.

Medication forms part of our complex procedure, with which we hope to influence primarily vegetative dystonic symptoms, as well as to better prepare therapeutic intervention (cooperation) in each phase of the treatment procedure.

Our complex procedure requires a *two-year treatment* period, in the course of which stutterer and therapist work closely together. Treatment should be continued beyond this two-year period only if absolutely necessary (otherwise infantilization of client may ensue).

Treatment takes place in two sessions weekly, each session lasts forty-five minutes. In addition, clients are requested to practice at home every day.

Treatment is always individual.

The five main elements of treatment of our complex method (movement, speech therapeutic relaxation, verbal confidence exercises, interactional nonverbal communication exercises, confrontation) may be employed in tandem, but no more than two elements should be taken each time (in view of disposition, load, group effect, absence of effect, symptom change, etc., all of which must be given serious attention).

It is recommended that the therapist acquire his/her own *experience* in each of these exercises.

The client is not requested to report on having done the homework. The family is given detailed information about the exercises, but is asked, in the interest of favorable development, to refrain from interfering, checking or exercising pressure on the client. In our view, all forms of disapproval are detrimental for they counteract the combined effect of the sessions and the therapist to lead the client towards a recognition of, an awareness of, the need for natural self-direction, self-improvement, and in the course of this process only indirect approaches are used.

In view of the fact that the development of stuttering, the appearance and combination of symptoms assume unique forms and proportions, formalization or rigid programming of treatment would prove unprofessional and dangerous. For this reason *we have not even considered prescribing a method.*

A recommended therapeutic procedure, based on a very wide range of *practical experience*, is as follows:

- thorough mental and physical examination; logopedic diagnosis;
- personalized plan of therapy (for influencing the leading symptom, or symptoms, described by the stutterer and objectively identified by the therapist);
- use of medication (if necessary);
- acceptance of each other by client and therapist (if this is lacking, we should not begin treatment);
- winning the stutterer over to undergo treatment (relieving of burden).

The proposed *course of treatment*:

First year, first quarter: explorations, motor exercises;

second quarter: explorations, speech-therapeutic relaxation, exercises to facilitate nonverbal communication, supportive care;

third quarter: speech-therapeutic relaxation, exercises to facilitate nonverbal communication, supportive care;

fourth quarter: verbal confidence exercises, speech-therapeutic relaxation, speech-therapeutic homework, spasm analysis, supportive care;

Second year, first quarter: verbal confidence exercises, speech-therapeutic relaxation, speech-therapeutic homework, spasm analysis, speech during relaxation;

second quarter: speech-therapeutic relaxation, verbal confidence exercises, speech-therapeutic confrontation, speech analysis, speech during relaxation, prolongation of spasm, speech-therapeutic homework;

third quarter: speech-therapeutic confrontation, speech analysis, verbal confidence exercises, prolongation of spasm, speech during relaxation, role taking, speech-therapeutic homework;

fourth quarter: speech-therapeutic confrontation, speech-therapeutic homework, speech analysis, prolongation of spasm, role play, speech during relaxation.

Course of treatment according to age

8-10-year-olds: exercises to facilitate nonverbal communication, motor exercises, basic and intermediate exercises of speech-therapeutic relaxation, verbal confidence exercise, speech analysis, speech during relaxation, supportive care.

10-14-year-olds: exercises to facilitate nonverbal communication, motor exercises, basic, intermediate, and advanced exercises of speech-therapeutic relaxation, verbal confidence exercises, speech analysis, spasm analysis, prolongation of spasm, speech during relaxation, supportive care.

Over 14 years of age: motor exercises, basic, intermediate, and advanced exercises of speech-therapeutic relaxation, verbal confidence exercises, speech-therapeutic confrontation, speech analysis, spasm analysis, speech during relaxation, prolongation of spasm, role play, supportive care. (This order is simply recommended, it should not be rigidly applied, because each of the steps may merge one into the other.)

Let us stress that in our view the lack of "perfection" in the formal aspect of speech does not mean the failure of treatment. The client may stutter, or stammer, but he or she should do so with unconcern, he/she should be free of reactive, secondary physical and psychological traits, be unfearing, self-assured, exercising formative power (meaning that it is the stutterer who controls events and not the other way around) as part of a behavior without a fear of speech. The stutterer does not fight his/her handicap, but learns to live with it. This is what we aim to achieve in our work, and if we do or come close to it, we consider it a positive result of the treatment. This is the purpose of our procedure.

A few of the general characteristics of the therapist's conduct

Speech is not an isolated characteristic of human existence, since, directly or indirectly, it influences the development of other areas of the personality. This fact justifies the use of therapeutic procedures aimed at the whole of the stutterer's personality.

The recognition that stuttering may have many causes and many symptoms raised the need for differential therapy combining several special fields, influences and methods.

The therapist's personality plays a central part in this work. His/her conscious and unconscious behavior carries a meaning which exerts an influence on the various elements of therapy.

In the following we shall discuss some of the practical aspects of this question, recommended in routine treatment.

Our approach should be characterized fundamentally by a stutterer-centered and stutterer-specific course of treatment. The former means that treatment is adjusted to the stutterer's personality (and not the other way around), and also that current and past complaints and symptoms are viewed in relation to the whole personality. The latter means that we get to know the special, characteristic personality traits of the stutterer. This is possible only

- if both therapist and stutterer take an active part in the treatment;
- if there is interaction;
- if therapist and client assume coordinate roles instead of superior and inferior ones;
- if there is no stereotyping (emotional effects are the motivating force);
- if familiarization takes place in depth.

The stutterer must always be aware of what is happening, what will happen to him/her in the near future. For this reason he/she must be told about the kind of treatment he/she will undergo; if he/she's given medication, why he/she's getting it, what result is expected, what kind of psychotherapeutic intervention we plan, what kind of speech exercises we're going to do, etc. In other words, we generally explain to the stutterer the treatment that is to follow (this is especially important at the beginning), and try to win his/her cooperation. It only increases resistance if we "attack" without preliminaries and ask very personal questions about emotionally laden events. Further, it's advisable to inform the client about the duration of the treatment, as well as about the expected result. If this preparatory discussion is neglected, we may find ourselves in an unpredictable situation, and the client may be disappointed by the result of therapy. These discussions also help the therapist to follow methodological rules even more closely, and the client to

focus more on his/her work, to attend the sessions regularly, because he/she knows that the exercises and talks serve a purpose, that they do not express mere curiosity on the part of the therapist, that the therapy has a beginning and an end. Therapy must be followed by a discussion when the client and his/her family are told about the result of the therapy, what still needs to be done, about the mutually accepted ways of self-direction and conduct, and, in case of failure, by a minute examination of the reasons.

In the course of therapy stutterers reveal their innermost feelings, secrets, various events of their life. These may be reprehensible, censurable, where the client and his/her environment is concerned, therefore the therapist is under the obligation of official secrecy. Therapy takes a long time and much patience. For this reason frequent and lengthy sessions may result in good personal relationship between stutterer and therapist. If it turns into friendship, or an even closer relationship, then therapy loses its effectiveness, and should to be discontinued.

In treating the stutterer, the therapist must possess strong empathic ability in order to be able to empathize with, to follow the manifestations of, another individual from one moment to the next, from one session to the next. This is possible only if the therapist does not playact, but truly experiences empathy. In our everyday life we all know people who always hide behind a mask, play roles, who tend to say and do things they do not really feel. We also know people whom we can trust, because we feel they really are what they show themselves to be, i.e., open and honest. We feel we are dealing with a living human being rather than a merely politely impersonal one. This is the attitude therapists need to possess in this area of work. Genuineness in the stutterer's therapy means that the therapist shows his/her true self, which assumes self-knowledge and self-awareness. It is of fundamental importance in this field of speech therapy that the therapist be free of so-called psychological deficiencies, be mentally healthy and a humane person, who does not exploit the stutterer and the treatment process for his/her own self-therapy.

Furthermore, it is important that the therapist know what questions to ask and clarify for himself, which will help keep therapy objective and unbiased. These questions are:

- does the client want to tell the therapist something, and can he/she put it into words;
- what is the client's manner of speaking (honest, disguising, dissimulative, etc.);
- does the client accept the therapist;
- is a physical approach to complaints and symptoms sufficient, or do they have a psychological aspect as well (secondary signs, psychosomatic signs, etc.);
- if a physical approach is not sufficient, why not;

- is the therapist what the stutterer needs, does he/she have the necessary qualifications to be able to help;
- is it easy to tell the stutterer the diagnosis and the therapist's opinion; if not, why;
- does the stutterer accept the therapist's plan of treatment; if not, why;
- with regard to the therapy, do client and therapist have the same expectations, what does the client expect from the joint effort;
- what effect does the stutterer's person, their complaints have on the therapist;
- does the therapist's behavior change while he/she is with the stutterer, do his/her movements or speech behavior change (does he/she speak too much, too little, too fast, etc.);
- does the therapist feel free or inhibited with the client;
- does the information offered by the stutterer inspire the therapist;
- does the therapist wish to continue seeing the stutterer, or hopes to never see him/her again.

The above questions do not cover all of the problems, but represent the tendency of the therapy; the therapist cannot answer most of them after the first session, nor the second. But sooner or later he/she will arrive at an increasingly greater understanding of the client and him/herself. The therapist must come into direct "contact" with the stutterer on a person-to-person basis. This, of course, does not mean that the therapist has to reveal his/her own personality to the client. It does mean, however, that he/she must attend closely to the client and his/her difficulties, and without any preconceptions that would result in disregarding the quality of the client's thoughts, feelings and conduct. The therapist cannot accept some parts of the client's personality and reject, even condemn, others. An atmosphere of unconditional acceptance is necessary, which means that the therapist must always be receptive to experiences promptly as they occur. It would be of little use if the therapist were to realize what actually took place at the session only after the session. Laying too much stress on or belittling the importance of information, complaints, arguments, feelings and beliefs told by the client and observed in the session would equally be a mistake. Their value and quality can only be judged in relation to the stutterer's personality. We may arrive at greatly erroneous conclusions if we compare them to some general standard, or to ourselves, our own "norms". The fundamental position is that a specific stutterer indicates specific complaints, which complaints pose a difficulty, have an adverse influence on his/her life and achievement.

A true and full understanding is reached only if we are able to maintain contact with the stutterer throughout the therapy. This should never amount to

dogmatic comments (such as I know what the matter is with you; I understand the reasons for what you did, etc.). Such rash, superficial evaluations are indifferent and impersonal, and the client cannot make anything of them. After a while or after a preparatory phase, these too may play a part in the discussions, in helping the stutterer to understand him/herself. Discussion of the therapist's opinion with a client who is prepared to receive it, who is capable of mental endurance, enables the stutterer to give a better, clearer and broader interpretation of his/her own feelings, behaviors.

The stutterer may ask the therapist for advice regarding his/her problems, complaints about lifestyle. No such "advice" can be given, instead the stutterer must be prepared to make decisions. To accomplish this the client's self-knowledge must be developed, he/she must be taught to observe and analyze the situation and his/her relations (e.g., the recurrence of failure) in the course of the sessions. Having achieved these goals, we help the client, by calling on his/her understanding, to select one of the realistically possible solutions to the problem. Through this effort to increase awareness we help the stutterer to see how his/her true experiences, his/herself, differs from his/her concept of him/herself, as well as to get to know his/her own characteristic distinctive feelings, specifically, 'what I am and what I show myself to be', or, 'what I am and what I would like to be'. We consider the person and conduct of the therapist in the examination and therapy of the stutterer significant.

Our investigation of client expectations concerning the therapist serves to throw light on another aspect which is just as significant as the one above. Stutterers were asked their opinion of what a good therapist is like. A summary of the expectations is that *stutterers list fundamental human traits in the first place*. They describe a good therapist as possessing emphatically and manifestly positive, human characteristics and as capable of exerting influence (free of deviances, mental deficiencies).

The relationship between stutterer and therapist is given in the second place. Accordingly, the therapist is willing to make contact, he/she expresses intense and deep interest in the course of transmitting the applied method, he/she creates an inspired therapeutic atmosphere based on equality (symmetry).

Professional demands are described in the third place. Specifically, a good therapist employs an effective, successful and modern method of work, is highly qualified and his/her job is to influence personality.

In our opinion, successful therapy of the stutterer and the therapist's proficiency and knowledge, as described above, are correlated.

The stutterer reports for therapy

In this chapter we shall discuss what happens when the stutterer (alone or with his/her parents, or relatives) first visits the speech therapist. The aim of the ensuing brief conversation is to enable the stutterer to decide whether or not to undergo therapy. Therefore, at the end of this conversation we advise the stutterer to think over what was said, to read through a booklet on therapy (A dadogók komplex kezelése [Complex Therapy of Stutterers]), then, if he/she thinks he/she knows what he/she has set out to do and is determined enough to do it, he/she should make an appointment and treatment can begin. Stutterers usually return after 2-3 weeks having decided that they are ready to undergo treatment.

This so-called thinking period allows the therapist and client to coordinate their expectations, and prospects, which prepares the ground for therapy; another advantage is that the number of those who give up therapy declines (we must also note that approximately 20-25 % of those who inquire about therapy, do not return).

The question arose whether every stutterer reporting for therapy should be allowed to have a thinking period. The answer is affirmative, because in this way the stutterer begins therapy with greater awareness of what he/she will have to do, and also because there are a large number of clients awaiting their turn at the speech-therapeutic clinic whom we cannot always see immediately. Nevertheless, the question should not be treated in a rigid manner, for there are cases when this methodological step must be left out (because of some acute event, conspicuous psychological symptoms, poor mental state, etc.).

Thus it follows from the above that accepting stutterers for therapy through a telephone or mail appointment, should be avoided as it can happen that there would not be any correspondence between the stutterer's and the therapist's expectations, and the latter's professional views at the first session. A brief personal meeting of stutterer and therapist protects both of them from this confrontation.

At this meeting, which should not last more than 20-25 minutes, the speech therapist must pay attention to the following and ask the "compulsory" questions below.

What the speech therapist must attend to:

— In this situation stutterers are usually strongly motivated owing to their determination. For this reason we should help them with their speech and communicational difficulties by listening, by being patient, by unobtrusively shouldering troublesome speech actions, by verbal and nonverbal expressions of sympathy (these have a positive effect on the given situation, and also fill the client with confidence as regards the future and the therapy).

— We should not at this point analyze, look for a relationship between, the answers given to the brief questions raised in the course of the conversation (this will be the task of the therapy). We would be satisfied for the moment with the facts offered by the client.

— The questions discussed may sometimes partly coincide with questions put in the course of other examinational and therapeutic steps of our complex method. We, therefore, stress that here the speech therapist makes only brief inquiries in order to obtain a general picture, and the stutterers are also given only brief information.

What the speech therapist must ask:

— Regardless of whether the stutterer comes to us alone or is accompanied by someone, we must always speak with the stutterer him/herself, since he/she is the one involved. First we ask the stutterer whose idea the therapy was, the stutterer's or a relative's. In the latter case, we tell the stutterer that the entire therapy is based on the stutterer's self-reliance, therefore, the result, the success of therapy depends on the stutterer's will and perseverance. If this determination to work and to be cured is missing (i.e., only the parent or relative has it), then therapy is not recommended for the time being. At this point we ask the stutterer what, in his/her view, prompted him/her to report for therapy just then, why he/she did not seek treatment before, if his/her complaints did not bother him/her before, why do they bother him/her now.

— We must tell the stutterer how long the therapy will last, and that in addition to our working together he/she must practice daily at home. In other words, he/she must "make room" for this work in his/her life, he/she must change his/her lifestyles, alter the priority of things. We must also tell him/her what he/she can expect of the therapy, what the science of speech therapy can do for stutterers today (we should cite proven results), and we must also mention what he/she can expect without treatment. At this point we should also talk about what happens after therapy is over, i.e., about aftercare.

— We must also ask if the stutterer has ever received prolonged treatment before; was the treatment completed or interrupted; in the latter case(s), whose fault was it.

— We must have information on the stutterer's education, school performance, profession, whether he/she has found his/her place in life (i.e., does he/she work, live with his/her family).

— We must learn whether the stutterer's speech problem coincides with other physical and/or mental symptoms. If so, we should offer our help to have them diagnosed and treated during the thinking period. (This will help clarify which symptoms concern the speech therapist and which do not.)

At the end of the talk the speech therapist must be able to answer the following:

- is the stutterer motivated to be cured,
- what is the expected level of cooperation (mental level),
- are there any coincidental physical and/or mental symptoms, and whether these need any treatment.

CHAPTER TWO

EXAMINATION PROCEDURE

These examinations should be performed in every single case in order to obtain an objective picture of the stutterer's physical and psychological condition. The steps given here represent only the main direction of the course of examination, and in our view, other examination elements may be added as the task requires).

The steps of our examinational procedure are:

- anamnesis,
- psychological examination, observation,
- exploration,
- family visits, whereby the therapist studies the family environment of the client,
- medical examination,
- diagnosis.

Anamnesis

The various — somatic, organic, psychological — schools of stuttering therapy equally stress (though from different points of view) the significance of anamneses.

The growing experiential material and knowledge of related branches of science serve to broaden the sphere of study of logopedics. This increased knowledge must be reflected in the phrasing of questions of logopedic case stories.

Treatment of the stutterer begins with drawing up his/her case history. In the case history we collect data for making a diagnosis, for planning the therapy. Through a network of questions we hope to learn the causes responsible for the

appearance and maintenance of a given symptom, i.e., the psychomechanism of the phenomenon. This is a multi-layered, complex process involving a dynamic set of elements. This retrospective work, the questions, must cover the physical-psychological environmental background which contain possible causes.

We chose and phrased our questions in accordance with the principles of *dynamic psychology*. This psychological view states that psychic manifestations have a prehistory and that the idea of something taking place accidentally is unacceptable in psychology. The driving force behind these manifestations is some need, intrinsic motivation and its transference. Mental life is the projection of that drive by way of which the organism tries to maintain a balanced function. Hence, every reaction is a response to maintain this balance, or a move toward its restoration. A dynamic element of mental life signals the disturbance in balance and thus compels to action, reaction. Two elements of the theory of dynamic psychology, namely, personality and psychological environment, are combined to form the so-called psychological life space. Life space represents the totality of factors that determine the individual's behavior at one given moment. It includes the environment as well as the individual. In our case histories we trace the always changing psychological life space of the stutterer, one form superimposed on the former. In this retrospection we seek to pinpoint the tensions, blocks, delays, and obstacles in psychological life space needs as they are transmitted by somatic, psychological and social-psychological data.

Our points of view in preparing *logopedic anamneses* were:

— Psychological, social-psychological questions and medical data allowing us to penetrate the unique mechanism of how this phenomenon comes about (these questions help us to plan therapy of the stutterer).

— Data disclosed by the stutterer's anamnesis can be readily interpreted and put into practice. Therapists know what they are dealing with, what they have to do, therefore, they will not treat stuttering in general. Therapy can never be independent of the psychomechanism of the phenomenon uncovered. In this way we correct what we have diagnosed.

— In preparing anamneses, we should not be satisfied with purely formal somatic data, but should look for interactional indications that influence function (interactions between stutterers and individuals in their changing psychological life space).

— Anamnestic data must be collated with other examinational inferences in order to trace the dynamic, progressive evolution of the symptoms.

A few of the *experiential aspects* of stutterer anamnesis are:

— Of the three important factors (somatic, psychological and environmental) responsible for stuttering, elements transmitting psychosocial events should be

tressed. Data in the literature and practice indicate that these play a decisive role; these effects elicit somatically prepared dysfunctions. The localized nature of somatic events is not necessarily connected with the speech organs. External effects that pose a difficulty for the organism (those it cannot resist or incorporate) move homeostasis to a zone where, in early childhood, clusters of somatic and mental illnesses, psychological effects caused regression, i.e., created a locus minoris resistentiae. The question is, why do external effects convert these into a speech defect rather than something else?

— Negative biological and social influences in early childhood hinder socialization, creating thereby the so-called *neurotic potential*. This may become manifest in a number of symptoms beside the sign appearing as the *chief symptom*, i.e., stuttering.

— Diffuse, indistinct, infantile sensations which stuttering children experience merely as tension and which do not become conscious, are important. They cannot comprehend the changes taking place inside themselves, they only experience defenselessness and anxiety. The *reason for symptom-formation* is that symptoms help to solve tension, they provide release from the painful, tormenting restlessness that the child feels.

— It seems quite likely that, owing to the rapid and uneven changes in development, stutterers have rather unstable personalities. Changeability and unstable development facilitate the appearance of such mental and somatic disorders that are characterized by temporary or lasting symptoms, by changes in behavior. The range of these symptoms, reflecting a disturbed balance, is extremely wide, and they sometimes indicate severe disorder. Their common feature is that they characterize a specific stage of infant development and they take only such forms of expression as the child is capable of at the given age. The *condition of unimpeded development* is that the child be equally capable of change biologically and psychologically, as well as socially. However, speech presents an obstacle precisely in this capacity to change. In order to *realize the changes*, the child must acquire knowledge, and conflicts will arise only if the external and internal conditions of social learning and development are missing. In these cases the child will not be able to pass beyond a given age level without incurring damage or becoming impaired. The reason being that he/she cannot successfully meet the requirements set by the environment to ensure development.

In drawing up the stutterer's anamnesis, we consider investigation of the following trend-setting questions as important, which, of course, may be narrowed or broadened according to the specific nature of the case. Questions of the anamnesis and exploration are not separated here. The former is concerned with the period and events preceding the complaints, the latter with the current condition.

Did sexual intercourse ever occur in an alcoholic state?
 Are parents alcoholics (and/or abuse prescription drugs)?
 The mother's physical-mental condition at the time of conception.
 Did the parents want the child?
 Is the child with impaired speech the first child in the family?
 Were the parents psychologically prepared for the child (with speech defect)?
 In what season was the child born?
 Diseases of parents prior to pregnancy.
 Diseases of grandparents.
 Age of parents at the time of conception.
 Conditions of birth.
 Duration of parturition.
 Dry birth, Caesarean operation.
 Rhythm of parturition.
 Weight at birth.
 Deformity, damage.
 Jaundice.
 Breast-feeding (very detailed information as regards suckling: place, time, state of mind, etc.).
 Weight gain.
 Motor development.
 Speech development (each phase questioned in great detail).
 Toilet training (its conditions: aggressive, regressions, punishment).
 In the first six months of life was the child exposed to loud sounds, to noise?
 For how long after birth did the parent stay at home with the child?
 Was the speech-impaired child placed in a nursery, kindergarten?
 Family environment in the first year after birth.
 Disposition characteristics in the first year.
 Unexpected effects, if any, on the child (falls, insecure body position, incomplete situations).
 Quality of sleep in the first three years (tossing, kicking, grinding of teeth, speaking in sleep, rhythmic movements, hands held between the legs, etc.).
 Does the child deviate from his/her acquired habits?

Which parent does the child turn to most, which one does he/she like more?

Disposition characteristics in the first three years.

Was the infant often, or usually, held in parents' arms?

Solitude.

Daily net active time spent together with the child in the first three years.

Overprotection.

How long after birth did the mother begin sexual life again?

Libidinal feelings after birth.

Mother's position in the family in the first three years.

Enuresis.

Episodes of pavor nocturnus.

Habits in bed before falling asleep and during sleep.

Fetishes.

Thumb sucking.

Masturbation, onanism.

Sexual interest, feelings.

Group position in the kindergarten.

Need for motor activity.

Loudness—quietness.

Regression experience.

Has objectless, personified terror ever been employed as a method of education?

Difficulties of expression, establishing contact at home and in an unfamiliar environment.

Difficulty in making contact (detailed description of the situation).

Behavioral characteristics.

Accident.

Disposition to spasms.

Constitution.

Attention, discipline, perseverance.

When did the speech defect first appear?

Events preceding appearance of speech defect.

Dream work.

Were there any attempts on the part of the parent, the immediate environment to correct the child's speech defect?

Typical block situations in speech.

Speech behavior of the environment.

Has the speech defect been treated?
 Was psychotherapy employed (and what kind)?
 Use of drugs in therapy.
 What is expected of the therapist (learn precisely what the
 parents and the child expect from therapy)?
 Who wants the therapy?
 Does the client consciously experience his/her speech defect?
 Is the speech defect disadvantageous for the child?
 Where and for how long did the child receive treatment?
 Why did they wait until now to begin treatment?
 Influence of school on speech.
 Achievement in school.
 Group position in school.
 Friends.
 Conflict situations.
 Vegetative signs.
 Left or right side dominance.
 Vision-hearing.
 Disposition to spasms (familial features).
 Continuation of education.
 What does the parent expect of the child (only of the speech-
 impaired one)?
 Do parents help the speech-impaired child more than their other
 children?
 How do the other children get along with their speech-impaired
 sibling?
 How do parents view the speech defect?
 Parent-child relationship.
 The child's opinion of the parents?
 Educational stereotypes.
 One or more kinds of education.
 Punishment.
 Is there a fundamental conflict between the parents?
 Divorce.
 Widow, single parent.
 Unmarried mother, stepbrother or -sister.
 Members of the family.
 Who is the dominant person in the marriage?
 Mother's disposition, father's disposition?
 Education of parents.

Are parents religious?
 Interest of parents.
 Family atmosphere.
 Do parents make friends easily?
 When parents have a fight, what form does it take?
 Materialism, thinking in terms of money.
 What difficulties are there in the family?
 Objective home environment.
 Do parents abide by family habits, tradition?
 Mutual respect and honor of the couple.
 Is the family also a community?
 The role and influence of family members.
 Do the parents have a satisfying sexual relationship (pleasure principle)?
 Parents' attitude to sickness in general.
 Parents' tolerance of psychological problems, complaints.
 Are parents ashamed of their speech-impaired child?
 Is parent satisfied with his/her own life?
 Is parent satisfied with his/her job?
 Reason for parent's dissatisfaction.
 Parent's childhood.
 What does parent do to make his/her life better?
 Where did the parent make a mistake in his/her life?

Psychological tests, observation

As part of the psychological test, observation of stutterers, we are concerned with three things:

- examination of intelligence,
- examination and observation of behavior,
- observation of motor activity.

One of the reasons for the intelligence test is that the method is recommended for stutterers of intact intelligence, the other is to maintain a standard of *cooperation* (let us note that stutterers have average IQs).

Examination and observation of behavior and motor activity are necessitated by recognition of predispositional, so-called *secondary difficulties* brought about by stuttering. As a result of the speech act stutterers show varied behavioral and

motor symptoms. These support the probability that, in general, the stutterer's neurosis is a greater or lesser emotional disturbance, which, on the behavioral level, is manifested in a disorder of conduct, interpersonal and object relationship. From the point of view of symptoms, it is a sign of illness, which may become manifest in many and varied somatic, organic, vegetative, motor and behavioral disorders.

The *HAWIK test* can be recommended to measure intelligence. Projective personality tests (Szondi, Rorschach, PFT) may be employed to study behavior. In the author's opinion, detailed anamnesis, an exploration series, and careful observation of the stutterer may also reveal to the therapist the nature of behavioral and motor symptoms. We must then interpret these results after collating them with other data.

Behavioral and motor data determine the material, direction, theme of the therapy. A comparison of motor and behavioral data obtained at the beginning and at the end of the therapy serves to show psychological changes, cure.

We should verify the information thus received in the stutterer's psychological life space. We must interpret these data in the course of visiting the school and the family. Often these help us to a quick and successful solution of vague and unclear problems (or provide new points of view), which are extensively treated (and disguised) as symptoms in therapeutic sessions.

In the following we shall introduce the behavioral and motor characteristics of stutterers on the basis of data in the literature and our own observations. Two stages may be distinguished in both areas:

- general characteristics (with uncertain occurrence);
- probable characteristics (with probable occurrence).

Probable characteristics were obtained from the general characteristics as a result of computerized factor analysis, consequently, they overlap. (Motor and vegetative characteristics, to be discussed later, were similarly processed.)

General behavior characteristics of stutterers are:

- problems in school, work place (problems of realization);
- dependence on others;
- lack of perseverance, effort;
- isolation, unsociability;
- narrow interests;
- narrow range of activity (spends much of his/her time at home);
- uncertainty in planning and setting a course of life;
- low initiative;
- rejection of role play;

low tolerance of failure;
tendency to complain (in essence a dissatisfaction, a difference between 'what I am and what I would like to be';
avoidance of problems, difficulties;
seeking security, tendency to withdraw;
peripheral group position;
concentration difficulties (in work, studies);
turning to others for help in solving problems;
low tolerance of unexpected, novel situations;
mental-somatic complaints;
rejection of public roles, tasks.

Probable characteristics of stutterers are:

contact-pathy;
fluctuating perseverance and effort in work and studies (as well as emotional involvement);
uncertainty in planning and conduct in everyday life;
low initiative and creativity (dependence and tendency to conform);
low tolerance of failure (intolerant reactions, insufficiency feelings, adjustment difficulties in novel and unexpected situations);
pleasure and comfort feelings are bound to many conditions;
frequent somatic complaints (which belong to the category of subjective exaggeration of "I feel as if");
disinclination to make public appearances.

General motor characteristics of stutterers are:

motor manifestations accompanying and related to speech (meaning aimless excess movements which must be distinguished from meta-linguistic gestures, though it is very likely that there are overlaps);
frowning;
closing and opening the eyes, blinking;
tensing the muscles, uncoordinated movement of the lips;
lateral movement of the jaw;
movement of the nose, wing of the nose;
movement of the external ear;
movement of the tongue outside the oral cavity;
change in the tone of voice (periodically, in certain situations);
arch-like tensing, clinging of the tongue;
turning of the head;
tensing of the muscles of the neck;

movement of shoulders;
flexing of arms;
separate movements of fingers;
turning of body, forward bending;
touching or getting hold of some part of the body;
movement of legs;
movement of feet, stamping;
movement, rising from sitting position;
movement from standing position, taking a step;
manipulation of clothing or some object in standing position;
looking for something to lean on in a standing position;
whole body becomes rigid;
irregular breathing.

Probable motor characteristics accompanying the speech of stutterers:

asymmetric movement of lip and facial muscles;
lateral movement of the jaw;
tensing of the muscles of the neck;
movement of shoulders;
movement of legs;
manipulation of clothing or some object in a standing position;
irregular breathing.

The stutterer's behavioral and motor data provide the material for the declaration of intent of relaxation, as well as for the confrontation (naturally, there are also other ways of working through these data). Motor symptoms form the basis of the therapeutic design of motor exercises.

Exploration

Schools and experts take the same stand as regards stutterer exploration, namely, that it is important (though there are variations in task, approach, extent, expectation, and "depth").

Stutterer exploration is a *conversation* in the course of which, in addition to exact observation, we collect data on the mode of life, psychological development, environment (successive psychological life spaces), conflicts, secondary symptoms of stuttering, assumed or real complaints, interactional characteristics, etc.

This collection of data serves several purposes:

- the talk itself exerts a favorable influence by reducing mental burden (“dialogical reduction of suffering”);
- the facts thus obtained are made use of in the course of treatment (anamnestic data are elaborated at this stage);
- specialists are consulted to help classify attendant symptoms arising during the explorative conversation.

In the course of the examination, following anamnesis and the psychological tests, the first personal, direct meeting of client and therapist takes place in the exploration step, which must not stop at this point. The continuously updated explorations determine (quite often modify!) the course, the plan of treatment, the group situation, data obtained on family visits, etc.

Speech defect is no bar to exploration. Preparedness, expression of sincere, deeply humane interest, patient tactfulness, expertise are of help here, too.

In our opinion, exploration of stutterers must meet the following requirements:

- there must be a positive emotional atmosphere;
- the stutterer’s inner world must be penetrated;
- the talk must be dialogic (not a reasoned exposition);
- the approach must be stutterer focused and stutterer specific;
- both client and therapist must play an active role;
- there must be no stereotyping (emotions must always be the motivating force);
- the relationship must be characterized by mutual empathy;
- the therapist must not be biased;
- in the course of the conversations client and therapist must become partners, allowing the therapist an insight into complaints and symptoms, and enabling the client to achieve, through verbalization, greater self-knowledge.

A few general practical points of view of application of exploration are described in the following.

It is important to prepare the stutterer for this step. Therefore, it should not be introduced during the first few sessions. Let some other examination or logopedic work precede it. Forceful conduct, overconfidence on the part of the therapist is a mistake. A real picture of the stutterer can only be obtained in a situation of reciprocity and acceptance. If, for example, the stutterer refuses to cooperate, we should postpone exploration. Before beginning this examination, the stutterer must be told what is going to happen, and what is expected of him/her. A prolonged preparation of the exploration is also inadvisable, because it may create resistance in the stutterer against a background of diffidence, anxiety, contact problems.

There are stutterers who are aware of their problems and want to get rid of them of their own volition, therefore, they speak readily about their conflicts, problems. Usually, a few anamnestic questions will provide us with sufficient information about the problem areas we must investigate. Some therapists, during their preparation for the exploration, strike a tone of familiarity, which the client may feel as an intrusion, whereby the entire situation loses its seriousness. As a result, personal questions will seem to be mere curiosity and stutterers will not open up in the exploration situation.

The question of sympathy between client and therapist is settled early on. If we feel it to be an excessively negative one, we should not begin treatment at all.

Usually, exploration causes an excess of tension. This is due partly to the situation itself, to self-consciousness, and partly to the activated conflicts, anxieties, repressions of the stutterer. A favorable exploration atmosphere will tend to reduce this. Tension may have two well-known results: the stutterer will not speak at all, or he/she will speak too much. In the former case, a great deal of tact and help is necessary, in the latter, after allowing the client's volubility to run on for a while, the therapist should direct the conversation by interjecting appropriate comments, by mild and good-willed reminders. This also involves a risk insofar as a number of relevant facts may thus remain hidden. With time and practice the therapist will learn when to keep silent and allow the stutterer to speak, and *vice versa*. All stimuli which the therapist conveys continuously and automatically in the exploration are important (his/her attire, gestures, intonation, age, smoking habits, scent, manner of sitting, etc.), but their effects can only be measured subsequently. The influence of verbal and nonverbal stimuli is very important in exploration. Neutral signs, conventionality, cause the least difficulty, assuming, of course, undivided attention.

The exploration plan may serve different purposes. The theme, its development, the sphere of emotional reactions must be directed accordingly. Generally speaking, we may say that the goal is to reveal the stutterer's personality, his/her difficulties, conflicts, anxieties, fears, tolerance, creativity, sense of reality and unreality, failures (typical failures), symptoms caused by stuttering, macro- and micro-environment, etc.

How to begin? Starting with "talk about yourself" or "I'd like to get to know you" tend to intimidate stutterers. In such cases they will relate an ideal, conscious picture of themselves, rather than the conflicts solved by them on their level. Starting with questions such as, "What were you like as a child", "What was your childhood like", "What kind of problems did you have", "What were your parents like", etc. is also inadequate. The correct approach is a spontaneous, emotionally neutral conversation; we can return later on to probe the parts the client leaves out at this point — and which we consider to be of importance. It is not necessary to have the stutterer speak immediately about his/her most painful difficulties. It is

important, however, to learn during the conversation how he/she behaved, or behaves, in difficult situations under the influence of conflicts, how he/she solved, or solves them, what is the general and the characteristic method of solution; to learn about his/her physical-mental stamina in the face of difficulties; whether he/she needs to seek the help of others in combating his/her problems; does he/she have friends, can he/she make contact with people, is he/she capable of stable and intense relationships. The foregoing provide a frame of reference for understanding the personality involved, for beginning the exploration. The main points of further topics are: earliest memories, personal difficulties, anxiety proneness, what the stutterer would do if he/she were symptomless, etc. Diagnosing the awareness of illness, that is, the influential power of a speech defect, is a separate topic. Theoretically, the role of family members in the development of complaints, as well as interviews with family members belong here. The injured ego must be allowed to go through a "supplementary ego development", in which process the family as a group plays an important part.

During the explorational conversation when the stutterer plays the active part — but the therapist also stands by to be active — he/she tells facts about him/herself. These inform the therapist about actual or chronic conflicts, conflict clusters, that preserve the complaints. However, these facts are not always articulated immediately, and perhaps cannot even be explored on the first occasion. It is important to bear in mind that the defense mechanism aroused in the stutterer acts to drive conflicts, representing unbearable facts in the individual's life, out of the conscious, to manipulate and transform them, and for this reason the client does not even mention them. The difficulties of recalling some conflict are most frequently caused by the following psychological mechanisms:

- repression (it makes the conflict totally unrecognizable, the client is completely unaware of his/her difficulties, which consumes enormous psychological energy);

- aversion (clients talk about problems other than the real conflicts, attribute greater importance to them, in other words, they deceive themselves by belittling the tension caused by the real conflict).

"Areas" of the types of resistance characterized by stutterers, and their prevention:

- why was previous treatment unsuccessful, why was it interrupted;
- why did they change, what was the objection to the therapist (thus we may learn what to expect);

- has the client taken any medication, does he/she expect an improvement in his/her condition from drugs;

- suppression, omission (these are not necessarily conscious acts, usually there are episodes connected primarily with parents, siblings, teachers, etc. in the background);

- loss of relevant person (mother, father, sibling, etc.);
- in the stutterer's opinion what would lead to an improvement in his/her condition, what are the chances (information about previous efforts).

Yet there are cases when the stutterer "does not open up". This is true mostly when the problem is not big enough to share with someone, when he/she does not perceive stuttering as a serious impairment. In such cases, instead of assuming a position of authority to prod the client on, the offer of relief is the correct approach — e.g., "I see you're distrustful of having a conversation. Would you mind telling me about that?"

Generally, therapists tolerate silence less well than clients. Breaking the silence must always be done by overcoming the resistance of the stutterer and not to overcome any anxiety the therapist may feel.

If the conversation comes to a standstill, we return to the informal and random dialogue to pick up the thread. For example, "Don't you want to add something?" and if the client begins to talk, we can later say, "You mentioned before ...", and continue from where we stopped earlier. If in the conversation we come to the conflict and the client again remains silent about it, we can again ask an exploratory question — e.g., "If you're afraid that I don't empathize with you, don't respect your things, then don't say anything about what you're holding back". To *overcome the silence*, we must employ the method of graduality by *asking questions only distantly associated with the causes*, rather than direct questions.

The duration of the exploration may vary. The question is, what decides whether the session should last 40 or 50 minutes, or as long as it takes to obtain sufficient information and a clear picture of the stutterer. The client's endurance is an important factor, furthermore, the therapist's attention also wavers after a while. There is general agreement that the optimum length of time is between 30 and 40 minutes. The client's fatigue is an exemptive factor, in which case exploration must be postponed. A sudden ending and keeping a close watch on the time, are inappropriate ways of concluding a session. If only a little time is available, we must let the client know before beginning the exploration. The reason is that some stutterers begin to talk about their relevant experiences only after a certain time. In such cases the above time limits should be ignored. If we are unable to create a suitable atmosphere (either because of the client or the therapist, or merely due to an indisposition), we should not force the conversation. We must always keep in mind that exploration represents an intense emotional exertion for the client (and the therapist), and lack of cooperation in most cases indicates strong repression.

Exploration demands flexible, steady and frank conduct on the part of the therapist. His/her verbal and nonverbal manifestations (anger, raised brows, hemming, gesturing, etc.) are immediately interpreted by the client, allowing for

misunderstandings, mistaken reinforcement. These manifestations serve as points of reference for the stutterer in phrasing what he/she has to say. It is important and very beneficial for the therapist to do a retrospective analysis in unsuccessful cases, to consult someone about the reasons of the failure to cooperate, the lack of improvement, about what and where the mistake was. Apart from the talented and intuitive ones, good therapists are usually a little inhibited, but given proper self-knowledge, they are flexible and capable of regression, therefore, exploratory work poses no difficulties.

Sometimes, due to the failure of other techniques, the therapist has to resort to persuasion. If persuasion is employed at the beginning of the client-therapist relationship, it exerts its effect in a as yet unchanged, so-called asymmetrical relationship in a traditional manner. That is to say, authoritarian elements gain greater importance in stuttering causing regression and anxiety. Regression means that the stutterer becomes infantilized and therefore unable to understand reason. Real persuasion comes about as a result of an emotionally well-founded client-therapist relationship, since the questions, arising in the course of the dialogue, and their associations are worked through together.

We think that it is needless to give advice during exploration (there may be exceptions, of course). The therapist should strive to lead the client towards self-knowledge, to make him/her capable of self-determination, of responsible decision-making (independent of the difficulty of the task, which only has a subjective value). The goal is to make the client feel, the therapist wants to help him/her to be able to once again make decisions on his/her own, i.e., to no longer need advice. An enormous amount of information is obtained in the course of the exploration. So there is a great temptation, or rather danger, that the therapist will become involved with things that do not concern him/her. It must be emphatically stressed that in such cases the therapist must remain within the bounds of his/her profession (i.e., leave treatment of somatic complaints and medical advice to doctors).

The therapist's manifestations during logopedic exploration should be minimal. However, if he/she feels it is necessary, then he/she should employ it to make the client talk, to provide room for (and not determine) the manifestation of the client's own uninterrupted flow of utterances. In general, therapists tend to talk more than is necessary in the exploration, thereby interrupting the stream of associations and communication, or modifying these with questions. Perhaps one of the most difficult things is to learn to keep silent.

In the logopedic exploration of stutterers, the everyday reaction to give ready response, to offer immediate solutions and advice, must be forgotten.

The apparent slowness of the conversation should not disorient the therapist. He/she must think of confusion, repetitions, inaccuracies, as stages in which the client seeks to find the most appropriate words, the thread of events.

A further question is whether to act immediately on the data obtained during the exploration. On the basis of past experience it is advisable only if the therapist is absolutely sure of what he/she wants to say. This the client can tolerate, accept, and incorporate. If the therapist chooses this alternative (which is very rarely done), he/she should not undertake counseling more than once on each occasion.

This exploration may be ended when there's no doubt that the client's complaints and symptoms show subjective improvement. The series of explorations must not be discontinued without first allowing the client to ask questions, make comments, and agree to maintaining contact (though in this case the client should take the initiative).

It is essential to decide whether or not the therapist is the right person for the client. If not, we should refer him/her to a colleague, or consult with the necessary specialists. Great care must be taken in preparing the client for this event in order to avoid causing a feeling of "this is the end", or to negatively influence his/her intent to be cured. After discussing this step with the client (and his/her family), the therapist who will treat him/her, must be provided with detailed information, and do everything to make the transfer a smooth one.

During the exploration stage no written records should be made. It draws the therapist's attention away from the client. Furthermore stutterers do not like to have their thoughts, sentences, secrets, recorded right before their eyes. However, on concluding the exploration the therapist must record in great detail every single verbal and nonverbal datum (change of topic, accelerations, pauses, posture, loudness, blushing, confusion, etc.) as if he/she were writing a musical score.

In the conclusion the focal ideas must be stressed, what occupies the client's mind, its developmental mechanism, the elements and persons maintaining it, the client-therapist relationship, its intensity, and the data obtained for interpretation; on the basis of which the exploration answers questions as to the background of the central symptoms, the probable mechanism responsible for the beginning of stuttering.

Although exploration, or explorations, cannot be considered as psychotherapy, it does have a therapeutic effect: it enhances self-knowledge, improves the standard of cooperation. It is advisable that those involved in such logopedic work consult with one another, if not continuously, then from time to time, to discuss cases, decisions, solutions.

In logopedic exploration we seek to discover the underlying causes of conflicts on the basis of events and symptoms, temporal and motive order. This is rarely achieved after a single session, at the same time, the margin for error is great and practically irreparable. For this reason, when summing up the events at the end of the exploration, we should describe the symptoms and merely hypothesize their source, the mechanism of development. Supportive or exclusive elements should be supplemented with further work and the employment of different procedures.

The therapist cannot avoid telling the client his/her diagnosis, and he/she must do it in a way that will augment the client's image of him/herself, that will further a better understanding of his/herself. In this way everything, that up to then stutterers considered as alien to his/herself is now reversed. That is, complaints are no longer merely somatic indicators, but information, conflicts originating in human relations. Vague, diffuse feelings become conscious, the picture assumes definite outlines, uncertain factors become meaningful, anxiety diminishes, fears lose their significance. Logopedic exploration is the most important phase of the examination. The method contains many practical elements, therefore practice and experience plays an important part. The therapist's personality has a salient role (so we must preclude the possibility that a therapist's decompensated personality dominate therapeutic work).

Exploration provides an experience for the stutterer. A prominent feature of this experience is the turning of the client's attention towards him/herself, i.e., an involvement of such intensity that he/she feels the therapist wants to help him/her then and there. From this experience stutterers should take with him/her (to the therapeutic phases) the awareness that with effort he/she can get rid of the depressive influence of emotions, moods, obstacles, and the speech defect.

Family visit

The family is the oldest and most stable form of human coexistence. It is an ancient institution present in all stages of human civilization, a framework within which the biological and psychological development of the individual takes place. Experience in psychiatric care and social-psychological investigations furthered the development of genealogy. Many investigators find the child's psychopathological events to be related to symptoms exhibited by the parents, others emphasize the role of socialization. Stable conflicts, deprivations, too close or too distant relation with the child are also listed as causes underlying the child's complaints. According to investigations of family interaction, communicational disorders among family members are related to the children's personalities. These latter investigations were supplemented with studies about the relation between the family and the external world. Double bind plays a critical role in the first phase of development, but its continued presence may be responsible for a weak ego, which may later on form the basis of negative deviation. Family-role examinations show that if one or more family members cannot fulfill their roles, then role-rivalries may ensue, and parents' uncertainty about their role may cause identification problems in the child.

Genealogical research indicates that in the course of personality development many different influences are necessary, and they are exercised first and

foremost in the family. Everything that takes place in the early phase of development, exerts an influence on later events. Human influences ensuring psychological development stimulate, at the same time, the development of the nervous system. Full realization of hereditary factors also require, at a given developmental stage, the presence of characteristic, unsubstitutive social stimuli. The *partner*, the family is a *biological necessity* in development, and serves, at the same time, as a stimulus and a model of human behavior.

Family visits, environment studies, visits to the school or kindergarten, in other words, an acquaintance with the client's *psychological life space*, constitute a significant exploratory step. Family visits are the most important element, during which the therapist meets the parents and siblings, who, consciously or unconsciously, share in, bring about and maintain the stutterer's complaints.

Investigations of stuttering stress that, in addition to treating the stutterer, his/her environment, parents and relatives must also be dealt with in order to achieve good results. That is to say, beside the stutterer's complex examination and therapy focusing on the individual, the interaction between stutterers and their family, their environment, must also be considered.

Family visits, interviews, are expressly *treatment oriented*. What is the family background like, who constitutes the client's family and what is its basic characteristic, what kind of environment does the client return to after each session?

The family is considered as the stutterer's formal psychological life space, which means the sum total of factors (mother-father-sibling) that continuously determine the individual's behavior. Life space is the sum total of events which includes the environment and the stutterer.

There are different forms of logopedic sessions with the client's parents, relatives: regular meetings with parents, interviews, explorations, parent-teacher meetings, school and kindergarten visits, therapy of married partners, stutterers' club, participation of relevant persons in the therapy, shared interpretation, classroom visits, homework, training of parents, etc. Comparative examinations of stuttering and families living in different cultures are also well known.

Data from the literature and our own investigations show that a great number of factors present in the stutterer's family are most probably responsible for the development and maintenance of symptoms. These factors are:

- permanent, open and fundamental *conflicts* between the parents of the stutterer;
- the higher divorce rate in the families of stutterers (the event preceded manifestation of the speech defect);
- the most important persons, the *parents*, in the stutterer's psychological life space exhibit an extreme and contradictory set of characteristics;

- the stutterer's relation with the parents is *ambivalent*;
- the stutterer and the parents are well-off;
- family habits are not strong;
- in the first years of his/her life the stutterer spent little time with his/her mother; *family atmosphere was unfavorable* (disorganized).

Let us take a look at the more important pilot questions probing the substance of these factors (compiled on the basis of the literature and our own data), to which we must find the answers during family visits. The questions may be amplified or narrowed down according to the requirements of the task and the situation. A few questions cover the same field as the anamnestic questions. The reason being that we consider it of paramount importance to return to them and to examine them with greater scrutiny.

Is there some *fundamental conflict* between the parents which existed even prior to the birth of the child with the speech defect, and continues to survive?

Elements of the fundamental conflict are:

- lack of psychological sensitivity;
- lack of patience;
- recognition that parents are incompatible;
- inability to adopt partner's characteristics;
- dominance-dependence;
- small apartment;
- disproportionate distribution of responsibilities within the family, child raising (specifically as concerns person with speech defect), did parents change unfavorably during their marriage;
- "tidying up";
- concern with money (expenditure-savings);
- "look at..." (mention of examples from outside the family);
- lack of care about the family because of unfulfilled desire of being promoted at job (ambition);
- question of personal hygiene, bodily offensiveness (odor, rash, sweating);
- unreliability (emotional, financial, moral);
- acquaintances, friends, "buddies";
- the "third person";
- right of family members to voice opinions about the marriage;
- bringing home the tensions of the workplace;
- selfishness, sexuality, sexual deviance;
- divorce (period before development of child's speech defect, circumstances of the divorce, who was given custody of the child, process of the divorce, family members living together after the divorce, etc.);

- parents (married) live together, but would get a divorce if they could;
- social recognition, punishment (disciplinary procedure, dismissal, imprisonment, etc.);
- disciplinary methods employed by the parent;
- mother's disposition;
- father's disposition;
- parents' education;
- parents' interests;
- making of friends by parents is easy/difficult;
- concern with material things, thinking in terms of money values;
- is there any goal of attainment on which the family concentrates its mental and financial efforts?
- difficulties in the family (emotional, cohabiting, emptiness, aimlessness, passion, deviance, illness, etc.);
- who is the dominant partner in the marriage?
- are parents ashamed of their speech-impaired child?
- are the parents alcoholics?
- parents' general attitude towards the so-called functional illness,
- parents' tolerance of their own psychological problems,
- parents' attitude towards somatic and psychological problems of others,
- how do parents usually choose to solve their problems (direct avoidance, turning to others)?
- is the parent satisfied with his/her own life?
- is the parent satisfied with his/her job?
- reason for the parent's dissatisfaction,
- what does the parent do to better his/her life?
- where have they have gone wrong in their lives?
- what does the parent want of the child?
- does the parent help the speech-impaired child more than the others?
- parents' opinion of the speech defect;
- parent-child relationship from the point of view of the parent;
- educational stereotypes;
- use of punishment;
- when parents are on bad terms, what form does it take?
- is objectless, personified fear introduced as a method of education?
- is there a contradiction between what the parent tells the child and the way he/she lives and behaves?
- does the parent have any really close friendships dating back more than ten years?
- are the parents outgoing or withdrawn?

- does the parent consider him/herself a happy, satisfied person?
- were the parents punished as children (by whom)?
- was the parent a timid, nervous, sensitive child?
- did the parents' parents divorce?
- when did the parents' parents die?
- was the parent brought up in a boarding school, was he/she ever in state care, placed with foster parents?

- does the parent lead a well-planned life?
- compulsiveness;
- does the speech defect occur in the family, in the immediate environment?
- familial diseases, neuroses;
- tendency to cry, have an emotional storm;
- are the parents influenced by opinion of others?
- do the parents have recurrent dreams (are they full of anxiety, depressive)?
- do the parents express fear, disgust of dirt and germs?
- do unexpected ideas, "intrusions", modify the parents' habits?
- did the parents have a happy childhood?
- did the parent experience as a child or an adolescent some great, memorable event, failure, tragedy influencing his/her life, which still depresses him/her?

- who exerted the greater influence on the parent: his/her mother or father?
- did the parents ever have suicidal thoughts, attempt suicide?
- is there anyone the parent hates, does he/she have enemies?
- does the parent like children, or only his/her own?
- is the parent's life guided by ideas, ideals, goals?
- do the parents have a tendency to be jealous, suspicious?
- basis of relation with people (personal interests, consideration for others);
- position of speech-impaired child after divorce;
- activities of the speech-impaired child outside the regular curriculum and the school;

- stepbrother, stepsister;
- how do siblings get along with speech-impaired brother or sister?
- child's opinion of parents.
- which parent helps with the studies;
- which parent keeps in touch with the school;
- description of apartment;
- leisure activities of parents;
- the child's own possessions;
- family, cultural events of the past year that were celebrated together;
- family habits;

- what kind of presents does the child receive from the parents on his/her birthday, nameday?
- are family events celebrated together, is the event a special occasion?
- do the family have lunch together?
- do the family have dinner together, do they have a conversation, make plans together?
- do parent and child play together, have fun together?
- family atmosphere;
- family rules that are set up and expected to be obeyed by both parents;
- is the family a community?
- do they keep in touch with relatives?
- does family life have its own rhythm (with recurrent elements)?
- does the parent show him/herself without any clothes on in front of the child?
- did the parents receive sexual education?
- who was responsible for the sexual education of speech-impaired child?
- extramarital relationships of parents (to be dealt with great tact);
- quality of sexual relationship between parents (based on pleasure principle);
- orgasmic capacity;
- the mother's somatic-psychological condition at the time of conception;
- was the mother psychologically prepared for a speech-impaired child?
- for how long after the birth did the parent stay at home with the speech-impaired child?
- mother's position in the family in the first three years;
- family atmosphere following birth;
- in the first three years of the child's life, which parent spent the most time with the child?
- overprotection.

Medical examination

Medical examination and ensuing *medication* are an important part of the complex treatment of the stutterer. Therefore, we insist that every client undergo a medical examination. Without it we should not begin preparing the therapeutic procedure, we should not start work.

We expect medication to exert an effect primarily on vegetative dystonia, to prepare the grounds for psychotherapeutic intervention, when applied at given stages of treatment, principally in the first months of treatment. Prolonged medication (lasting more than 3 months) should be avoided, to preclude its effect

on the formation of new behavioral and reaction characteristics that are expected to take place as a result of other parts of our complex procedure.

Prescription of medicine, its beginning and end, should be supplemented with verbal explanation. In other words, essentially medicine helps our work, but only the stutterer's own efforts can achieve real success. On finishing medication (after a consultation with the doctor concerned) the client is told that he/she no longer needs the help of medicine, and should try to work without it.

In general, in the first months of treatment only those stutterers who show anxiety, insecurity, lack of contact and initiative, strong vegetative symptoms, emotional instability, as well as motor hypertension of the muscles receive medication, but only until the somatic-psychological effects of our procedure begin to take root.

At a later stage of treatment medication is recommended (for a brief period) in the following cases: relapse; widening range of symptoms, symptom change; "refractor stage" of the spring and fall period; somatic illness, etc. In cases of organic stuttering (e.g., epilepsy) medication is essential even if, as observed, anticonvulsive treatment does not always reduce speech symptoms (but causes positive behavioral changes).

A medical examination reveals a number of other factors directly or indirectly related to the symptoms of stuttering and thus helps therapy. This is why we consider it an important part of our procedure.

In our opinion, medication supplements, supports, therapy, and its *application by itself is not justified*. Our therapeutic concept is based on effort, and is aimed at developing new characteristics. We realize that a medical examination provides indispensable information about the physical condition of the stutterer, and medication supplements complex treatment. Our experience also indicates that in certain cases, in the *initial phase* of treatment, *medicine serves as an ameliorant*, which creates more favorable somatic-psychological conditions for psychotherapeutic-logopedic work, for promoting development of new behavioral and reaction attitudes not yet an integral part of the personality.

According to data in the literature and our own research, stutterers exhibit characteristic vegetative signs (these are listed here individually, but, of course, they also occur in combination). These characteristic signs are evident in other syndromes as well, which proves there is a relationship with functional nervous system conditions. In the following characteristic symptoms are divided into two groups: general characteristic symptoms and probable symptoms.

General characteristic vegetative symptoms are: sweating, blushing, loss of colour, tachycardia, trembling of hands, frequent urination, tendency to have diarrhea, abdominal pains, hot flushes, sensitivity to meteorological changes (when physical and mental achievement declines), ejaculatio praecox, suborgasm, dizziness, nervousness-study tension, spasmodic weakness, collapse, odor-taste-

light-noise sensitivity, problems of sleep (stutterers are known to sleep for brief periods), problems of relaxation, recreation and making changes, sudden changes of mood.

Probable vegetative symptoms are: sweating, predicting meteorological changes, nervousness-study tension, odor-taste-noise-light sensitivity, problems of relaxation, recreation and making changes, sudden changes of mood.

Influencing the vegetative symptoms of stutterers must be included in our plan of treatment (relaxation, for instance, serves this purpose well). Comparison of vegetative data as observed at the beginning and at the end of treatment, enables us to reliably predict *psychological changes* (cure) due to therapy.

Diagnosis of the stutterer

We emphatically stress that this does not mean diagnosing tonic, clonic, tonic-clonic conditions which determine the nature of stuttering (namely, speech symptoms), but the formulation and tracing of the core motives which cause, maintain and link the speech event and its resultant secondary symptoms; the phenomenon and dynamics of contact-pathic speech behavior.

From a methodological point of view, *two main phases* are distinguished in stuttering therapy: examination and treatment.

Examination (anamnesis, speech examination, intelligence tests, drawing tests, exploration, personality tests, medical examination, etc.) concludes with a diagnosis. In this diagnosis the highly important task of summarizing and identifying objective examinational data with the symptoms and complaints is performed. Based on this, the therapist makes a decision regarding the concept, the method(s) of *treatment* and then prepares the therapeutic strategy.

Together the two promise a cure for the stutterer, an influencing of symptoms (which at the same time proves the validity of the diagnosis).

In the literature the problem of stuttering diagnosis is duly dealt with. The various formulas, approaches, however, are but projections of concepts about the nature of stuttering. Naturally, the question cannot be isolated from the setting from which stuttering springs (and this holds for our work, too). In our opinion, however, recommendations in the literature for diagnosing stuttering, grasp only certain elements, aspects of the question, and essentially gather around two poles:

- speech diagnoses and
- psychological diagnoses.

These we find insufficient, because they are not comprehensive enough.

In our view stuttering is a psychosomatic dysfunction characterized by a prominence of speech symptoms. This formulation indicates our concept concerning the diagnosis of stuttering, namely, to consider *stuttering as a whole*, as a combination of somatic and psychological manifestations. Our diagnostic concept embraces the following categories:

- somatic symptoms;
- psychological symptoms;
- motor symptoms;
- speech symptoms;
- study of the environment.

These categories constitute a methodological system, a recommended course of action, the application of which leads every time to a *diagnosis of stuttering* (naturally, these categories may be modified according to the nature of the given case).

Our work involves the following methodological goals:

- systematic, conscious, objective and conceptual collection of data by the therapist (the methods used for diagnosing stuttering are *examination and observation*);
- the therapist's method of obtaining data is based on logopedic and psychological knowledge;
- data gathered by the therapist cover the possible zones of the client's psychological life space;
- data obtained through examination and observation constitute the professional basis of diagnosis;
- these data are interpreted together with other information about the client;
- the therapist should plan therapy in view of the data gathered.

It is important to stress that the reason for making this classification, distinction, lies merely in the *methodological nature of the task*. We recognize the contradictoriness of doing this and it may seem arbitrary, furthermore, as there are quite a number of overlaps, "categorizing" may seem forced. These functions are not independent parts of the personality, rather they are organic parts of the whole, exerting *reciprocal influence* in development and time.

Each of the categories to be discussed is based on Hungarian, including the author's own, experiences in speech therapy gathered by everyday practice.

In the following we shall discuss the examination and observation zones, their elements, that must be taken into consideration in every single case when making a diagnosis (the order of treatment of the zones expresses the therapist's point of view).

Motor data

The underlying main idea is the spatial relation between the self and the given environment (people, objects), compliance with and fulfillment in time of intentions and expectations (situations). The following also belong here:

- appearance in terms of motor activity (total motoric impression during the introduction);
- characteristics of the interactional situation;
- openness-reservation of motor behavior;
- temporal quality of motor activity;
- the extent to which motor space is made use of;
- uncoordinated movements;
- economy (distribution) of movements;
- deficiencies of motor activity;
- inclusion and use of objects in motor space;
- movement repetitions and blocks;
- movement phases accompanying speech;
- looking for objects of reference;
- posture characteristics (in a given culture every situation has its own body posture scheme);
- interruption and absence of movement;
- characteristics of the rhythm of movement;
- conventionality of movement;
- bizarreness of movement (borderline case, illness, pathological form);
- disorder of movement;
- movement deficiency.

Information is obtained by *observation*.

An *example of diagnosis*: motor space is made little use of, slow motor behavior, absence of speech articulation during interaction, absence of movements.

Somatic data

The main idea is the “medium” maintaining and transmitting the symptoms, formal and functional data, characteristics of the body. These are:

- vegetative data;
- orofacial data (grimaces, compulsive and redundant movements, asymmetries of the mouth and face, oral and lingual muscle tensions, spasms);
- movement of the head, shoulders, body, hands, legs, and their repetitions;

- feelings of becoming rigid;
- tonus disproportions;
- torsions;
- synergetic movements;
- characteristics of physiological breathing;
- organic and hereditary data of speech symptoms.

Method of obtaining information: physical examination and observation.

An example of diagnosis: vegetative dystonia (physical examination), orofacial redundant movements accompanying speech.

Environmental data

The main idea is about getting to know the client's life space.

The following belong here:

- balance between what is expected of the stutterer and its fulfillment;
- role situations;
- blocks in the way of role situations (objective or rationalized);
- persons acting as agents or causes of conflicts;
- relationship between parent and client;
- relationship between spouse and client;
- client's "sources of pleasure";
- activities;
- dependence;
- situation at work place, school;
- relationship between client and his/her child;
- friendships;
- motives of friendship, motives preserving it;
- passions;
- objective conditions of client' life.

Method of obtaining information: observation, family visits (the therapist becoming acquainted with the important persons of the client's psychological life space at the place of treatment, listening to what they have to say and informing them about the therapy, then at a later date visiting the family) forms part of the examinational procedure.

An example of diagnosis: excessive expectations of the child on the part of the parents; they would like the child to be a good student. Parents think a speech defect can be influenced by willpower. Family give the impression of being precisionists, perfectionists.

Psychological data

The main idea is to become acquainted with the client's conscious and unconscious personality traits, with their role and their relation to complaints, symptoms, as well as with the secondary symptoms caused by impeded speech behavior (the intelligence test is performed in every case in order to have an idea of the expected level of therapeutic cooperation). The following belong here:

- somatic-psychological sensations;
- "life feelings";
- presentiment of a block;
- behavioral strategies (solutions, avoidance of speech situations);
- desires, beliefs (their supposed or real basis);
- relations with the opposite sex;
- communicational characteristics;
- reality-unreality feelings, thoughts;
- reality, standard of living (quality of the ability and reality);
- feelings of pleasure;
- ability to work and to love;
- feelings of satisfaction (fulfillment);
- tensions;
- sociability;
- emotions accompanying speech;
- fear of speech;
- fear of speech behavior (causing under-achievement);
- situational fear (fear of entering conversation);
- eye contact;
- sleep-dream;
- loneliness, isolation;
- fear, moodiness, anxiety;
- avoidance of speech situations;
- nonverbal characteristics;
- presence of motive to be cured;
- awareness of speech defect (does it reduce quality of client's life).

Method of obtaining information: series of explorations, tests and observation.

An example of diagnosis: mental achievement corresponds to age and requirements. Complaints, fear of introduction and corresponding situations appeared before and during present situation (an only child: as a small child parents always made him/her "perform" before strangers). Signs of speech-situation avoidance accompanied by anxiety.

Speech data

The main idea is to study the salient speech symptoms, their content, formal and functional characteristics underlying the personality's function disorder. The following belong here:

- the formal characteristics of speech;
- the content characteristics of speech;
- frequency of interruptions;
- extent of interruptions;
- sequence of interruptions;
- emotions accompanying interruption;
- repetitions;
- prolongations;
- stops;
- internal stuttering;
- mechanism of articulation;
- oral characteristics;
- breath management;
- speech rhythm;
- motor characteristics of speech;
- monotony;
- expletives;
- speech hesitations.

Method of obtaining information: observation.

An example of diagnosis: arhythmic breath management, oral asymmetry accompanying tonuses, facilitating movements of the shoulders and hands. Interruptions follow no rule, they occur mostly when there is some disturbing element present. The client has discovered the method of devaluation for solving difficult speech situations.

The data obtained in the series of examinations and observations are analyzed and classified according to the main concepts outlined in the above categories. Then the diagnostic structure is prepared (comparing data with symptoms), which expresses and supports the actual self and complaints of the stutterer.

In spite of the divisions we have set up, we must always think of the stutterer as a *personality functioning as a whole*.

In the following we present a few diagnostic and therapeutic comparisons and fundamental principles (based exclusively on our own practice and data). These examples show a direct connection, the variations of which provide the different combinations which allow the therapist to approach, and to adjust, to any given case.

Suggested elements if motor symptoms are prominent:

- exercises in front of a mirror (self-identification, self-acceptance);
- exercises in front of a mirror (to monitor movement);
- exercises to “expand movement” (spatial “expansion”, making use of space);
- imitations (movement, speech, and the exercise together);
- breaking down complete movements into their constituents and rebuilding them;
- watching the whole body in the mirror (to monitor movement in space);
- spatial fixation of control over the movement (verbally only);
- spasm analysis;
- action aggregates (independently);
- action aggregates (linked together);
- action aggregates (one after the other).

Suggested elements in case of somatic symptoms:

- fractionated relaxation;
- relaxation (basic exercises);
- establishing a rhythm of life;
- general recommendation of physical activity;
- medication (short term!).

Suggested elements in case of environmental events (this is a peripheral area of therapeutic work, family therapy should be conducted only by a trained specialist):

- getting to know members of client’s psychological life space, and informing them about stuttering in general, its treatment, about spontaneous manifestations;
- suggestions concerning the way of life (on “activity” level);
- establishing conditions of logopedic homework;
- suggestions for, interpretations of, interpersonal changes in, psychological life space;
- making the stutterers aware of their formal and informal relations.

Suggested elements in case of psychological symptoms:

- basic, intermediate and advanced exercises of logopedic relaxation;
- series of explorations (preparation of intent formulas);
- situational exercises (analyzing the feeling of time pressure);
- exercises to improve nonverbal communicational ability;

- role play;
- REP (rational, emotional psychotherapy);
- keeping a diary;
- observation of self and others (behavior analyses: recognition of the relation between speech and behavior);
- tape recordings of speech difficulties;
- carrying out promises made to oneself;
- therapist assigns tasks (that reflect with the complaints), performance of which is analyzed together.

Suggested elements in case of speech symptoms:

- mirror exercise;
- technique duplicating infantile speech development;
- technique of articulation;
- exercises to help verbal confidence;
- exercises of face to face speaking;
- techniques analyzing phases of stuttering (spasm analysis: feelings before, during, and after blocks);
- DAF exercise;
- maintaining eye contact while speaking;
- logopedic confrontation;
- speech analysis;
- spasm prolongation;
- speech in relaxation.

CHAPTER THREE

SUPPORTIVE CARE

This part deals with supportive care, which exerts a fundamental influence on the success of treatment of stuttering. It is an important question because supportive care and the realization of what has been learned in the course of treatment involves the same individuals and is carried out in the same place (this concurrence is, of course, planned).

The goal of supportive care is to extend treatment to include the actors and scenes of the stutterer's psychological life space, and thus acquire a better understanding of the forces surrounding and influencing the client, which enables the therapist to help apply the new skills learned during treatment, to help solve difficulties. In the course of treatment, therapeutic influencing usually focuses on the client, while supportive care is concerned with more than the stutterers themselves but focuses on interactional relations.

Supportive care coincides with treatment (it is, therefore, an integral part of our complex procedure), as the therapist must help the client in the practical application of the material lessons learned here, in creating favorable conditions (in other words supportive care does not follow treatment, as is the case with aftercare — in aftercare we can only deal with what we have already accomplished in the course of supportive care).

Supportive care is carried on as long as it is deemed necessary professionally (this means that not only the therapist considers it justified, but that the given institution, e.g., the school, is also receptive, is ready to cooperate with the therapist on the problem concerned).

On several points supportive care is in agreement with several elements of our complex procedure (family visits, logopedic homework, aftercare, medical examination), which we have already discussed above:

General aspects of supportive care are:

— It is introduced only in cases when professional reasons (when the therapist sees difficulties in applying acquired skills which the client has not yet

recognized, or cannot solve by him/her self, and on which supportive care may have a beneficial influence; when the therapist wants to learn something, otherwise inaccessible, about the client's psychological life space) and the client's intentions (client seeks therapist's help because he/she does not yet feel strong enough to "be able to assert his/her self" in tackling emotions, problems) coincide.

— We stress that supportive care is primarily the task of the first year of treatment (there are exceptions of course), after which period, as a result of our complex procedure, the client becomes an autonomously functioning personality. Therefore to continue supportive care is to weaken the client's intentions to change, to become autonomous.

— Supportive care always concurs with treatment, that is, the therapist works in the client's psychological life space, in real life situations (family, school, workplace, interpersonal relations, etc.). This means that during supportive care the therapist must take into consideration scenes, persons, goals suited to the therapeutic "phase", so that the treatment situation and the everyday performance of the client actively supplement one another. For instance, it is a logical step at the onset of treatment to visit and get to know the family and to discuss cooperation (the therapist must clarify what these talks are expected to achieve; initially, the requirements are kept simple in order to ensure their fulfillment, which in turn facilitates our work).

— Supportive care involves an important psychological effect. The therapist, by stepping outside the therapeutic situation and visiting the client in his/her everyday life space, demonstrates an acknowledgement of the client's problems and of their importance. This serves to enhance the authenticity of our work, and strengthen the client's trust and hope. As a result, the client will work to solve his/her own problems.

— In the course of supportive care the therapist always meets and talks with people who play some role in the client's life space, who are, for some reason, important for the client. The therapist must rate these roles because the importance of the position occupied by the individual concerned determines the nature of his/her approach and intention (e.g., different things are expected of the client's teacher, trainer, or mother). Furthermore, it must be noted that these meetings and talks hold a different meaning for those involved and for an "outsider" unaware of his/her part in bringing about and sustaining the client's difficulties. The relevance of this question lies in the fact that it determines the success of cooperation to help the client.

— The therapist often meets with "disappointment" in the course of these meetings because the client's relatives and others he/she is associated with, show a ready willingness to cooperate, but which they do not follow through. The reason for this is not ill-will or resistance, but the need to discard some of their own characteristics; it is very difficult to adopt an entirely different attitude and give up

time-tested characteristics. For supportive care to be successful, the therapist must primarily win over the family members and the professional educators who have an emotional and professional interest in the client. The therapist must meet with them several times and try to get them to acknowledge what is expected from them.

— It would greatly impair the therapist's work were he/she to express, in the course of the talks, a divergent opinion without preparing the individuals sharing in the client's life space (understandable, since essential characteristics are involved). The correct approach is to follow the person's way of thinking, then, at the close of the conversation, to make the person express, in the form of a deduction, the relevant important observations (thus as it were to draw his/her own conclusions).

— In the above presentation of supportive care we have concentrated on stutterers, but we must add that in the course of this work we come across many parental complaints. These complaints must be treated in the interest of the parents as well as the stutterer. Therefore, if it is at all possible and justified, parents are invited to join in the treatment of the client; or, preferably, the therapist refers them to a specialist.

— The issues, that form part of this work are of decisive importance from the point of view of the client's life. The therapist plays an active role in this work, but not making decisions, only as an advisor. It needs very great self-control not to abuse the positional advantages of a therapist. We must bear in mind, when dealing with these questions, that the therapist's objective is to help the client to become an autonomous personality.

The following are the main areas of supportive care (these areas are a matter of opinion expressing the author's way of thinking as elucidated in his/her complex method; the order in which these areas follow one another has no relevance, since the priority of the areas is determined by the specific case):

- a) school (college, university);
- b) place of work;
- c) issues related to the period which comes after finishing studies;
- d) creating conditions for working at home;
- e) medical examinations;
- f) advice on sexual life;
- g) "contact with the world";
- h) partner relations.

a) *School* is a salient scene of supportive care. It is important that the reason for paying the school a visit is not to seek favors for the stutterer, partly because it would only enhance the feeling of difference in the client, and partly because the stutterer must meet expectations and perform among healthy peers (for this reason we oppose the exclusive use of written tests in the case of stutterers).

The goal of supportive care in school is to change the attitude of teachers and peers, and to seek cooperation with them. In practice this means that the teacher should be aware of the fact that the student attends speech therapy; the teacher should also know that stuttering is an illness which affects the whole personality, and, maintaining academic requirements, he/she must endeavor to create an atmosphere in which the student is treated with unobtrusive attention, with tact, and ensure that the school and the therapist stay in touch. These are the main ideas that therapists must establish in the school as part of their work.

When visiting the school the therapist seeks communicates primarily with the class teacher (because he/she is the one with the clearest picture of the client and the school environment and who is in contact with other teachers), but sometimes talking with another teacher, or classmate(s), or, less often, a whole class may prove more important (the author had a few cases when it was desirable to speak to a whole class about stuttering in order to help form an objective opinion about, and promote the position of, the stutterer).

Whomever the therapist speaks to in the school, he/she must first study the way of thinking, the views of the person concerned (over and above stuttering). The conclusions drawn will determine what steps the therapist will take to accomplish his/her goals. In the rare event that the teacher's human and pedagogical attitude is found wanting, supportive care should not be taken to the school to avoid further harm to the client. Usually, however, teachers are helpful, ready to cooperate, though, almost without exception, they say they know nothing about it and need instruction. Given this response the therapists have already "won their case", and from then on the quality of cooperation is entirely up to them. There is no general recipe for cooperation — it is always determined by the specific case and by the therapist's professional inspiration.

In *higher education institutions* (university, college) the therapist should turn exclusively to teachers of the courses the client takes. The objective is to create, as much as possible, favorable conditions for proving the client's abilities, testing his/her knowledge. This has never been a problem since university rules allow individual oral examinations, which teachers readily undertake and clients take advantage of.

University entrance examinations are also part of this issue. The therapist, at the client's request, accompanies the client as a gesture of support to the entrance examination where the client performs on his/her own backed by what he/she has learned in therapy.

b) In the course of supportive care the client's *place of work* is seldom visited. The main reason is that clients rarely request it, further, only a very serious professional motive would induce the therapist to take this step.

In the author's experience there were only a few such cases. This step is taken if the clients are dissatisfied with their position at work (not with the work itself, but with their colleagues, who make practical jokes, comments about the client's speech defect) and if there are more favorable working conditions elsewhere within the same institution (according to the client, of course). Then the therapist requests an interview with the client's boss and asks for his/her support in solving the problem (our experience is positive in this respect). Note that these clients do not occupy management positions.

c) A part of the therapist's work is to help the client solve problems that arise *after finishing school*. Often there is no need to take the initiative, since clients themselves tend to seek the therapist's counsel (as regards choice of career, higher education, finding a job, unemployment, career adjustment).

The first question the therapist must be able to answer concerns the improvement of the client's condition, i.e., will the client's speech behavior act as an obstacle or not. Answering, or rather prognosticating an answer to, this question is a precondition for beginning supportive care, for outlining the client's prospects.

The question that the client often asks is, "will I get better, will I be cured?" The actual situation is important because it is highly probable that the client will make fundamental decisions concerning his/her future on the basis of the therapist's opinion (a great responsibility for both). For this reason the therapist must take great care in formulating an opinion. In our practice the therapist adjusts to the client's ideas (NB, unrealistic ideas are not very frequent, probably because long-standing complaints have given rise to greater realism), even if the client has a profession demanding communicational ability in mind, but, as a matter of course the therapist supports only plans and career ideas that are truly realistic. If the results of treatment give cause for doubt, the therapist should suggest that the client also consider a less public variant of the chosen profession (e.g., if the client would like to be a teacher, but is not likely to qualify, he/she may think about becoming a researcher, museologist, etc.).

Sometimes the therapist is unable to arrive at a decision concerning the client's choice of career, because the motives are balanced (the result of treatment is uncertain only in relation to the client's choice or ambition, or the client persists in his/her ideas and cannot, though advised, change course, etc.). In such cases, making a decision should be postponed, because during this waiting period (a maturing period, in fact, for treatment is continued) favorable changes may take place (changes in attitude which has a result in the client either accepting the therapist's suggestion or setting out on another course).

Quite often the career ideals of stutterers hide psychological deficiencies, in other words, the client's intention is supported by the mechanism of compensation (frequent career ideals are psychology, medicine, teaching of the handicapped,

child care, nursing, and, recently, missionary and church work). The psychological interpretation is that the client, still struggling with some psychological deficiency, perceives the imagined career as the medium for offsetting his/her deficiencies, which may be advantageous from the point of view of the client but not of those he/she would be dealing with. Therefore, the therapist must explain to the client the psychological mechanism of this phenomenon. Naturally, there are clients who do not give up their career ideals even after this talk which aims at enhancing self-knowledge, or following the conclusion of treatment. By then, however, the decision is made on this basis of a counterbalanced personality.

Clients are accompanied to a vocational guidance counselor for an expert and methodological examination. The aim of the examination is to determine what type of career the client is suited for in view of his/her abilities, achievements, personality. The therapist and the vocational counselor compare notes on the client. Naturally, the aim and the circumstances of the examination are discussed with the parents beforehand.

The issue of whether to continue studies or not is related to the results of this vocational test, the data of which are taken into consideration over this decision. This question is dealt with in two steps. First, the question is discussed in detail by the client and the therapist in the course of treatment, in one or two sessions. The client talks about what he/she would like and why, and the therapist about the results of the test, specifically, whether, on the basis of the expected results of the treatment, they agree or disagree with the client's decision. Second, the therapist visits the family, or the parents come to the clinic, and, in the presence of the client, they discuss which career choice they think is suitable (talking with the parents is important in order to learn, among other things, whether the family is willing or capable of financing the client's education).

Often clients are encouraged to work in addition to going to school or during the summer vacation in order to learn a little about the chosen career or vocation. Work allows the client to compare his/her mental picture with practice, furthermore, through work the client acquires a great deal of experience enhancing his/her knowledge of his/her self and human nature.

The question where should the client work is often asked, i.e., where should he/she apply the learned skill. In our opinion, and supported by negative experience in this respect, the therapist's role must be limited to the treatment situation. The fact is that employers did not view our intentions favorably. We have, therefore, come to the conclusion that the therapist's perceptible supportive presence in the background only spoils the impression the client makes; so this approach is no longer encouraged. However, in the treatment situation the therapist helps the client to find employment by giving them information and by comparing expectations with opportunities.

Unemployment is a twofold problem. First, loss of a job (or not finding a job after finishing school) causes serious self-doubt. The client, who is slowly becoming an autonomous individual with growing endurance as a result of treatment, cannot cope with this problem because of the belief that the decision is connected primarily with his/her illness (the core of the argument is that not one of the others, who keep their jobs, has a speech defect). The second concerns restarting and lack of funds. Professionally, the solution lies in giving support and looking for a job together (it is advisable to take advantage of the therapist's personal contacts to help solve this problem).

The problem of the client's career adjustment is related to the above. Often, when the client loses his/her job, the solution is to recommend retraining for some fashionable profession.

Retraining is also advised in cases of misguided choice of profession, or school. Within the bounds of the treatment situation the therapist may become involved in this problem and help the stutterer.

d) Becoming acquainted with the *conditions of work* during home and family visits differ in that in the course of the latter the therapist gathers data necessary for treatment, while the goal of supportive care is to transfer into practice the information revealed during treatment, including family visits, and to create the conditions for change (together with members of the client's environment).

Becoming acquainted with the conditions of work at home means that the therapist becomes acquainted with the exercises, the work the client performs in his/her home environment. Clients are very happy to show the place where "they fight their daily battles" and "build a castle on faith and hope" (in the words of one client). The therapist should interfere in the performance of the exercises at home only if he/she finds it inefficient, or at the client's request. The therapist's work becomes more difficult when the client lives away from home in a dormitory, workers' hostel, or is in the army. In each case the therapist calls on the head of the institution and informs him/her about the treatment, the essence of the complaints, requesting his/her helpful cooperation. The problem in these institutions is finding a place where the client can be alone to perform his/her exercises. Most often this place is the library or the sickroom — in one case the director of a dormitory lent his/her own office for the purpose.

In view of the fact that most of the clients attend school, school work and exercises performed as part of treatment are readily combined (one helping the other). In other words, clients are instructed to study by recitation, which is advantageous from the point of view of treatment (because the client applies the acquired methodological elements) and in school as well (because the client practices the material to be learned). A discussion about studying by grasping what

is essential and by taking notes also belongs here. This method is part of the therapeutic effort to teach the client to express the essence of his/her thoughts in a simple form.

e) In the course of treatment, owing to the added influence exerted by speech behavior, and in the course of supportive care, regardless of this influence, a *physical examination* to diagnose and treat other, secondary somatic and psychological complaints is indicated.

In supportive care the therapist must provide help, because our complex procedure involves curing people as a whole, on the one hand (speech is not an independent part of human existence), and on the other, because the client's difficulties in speech impedes communication of personal affairs during a physical examination. Furthermore, clients often do not know who to turn to with their complaints (it is no help to say, for example, "you must see a psychiatrist"). Professional ethics demands that the therapist recommend a medical examination, make an appointment on behalf of the client, and accompany the client (at least on the first visit).

For practical purposes the therapist should work with doctors who have an understanding of the nature of stuttering and have experience in treating it, with whom the client's special problems may be discussed, and whom the therapist may consult on a regular basis.

The therapist must know the results of the physical examination since they are important in his/her own work, and, in turn, the physician should be informed about the therapist's observations.

The physician's recommendations (medication, other treatments) should be "checked" periodically.

f) The therapist must frequently deal with the *sexual problems* of clients.

The question is deliberately not discussed under the heading of physical examination, though sexual complaints met with here do have their medical relevance, because in the overwhelming majority of cases we have found that these problems have psychological causes.

These complaints emerge in the course of explorational conversations. Women usually complain of suborgasm, men of ejaculatio praecox, fear of impotence and decline in potency.

We consider these complaints (that have a brief history and are fluctuating) to be a psychological projection of speech behavior, which, as a result of our complex procedure, disappear by themselves (specifically, this means that the client is questioned about his/her complaints, feelings, the client's spouse or partner is interviewed, then the "influence acting on the client's personality which arises from his/her communicational difficulties" is interpreted). If the complaints have a long history affecting sexual development and behavior, the client is

referred to sexual counseling (again, it is the therapist's duty to make the appointment and accompany the client and his/her partner, then work together with the specialist in making use of one another's findings).

Generally, sexual therapy does not interfere with the continuity of logopedic work. In view of the fact that a significant part of our clients are young, supportive care must also cover problems of sexual behavior and culture. A large number of cases convincingly prove that the young people belonging to this age group, who are yet to begin, or are just beginning, sexual life, possess inaccurate information on the subject. Therefore, the task at this stage of supportive care is to clarify, in a dialogic form, fundamental ideas, such as conception, male and female roles, methods of contraception, the subject of menses, venereal disease, the give-and-take of pleasure, etc. In addition, the therapist must try to help solve any problems the client raises (thus, in the course of the years, we have accompanied our clients to consult with specialists in gynaecology, urology, venereology, sterility, and on one occasion, in a case of unwanted pregnancy, the author acted as arbitrator between the client and the family who disowned her).

g) The therapists through their personal participation (which is decisive in affecting a change in the client's lack of initiative) provides clients, according to their needs, with the opportunity to establish contact, in as many ways as possible, with the outside world. The basic idea of the theme, "*contact with the world*", is to help the client, first, to enjoy its benefits, then, in return, to shape and add something to this world of ours. In this way the client will be able to get along better in the world, which in turn will reduce conflicts and increase the chances of tension transformation (i.e., through experience the client learns of solutions which adequately meet the requirements of given situations). The goal of supportive care (too) is to enable clients to establish as many ties with the world as possible, thereby increase their involvement, help them to experience the gratification of an increasing inner value, of learning, of giving, all of which serve to make the personality functional.

It is difficult to define supportive care in terms of methodological steps, therefore, we shall indicate merely the direction of our intention (the order given is important) stimulating the growth and uplift of the client:

- participation in common activities (clubs, folk dancing, study groups, camping, excursions, dance lessons, teams and foundations where the client is an equal member of the community),

- individual initiatives (making friends, acquaintances, made possible at the above gatherings, arousal of interest in the opera, theater, concerts, sports, study of languages, attending lectures).

In each of the above the therapist is the client's "first partner" (which ensures that the initiative is taken).

It is important to prepare the ground, so to speak, prior to introducing the client, because the client is more likely to "take root" if he/she feels there is attention, an interest in him/her.

h) Substantive analysis of the questions concerning *partner relations* will be dealt with later on. Here we shall study the behavioral, practical aspect of these questions, which will, in turn, greatly motivate substantive analysis.

In the course of supportive care involving the client's partner relations, the therapist, by creating favorable conditions and situations, attempts to prove the client's suitability for entering a partner relationship, or, given a partner relationship, his/her capability for establishing a family on a decentered basis.

The idea underlying the question of partner relations of the stutterer is that the client should first have morally and emotionally well-founded, satisfying relations. This given, he/she should remain open to establishing further new relationships in order to acquire as much experience as possible. Finally, having acquired these experiences, he/she should be able to make realistic decisions to start a family. The therapist's task is to help the client through these stages, namely: becoming acquainted, stable partner relationship, break up of the stable relationship, other partner relations followed by marriage, conjugal crises, divorce, restart.

The most important role of the therapist lies in creating the conditions for making acquaintances, discussed above as "contact with the world" (naturally, there are also other approaches to the question).

The other stages, as mentioned in the introduction, belong to a later phase of treatment (substantive analyses). We will, therefore, refer to only the occurrence of symptoms.

In cases of firmly established relationships, clients seek advice concerning questions of "can I trust him/her" and "I feel as if". (Since our clients have no practical experience in this area, they tend to judge others in terms of absolute categories, i.e., they are either good or bad.)

Breaking up of a partner relationship gives rise to a number of doubts in the client, greatly undermining his/her self-confidence. The client either becomes very reluctant to take the initiative in establishing a new relationship or does so much too easily, irresponsibly.

Disproportionate distribution of responsibilities, marital infidelity, appearance of a third person, irresponsibility in financial matters, and, recently, changes in conduct due to unemployment are the main causes of conjugal crises.

In the case of divorce, clients readily share their problems with the therapist, and would like to share the responsibility of the decision as well.

When making repeated restarts, on the one hand, they show similar behavior as in case of divorce (indecision), and yet on the other, they do not want to live in lawful marriage.

In our practice we have found referral agencies to play a positive part in establishing partner relations. We should turn to these agencies only if the client has no prospects of finding a partner, but feels a strong desire to have one. First reaction to the idea is often rejection born of prejudice. Following this we usually cite cases from our own practice, which have been successfully consummated (children produced). Another argument is that taking advantage of the agency does not have to end in marriage, that it is a means of making acquaintances, with a confidential management of affairs as regulated by law. This is followed by a period of consideration of varying duration, at the end of which the majority of the clients express agreement. The therapist must again help to realize this course of action.

TREATMENT STEPS

Each stage of treatment is preceded by a detailed discussion of the tasks, in accordance with the age of the client (using drawings, figures), specifying what we will do and why, and what we expect of him/her.

We must not begin work without first doing this!

Discussion should not be a one-sided communication of facts and explanations, but a true *conversation* where the client feels free to ask questions, no matter how simple they may seem, and receives an answer to them.

The steps of treatment are as follows:

- first treatment task;
- exercises to improve nonverbal communicational ability,
- action and active relaxation exercises,
- logopedic relaxation,
- influencing breath flow,
- spasm analysis,
- spasm prolongation,
- exercises promoting speech confidence,
- speech analysis,
- speech in relaxation;
- logopedic confrontation;
- logopedic homework.

These steps constitute the main elements of our procedure. This is not to say that other tested and useful elements (rhythm exercises, singing, puppetry, drawing, etc.), which are part of the gold reserve of clinical practice, are given up. We dispense with describing them here owing to the nature of our task and the fact that we are dealing with the main areas of stuttering therapy.

The individual treatment steps are described below in a suggested order of application.

Task of first treatment session

The following describe the characteristic “mental state” of stutterers when coming to the first treatment session.

Hopeful expectations. This is true primarily of those stutterers who turn to a specialist for the first time. They are aware of the fact that their complaints disrupt their everyday life and plans, and want to change this. They take the initiative.

Distrust. The fact that we use our complex method only in the case of stutterers who have reached the age of eight means that their speech problems have a history of several years. During this period the stutterer was treated by many therapists using many different methods with little effect. Despite failures of treatment, these stutterers continue to go from one therapist to another to “have something done with their speech”. In their case the main problem is not the speech defect itself, but a wide range of complaints accompanying it and the repeated failure of treatment, as well as the “fragile” intention to be cured.

Passive indifference. In this case the stutterer “does not experience his/her stuttering”, he/she can live with it “in harmony”. These stutterers are brought for treatment by parents, or they come at the wish of their spouse, or friend. The difficulty with them is that at first they lack motivation to be cured, to cooperate. However, the first positive results soon win them over.

Common to these “mental states” is that stuttering affects the entire life of the stutterer, and that every stutterer suffers from it, though for different reasons. We can help relieve this suffering at the first session by making our *answers* to the client’s questions *brief* and to the point (this is not exploration!). This first talk determines the course of the entire treatment. If our answers are reassuring, inspire trust and a sense of security, then the stutterer will feel that he/she has come to the right place with his/her problem and will have faith in therapist and treatment alike.

Since the experience of stuttering is varied, the questions reveal useful information about the client’s personality, which, together with other data (see examination steps), serve the purpose of treatment.

Points of consideration about questions and answers:

- the answers must always reflect our professional stand (thus we also prepare the ground for acceptance of treatment);
- the answers should be short, simple, easy to understand and relate to the question (i.e., be adjusted to age, gender, education, given case);
- the questions, whether rational or irrational, must be taken seriously (inaccuracies must be corrected tactfully);
- the answer should not be a “comprehensive” one, because too much information does not give reassurance. We should answer specifically what the client asks;

— it is frequently observed that clients ask questions in order to obtain relief. What is important here is tension reduction, not the specific complaint or question and the answer to it;

— there are stutterers who do not ask anything. Naturally, they too have questions, but their fear of speech keeps them silent. In this case the therapist's approach should be one of consideration for the client, though the fear of speech cannot be expected to disappear after the first session. The client should be given the opportunity to ask questions at a later date, when they will be answered.

Three questions follow below that the clients invariably ask at the first treatment session (after each question there follows the general trend of our answers, the sphere of ideas to be elaborated, usually outlined in this first session).

What is stuttering?

- the stutterer's speech organs are unimpaired;
- stuttering is not an error of speaking;
- it is identified on the basis of a readily observed symptom, but stuttering is only one of a combination of symptoms;
- in addition to speech symptoms, the stutterer is characterized equally by behavioral, motor and somatic symptoms;
- stuttering is one of the verbal manifestations of behavioral malfunction;
- stuttering is a speech-behavioral disorder;
- since speech is inseparable from people, events affecting people also influence speech;
- excitement, happiness, sorrow, etc. create favorable conditions for the appearance of stuttering;
- stutterers find it hard to tolerate and control emotional impacts;
- given a special disposition, somatic, psychological, environmental and familial influences help develop stuttering.

Is there any help?

- according to current knowledge, professional care can help the stutterer;
- unless treated, stuttering will not be cured;
- the extent of cure depends primarily on the diligence and persistence of the stutterer in performing the exercises;
- treatment is focused not on stuttering, but the stutterer;
- in the course of treatment the stutterer is given daily homework.

What result can be expected?

— if the stutterer attends treatment regularly and does his/her homework every day, then he/she is sure to "move" forward: he/she will feel better, be more

communicable, less fearful of speaking, his/her speech will not determine his/her plans for the future;

— with much practice he/she can learn methods to control the excitement, the confusion of the, for him/her inadequate situation preceding speech, which at the same time leads to improved verbal performance;

— with much practice he/she will learn speech techniques, with which he/she can defend him/her self against, prevent the appearance of, mental-physical spasm sensations;

— the stutterer will learn to face and accept his/her greatly reduced somatic-psychological complaints;

— according to our follow-up examinations, clients who continue doing the exercises after completion of treatment, show stable performance.

The following is a random list of questions that stutterers frequently ask in the first treatment session.

Do I have to take medicine?

Why don't I have any problems reciting poetry and singing?

Why do I have less problems with speaking at home than in strange places?

Why do I have less problems with speaking in a group than when alone?

Why does my speech become worse when a situation frightens me?

Why is it difficult to pronounce some sounds?

Why do I speak well periodically?

Is my speech related to weather, to season?

Why is it more difficult for me to speak with boys/girls?

Why is it more difficult for me to speak doing official business, or with my superiors?

Why does my speech become worse when using the phone?

Why is it difficult to introduce myself?

Why does my speech become worse during menstruation?

Why does my speech improve when I drink alcohol?

Why does my speech become worse when I have to ask for something, and better when I give someone something?

Why do I feel tautness and tension in my body?

Can stuttering be completely cured?

Is stuttering hereditary?

Why is my speech worse in front of my "boss"?

Why is my speech worse when I become excited?

During the first treatment stutterers not only ask questions, but also give "ready opinions" (usually concerning sound formation, the mechanics of the inhibitory spasm). This is important because stutterers expect a solution that answers their ideas. Consequently, in order to win over the stutterer, the therapist must correct his/her "ideas", if they are correct, make use of them.

Exercises to improve nonverbal communicational ability

So far, investigations of nonverbal communication dealt with normal, symptom-specific and ethnic groups. Only the findings of these investigations are available to logopedic literature since the study of the nonverbal communication of stutterers does not yet constitute an independent research project.

In the course of our research into the nonverbal communication of stutterers, we were concerned with the study of the following:

- movement phases of the head of stutterers/nonstutterers, and accompanying hand and body movements;
- movement phases of the head and body movements of the stutterer participating in the interaction but currently not speaking;
- study of video recordings of stutterer/nonstutterer interactional dialogues;
- use of video recordings to study facial nonverbal communication in interaction between two participants.

Summing up the findings of our investigations, we may observe the following:

— In the total number, as well as in certain elements, of the nonverbal spheres examined stutterers used uniformly fewer nonverbal signs in their interactional conversations, than nonstutterers. Thus stutterers use less information in nonverbal speech-behavior situations than their nonstuttering interactional partners. The general effect of this is a shortage of information.

— This smaller number of nonverbal signs, the quantitative difference, means that the ratio, the functional unity of verbal and nonverbal cooperation is loosened. As a result, nonverbal sending of "messages" fails to complement verbal communication in social interactions. A damage in verbal communication exerts a functional influence on nonverbal communication causing a decline in standard.

— The falling behind of the stutterers' nonverbal statistics, as compared with normal speakers, indicates a decline in functional standard in terms of numbers, i.e., the disintegration of nonverbal communication: impeded speech produces impeded behavior (realization), therefore, stuttering may be considered as a state of communicational deficiency, a decline in communicability.

The realization of the "human potential of abilities" is modified in the case of stutterers by inhibition caused by tension. Tension and energy correspond. Where tension is disproportionately great and unevenly distributed, there the even flow of energy is blocked: tension checks energy. This means that every psychic conflict has a corresponding somatic manifestation: emotions are expressed by movements, and muscle tension checks or obstructs movements, thereby the manifestation of emotions.

In nonverbal exercises we use material which is "artificially produced", but is always based on information derived from the client's exploration. The goal of this consciously constructed situation is to activate and to develop through practice the objects of consciousness, inhibited as a result of stuttering, as well as the unused nonverbal qualities.

Our examinations of nonverbal interaction have shown that stutterers are characterized by a nonverbal communicational deficiency. Therefore, we have developed a compensatory method, the application of which (together with other methodological steps of our complex procedure) will help improve the nonverbal communicability of the stutterer.

Nonverbal communication exercises are also expected to increase the standard of contact qualities that are necessary for therapeutic cooperation, for access to the personality.

Conditions of application of exercises promoting development of nonverbal communicability

Essentially, these conditions agree with the conditions of application of the complex treatment as a whole. In the following we shall describe only a few, diverging conditions relevant to our subject.

— It is important to make every client perform the nonverbal exercises, even if nonverbal communication is only partially damaged, because they are a good way of "testing" what has been learned, of getting to know the nature of expressive behavior.

— The material characteristic of the individual is derived from his/her logopedic exploration, and is used to plan, together with the client, the situation exercises (neutral, so-called ego-distant, material should not be used, because it tends to make verbal and nonverbal behavior incongruent).

— If the client's verbal and nonverbal communication is impaired to the extent that it disrupts fluent communication between client and therapist, then treatment may be started with this methodological step. In such cases the therapist should play a more active role in the interaction. A few of the more important characteristics of this activity are:

- greater number of movements by the therapist;
- increased use of space;
- use of emotion in speech (alternating intensity, pauses, stress);
- reflection of deep interest on the therapist's face, posture, attention;
- interruption of the therapist's speech by pauses (to allow comprehension);
- choice of a topic that interests the client and at the same time does not demand his/her active involvement, i.e., he/she does not have to respond frequently;
- physical distance between client and therapist should not be impersonally big (the therapist may touch, pat the client if justified).

The stages should be used in the order presented below. Two or three sessions should be assigned for each stage. Later on, however, having obtained a picture of the role difficulties of the client's speech behavior, nonverbal communication exercises should be reintroduced either one by one or combined with other elements.

These stages serve as models, on the basis of which others can be designed with the help of the exercises presented here.

Nonverbal interaction exercises, which transmit the condensed substance of our experimental data and help speech behavior desensitization, are discussed below in a systematic order.

Stages to help nonverbal communication in interaction:

1. Understanding the task

A brief and very simple discussion of what verbal and nonverbal communication means. We must tell, illustrate, that it acts as a message in human contact in a given culture; emphasize the concurrence of verbal and nonverbal communication; mention that despite the importance of verbal signs an average person uses twice as many nonverbal signs each day; illustrate that in certain situations only nonverbal communication is possible; illustrate the relation between nonverbal communication and art, etc.

The therapist is to introduce every single nonverbal element for each of the following units:

- head unit (movement phases of the head);
- face unit (brows, eyes, nose, mouth, jaw);
- body unit (arms, feet, fingers, shoulders);
- leg unit (legs, feet).

After this the client is seated in front of a mirror, in which he/she can easily see his/her head, arms, and body. He/she should not be able to see the therapist in

the mirror, though seated beside him/her. The client is informed that he/she will spend much time in front of the mirror while doing the exercises, that it is important to see him/her self, to get to know what he/she is like when speaking, to see his/her facial expression, to see what takes place on his/her face and body when he/she talks, stumbles, to get used to the sight of him/her self, the external and internal experience of speech blocks.

Some people are disconcerted by the mirror (either the client mentions it, or the therapist takes note of it him/her self). In this case, at first we work near the mirror, but turned away from it, then slowly "as if by chance" we turn to face the mirror for brief moments to accustom the client to working before it.

2. Observation of certain nonverbal elements in activity

This part deals primarily with the nonverbal elements of the face, the most important field of social interaction, as well as with the nonverbal communication of the head and the body.

Instructions for the exercises are:

- movement and speech should coincide;
- certain nonverbal elements should be practiced as part of a situation (the client should give the examples, the therapist at most helps);
- in the case of certain nonverbal elements, the therapist first gives a characteristic description of their operation.

Following this the client sits down in front of the mirror, studies his/her reflection closely, pensively, as if seeing him/her self for the first time (the therapist's whole personality and inspired effort is needed to help create an authentic atmosphere).

Exercises involving nonverbal elements:

- I wrinkle my forehead (variations: I raise my brows, I knit my brows, I unknit my brows, I frown, etc.), e.g., when I have to think very hard about something, I do this to express "how's that again?"; or when I come home late from training, my father does this when he says, "what time is it, young man?"
- I look long and piercingly;
- I move my jaw;
- I pout.

Afterwards the *combined, repetitive gradations of certain elements* are performed (instructions are the same as above):

- a) — head movement with wrinkling of forehead, e.g., when I don't give the correct answer to the teacher's question, he says, "come now, don't talk baloney",
- head movement with wrinkling of forehead and raising of brows,

— head movement with wrinkling of forehead, raising of brows and a long, piercing look,

— head movement with wrinkling of forehead, raising of brows, long and piercing look, movement of jaw and pouting.

b) — head movement with wrinkling of forehead and arm (hand) movement, e.g., when I cannot get out the word I want to say and my brother can't wait for me to say it, then he says, "come on, spit it out";

— head movement with wrinkling of forehead, raising of brows and arm (hand) movement;

— head movement with wrinkling of forehead, raising of brows, long, piercing look and arm (hand) movement;

— head movement with wrinkling of forehead, raising of brows, long and piercing look, movement of arm (hand) and jaw;

— head movement with wrinkling of forehead, raising of brows, long and piercing look, movement of arm (hand) and jaw, pouting.

c) — head movement with wrinkling of forehead, raising of brows, long and piercing look, movement of arms (hands) and jaw, pouting, movement of body (shoulders).

d) — movement of head and body (shoulders);

— head movement with wrinkling of forehead and movement of body (shoulders);

— head movement with wrinkling of forehead, raising of brows and movement of body (shoulders);

— head movement with wrinkling of forehead, raising of brows, long and piercing look, and movement of body (shoulders);

— head movement with wrinkling of forehead, raising of brows, long and piercing look, pouting and movement of body (shoulders);

— head movement with wrinkling of forehead, raising of brows, long and piercing look, pouting, movement of jaw and of body (shoulders).

3. Who's in the mirror? (A conscious identification of role situations)

In this part the stutterer is shown the different roles he/she has to play, and is thus made aware of his/her various duties, of what is expected of him/her. Each of these roles activates special verbal and nonverbal material, and the result is a change in speech behavior.

It is important to elaborate only such roles as actually occur in the stutterer's psychological life space. We should refrain from talking about current or future roles. Age and cultural background must be taken into consideration.

Example: the client, a 10-year-old boy, is sitting in front of the mirror with the therapist taking the lead in the conversation:

"Who's that in the mirror?" ... silence ... "me" ... "who's that?" ... "it's me" ... "Who's me?" ... "John T." ... "who's he?" ... silence ... "who else could it be?" ... "a boy" ... "who else?" ... silence ... "well, a student" ... "yes, who else?" ... "a shopper in a store" ... "yes, and" ... "a passenger on a bus and ... a viewer in a movie, a swimmer in a pool, a player on a field ..."

4. Action situations

The stutterers' characteristic behavior traits account for their treatment of their difficulties in taking action, in taking initiative. These traits are:

- introversion (determining the direction of elaboration, of the mode of experience);
- insufficiency (distancing of abilities, achievement, desires, "an experiencing of the difference between what I am and what I would like to be");
- inclusion (spatial feature, the feeling of being closed in and incapacitated, movement, rhythm, position between people and objects difficulties).

Stages of action situations:

- a) greeting situation;
- b) introduction situation;
- c) initiative situation.

The first two stages are brief, isolated action episodes, while the third is a series of action changes, a longer verbal-nonverbal interactional process.

a) Greeting situation

A discussion and demonstration of the better known differences, followed by common greeting situations in our culture: in the morning, at noon, at night, variants used by adults and by children, greeting the elderly, strangers, various ways of saying goodbye, etc.

Principle of working through: what nonverbal element and sphere belongs to the phrase, to the situation.

b) Introduction situation

Discussion of its essential components:

- establishment of contact according to the conventional roles of the given culture;
- clarification of role (age, gender, rank);
- nonverbal elements;

- verbal elements;
- verbal elements (greeting, name, subject of interest);
- extent of subject mentioned on introduction, exaggerations.

Following the clarification of the elements, of the task, we must go through the whole action as a single unit (first in the mirror, then in interaction):

- eye contact;
- bow;
- nod;
- smile;
- verbal elements;
- handshake.

c) Initiative situation

The crux of the exercise is that the initiative to communicate, to approach comes from the stutterer.

The situation is constructed exclusively on the basis of specific information in the exploration material that cause difficulties in the client's psychological life space.

A few general initiative situations that cause difficulties for nearly every stutterer are:

- asking a question;
- asking someone for something;
- making a suggestion;
- reasoning;
- explaining something;
- announcing a demand;
- phrasing a wish;
- rejection;
- giving an order, instruction;
- initiative addressed to a superior (teacher, boss, the office);
- taking initiative in front of several people;
- taking initiative in a sitting position with others standing around.

5. Changing the intensity of verbal and nonverbal elements

Here, each phase of the action situation is analyzed by decreasing and excessively increasing its intensity.

We demonstrate the change, distortion, in the meaning of verbal and nonverbal communication when imparted by loud speech, very dynamically, with broad gestures, and when imparted softly, with few gestures.

The aim is to show the relationship between the quality of communicational sensitivity and behavioral dynamics.

6. *Analysis and synthesis of nonverbal elements*

On the basis of the above we attempt to raise to consciousness and summarize the leading, definitive, most frequently occurring elements responsible for interactional nonverbal communication (the therapist's role in this is only to act as a guide):

- which nonverbal unit occurs most frequently;
- relation between proximity and nonverbal (verbal) communication;
- combinations (e.g., which unit does the face unit "concur" with, etc.);
- age and nonverbality;
- gender and nonverbality;
- illness and nonverbality;
- nonverbal analysis of positive conditions;
- nonverbal analysis of negative conditions;
- nonverbal drawing of attention;
- relationship between the above and the stutterer's person, etc.

7. *"Commentary"*

The therapist presents combinations of various nonverbal elements about which the client has to make relevant comments. Then the roles are reversed. What is important is that the growing number of zones is accompanied by a growing number of combinations (increase in difficulty).

8. *Drawing of nonverbal signs*

The client is requested to make a drawing of the nonverbal elements of his/her characteristic psychological states. The usual reply to this is "I can't draw". The client must be encouraged by telling him/her that he/she needs only indicate the main, characteristic elements, not make an artistic product [thus, for example, downward curve of the mouth (sadness), elongation of the line of the mouth (happiness), upward curve of the mouth (laughter), etc.].

The client is asked to "portray" someone in his/her immediate environment.

The goal is to make the client draw a growing number of finely distinguished, consciously recognized and used nonverbal elements.

9. Use of verbal and nonverbal elements in space

Hereafter the client has to solve tasks in space, in motion, therefore, he/she leaves the mirror. In other words, space and motion gain an emphasis in the tasks and their solutions. The client uses space as an action field (he/she touches, grasps, lifts, spins, walks up to, takes down, sits down, stands up, etc.), whereby the client and the constituent elements of space represent a functional unit (purpose and realization).

Tasks are constructed according to the following considerations:

— In social interactions, sociocultural relations there are conventional distances, proportions, each of which has its own corresponding conventional nonverbal communicational elements.

— For every distance there is a corresponding nonverbal field, which best ensures communication by the participant: with the increase in distance the number, intensity, extent, frequency of nonverbal elements also increase; proximity reduces the occurrence of nonverbal elements, and the new sphere of tactility takes over.

The principle of structuring the tasks is that a speech unit belongs to each movement stage. At the beginning tasks follow the "one movement, one message" course, then the complexity of movements and messages gradually increases.

10. Search for unity

This methodological step is a summary of the above, thus it is of outstanding importance. Essentially, it means that by way of guided conversation the clients themselves discover, come to understand and put into words the relationship between the situation, behavior, speech behavior, and the verbal-nonverbal material. Within a given culture, these may be ordered to form stereotypes, or units, constituting the basis of orientation and of information about oneself in everyday contact.

11. Search for client's own characteristic units

Essentially, this means that clients must take note of their own characteristic nonverbal traits, then name them, describe where, when, in what situation they use them, tell whether they are sufficient for them to communicate with, advantageous or disadvantageous, whether there is a need to add to, refine, their nonverbal communicational repertory.

12. Search for nonverbal units in others

The client is asked to imitate the characteristic nonverbal elements, units, used by well-known people who are important to them, and to demonstrate along with their corresponding verbal material. This involves primarily the permanent and important factors of the client's psychological life space.

What is important in this exercise is that the client recognize divergences, variations, combinations, which must gain expression in the verbal material, too.

13. Conscious application of verbal and nonverbal units

This stage is employed after we have obtained a wide range of explorational information clarifying the role difficulties in the speech behavior of stutterers. Here the clients have to consciously present, without any outside help, the role difficulties of their own characteristic speech behavior.

After the negative examples, the client is to work through (several variations of) his/her positive role. The therapist merely supervises this.

In the course of interpreting role difficulties, the client must answer the following questions (these answers will be made use of later on):

- what does the client feel when role difficulties in speech behavior arise (pressure, contraction, tension, spasm in the muscles, in what part of the body);
- what causes the difficulty (internal block);
- is there a readiness for action (does he/she have something to say);
- was he/she disturbed by some thought, feeling;
- what accompanying thoughts, feelings, does he/she have (it is important that they always be systematic);
- which technical elements of speech does he/she use, when and why?

Motor activity and active relaxation exercises

Physical manifestations reflect the person. On the basis of the client's posture inferences can be made as to his/her condition, his/her readiness for verbal and nonverbal communication. Posture also reveals many things about the person's past (long standing tensions may bring about a characteristic posture, e.g., in case of an anxious person).

Similarly to everyone else, the stutterer also possesses the "human potential of abilities", the expression of which is modified due to inhibition caused by tension. The concept of tension corresponds to the concept of energy, a physical phenomenon. Tension blocks energy, i.e., where there is tension in the body, the flow of energy stops. Thus, every psychological conflict has a corresponding

somatic manifestation: emotions are expressed by gestures, and muscle tension checks or inhibits manifestation of gestures, the expression of emotion.

In the process of influencing the *various divergences in the motor activity of stutterers* (excessive and synergetic movements, facilitating macro- and micro-movements, muscle hypertensions), these exercises may comprise the initial step of the complex treatment (they constitute the subject matter of approximately the first two months, with the client practicing at home). Parallelling this (in the second half of the sessions) the exploration and interactional nonverbal communicational exercises are performed. Three stages of movement are carried out as part of the motor activity and active relaxation exercises:

- coordination of movement and speech;
- fractioned relaxation;
- exercising the arm and leg muscles.

Coordination of movement and speech. Its stages are:

- movement in large space, without speech (these are small, so-called expressive movements);
- movement in large space, together with speech (simultaneity is important);
- activization of all verbal and nonverbal elements as part of the situational exercises (based on actual information);
- coordinated practice of expressive movements and speech in front of a mirror.

In these exercises emphasis is laid on *rhythm and expressive movements*. The subject of the exercises is based on the client's own, not yet conscious, material. The exercises are not muscle or isometric exercises based on muscle tension!

Fractioned relaxation. This method is used independently as a muscle relaxing procedure, with an introductory description preceding it. The following are stressed: the need for independent and regular exercise, the parallel neuromuscular process of muscular tension and psychological tensions, somatic and psychological manifestation of the relation between tension and relaxation, somatic concomitants of a relaxed state and the dispositional consequences of inadequate distribution of tone. The *goal* is to dissolve, to influence the tonic spasms and muscular defenses observed in stutterers, and to create a new balance of tone. *Words are used as conditioned stimuli* in this procedure of verbal reinforcement and conditioning.

This is followed by a description of conditions. The exercises are done in a seated position on a comfortable chair with high back and arms for support. The client is asked to sit as comfortably as he/she can. Note that *recital and the*

corresponding muscular movement begin and end at the same time. Recital is slow, very articulated, soft spoken. After each sentence there is a pause of about five seconds, to allow an understanding of the content, intended meaning, of the sentence. The client's voice must reflect the tautness produced in the given part of the body. When tautness reaches its maximum (corresponding to effort exerted in coughing of medium strength), the client is asked to hold it for about 5 seconds, then gradually dissolve and relax it. This too must be reflected in the quality of voice. The exercises are to be performed at the same time twice every day. After this we tell the client that he/she will begin to learn to distinguish between the sensations of tensing and relaxing muscles. The exercises listed below follow the same order as during sessions.

— The client is comfortably seated, his/her hands rest on his/her thighs, he/she watches the back of his/her right hand, and says: "My right hand is resting on my leg, the muscles in my right hand are loose, I tense my right hand, then I relax my right hand."

— The client's hands rest on his/her thighs, he/she watches the back of his/her left hand, and says: "My left hand is resting on my leg, the muscles in my left hand are loose, I tense my left hand, then I relax my left hand."

— The client's hands rest on his/her thighs. He/she says: "Both my hands are resting on my thighs, the muscles in both my hands are loose, I tense my hands, the slowly I relax my hands."

— Exercise with the right arm. Text: "Now I'm thinking of my right arm, the muscles in my right arm are loose, I tense my right arm, then I slowly relax it."

— Exercise with the left arm. Text: "Now I'm thinking of my left arm, the muscles in my left arm are loose, I tense my left arm, then I slowly relax it."

— Exercise with the right and left arm. Text: "Now I'm thinking of both of my arms, the muscles in both of my arms are loose, I tense the muscles in both of my arms, then slowly relax them."

— Exercise with the right shoulder. Text: "Now I'm thinking of my right shoulder, the muscles in my right shoulder are loose, I tense the muscles of my right shoulder, then I relax the muscles of my right shoulder."

— Exercise of the left shoulder. Text: "Now I'm thinking of my left shoulder, the muscles of my left shoulder are loose, I tense the muscles of my left shoulder, then I relax the muscles of my left shoulder."

— Exercise of the right and left shoulder. Text: "Now I'm thinking of both of my shoulders, the muscles of both of my shoulders are loose, I tense both of my shoulders, then I relax both of my shoulders."

— Exercise of the chest muscles. Text: "Now I'm thinking of my chest muscles, they play a role in breathing, my chest muscles are loose, I tense my chest muscles, then I relax my chest muscles."

— Exercise with the back muscles. Text: "Now I'm thinking my back muscles, my back muscles are loose, I tense my back muscles, then I relax my back muscles."

— Exercise with the forehead. Text: "Now I wrinkle the muscles of my forehead." (We raise our brows as if surprised, we tense the muscles of our forehead and feel the tension.) "I relax the muscles, the muscles become smooth." (We feel the slackening of the muscles.)

— Exercise with muscles of the brows. Raising the brows, looking upward, we wrinkle our forehead. Text: "The muscles of the forehead are tensed." Slowly relaxing the muscles of the forehead, the following may be said: "My forehead is now completely smooth."

— Exercise with the eye muscles. Let us tense the muscles of the eyeball as if concentrating on something, then relax the muscles. Then close the eyelids tightly and say: "The muscles of the eyelids are tensed." Then, relaxing the eyelids, say: "The eyelids are relaxed."

— Exercise with the nose and muscles of the nose: muscles of the wings of the nose are tensed, nostrils are distended. Text: "The wings of the nose are tensed." Following the "collapse" of the wings of the nose, we say: "The wings of the nose are relaxed."

— Exercise with muscles of the tongue: the tongue is pressed against the hard palate and supported with the teeth. Then the tip of the tongue is slid across the soft palate, all the way to the back. Text: "The tongue is tensed." Then, relaxing the tongue, it is rested on the bottom of the mouth cavity. Text: "The tongue is relaxed."

— Exercise with the jaw muscles: teeth are clenched, lips are closed. Text: "Muscles of the jaw are tensed, teeth are clenched." Then the lower jaw is relaxed, teeth and lips are slightly opened. Text: "Muscles of the jaw relax."

— Exercise of the muscles of the vocal cords. Text: "Now I'm thinking of the vocal cords, I'm trying to control them, influence their activity." After inhaling the client tautens his/her vocal cords (glottal spasm), followed by gradual relaxation and exhalation. Text: "I'm relaxing my vocal cords, now they are slack."

— Exercise with neck muscles: it begins with turning the head from left to right. Text: "I'm turning my head left and right, my neck muscles are loose. I'm tensing my neck muscles, then relax my neck muscles." Then the hands are linked at the back of the head, the head is dropped forward, and the head is slowly lifted against the downward pressure of the hands. Text: "My neck muscles are tensed." Hands are dropped and the lowered head is turned left and right, backward and forward. Text: "My neck muscles are relaxed."

— Exercises with abdominal muscles. Text: "Now I'm thinking of the stomach muscles, the stomach muscles are relaxed, I tense the stomach muscles, the muscles are hard, the stomach muscles are relaxed." The client is asked to draw

in his/her stomach as much as he/she can, then slowly let it relax. We observe the feelings, the work of the abdominal wall (its outward and inward movement).

When doing the exercises, it is important to always try to keep those muscles of the face and body in a relaxed state which we do not wish to tense. During the slow execution of movements breathing is calm and regular, and we focus our attention on the group of muscles exercised. This leads quickly to conscious experience of events coincident with the tensing and relaxation of given groups of muscles. After a certain number of relaxation exercises, when conditioning, using appropriate formulas, has been completed, all muscles of the face and the body can be relaxed at the same time. Text: "The facial muscles are completely relaxed, the muscles of the body are completely relaxed."

Recital is slow and well articulated, text is said in one breath (as planned). The number of elements of an exercise is increased gradually. Only one stage is taken an hour. The success of the exercises depends on the work done at home each day (twice a day, in the morning and in the afternoon). Instructions are the same as regards exercises of the arms and legs.

Exercises with muscles of the arms and legs. The basic body posture is an upright position. Arms, with clenched fists, are stretched straight forward. During inhalation we tense every muscle of the back of the hands, the shoulders and the arms, and we hold our breath for a short time. Text: "Muscles of the arms are tensed." During exhalation the muscles are gradually relaxed, the arms are lowered and after a few swings they come to rest in a vertical position by the side of the body. Text: "The arm muscles are relaxed, my arms are heavy."

— The basic body posture in the next exercise is an upright position. The arms are raised above the head side by side, hands are clenched. During inhalation the muscles of the arms are tensed, then the breath is held. Text: "The muscles of the arms are tensed." During exhalation the back of the hands, the arms and the shoulders are relaxed, the arms remain raised above the head. Text: "The arm muscles are relaxed, my arms are heavy."

— In the following exercise we concentrate, whilst walking, on keeping the arm muscles completely relaxed, making the arm move freely in the shoulder joint, keeping the fingers loose.

— Exercises with the leg muscles: the basic body posture is a standing position with legs spread to the width of the shoulders. During inhalation muscles of the feet, lower legs, thighs, and the pelvis are tensed, breath is held. Text: "The leg muscles are tensed." During exhalation weight is shifted to the right leg. The exercise is repeated twice for each side. Text: "My right (left) leg is relaxed and heavy."

— The basic body posture in this exercise is the so-called hansom-cab driver posture. During inhalation muscles of the feet, lower legs, thighs, pelvis are tensed,

feet are firmly planted on the ground, and breath is held. Text: "The leg muscles are tensed." During exhalation the muscles are slowly relaxed. Text: "The leg muscles are relaxed, my feet are heavy."

— In the next exercise stage the basic body posture is a lying on the back position. The arms rest by the body, hands are turned palm down, legs are slightly apart. During inhalation the right leg is raised 90 degrees and muscles are tensed. The exercise is repeated twice and the same is performed with the left leg. Text: "My right (left) leg is tensed." During exhalation the leg is slowly lowered, muscles are relaxed. Text: "The muscles of my right (left) leg are relaxed, my leg is heavy and relaxed."

— The basic body posture in this exercise is a lying on the back position. The legs, bent at the knee, form a 90-degree angle with the ground. During inhalation the muscles of the lower legs and the thighs are tensed, breath is held. Text: "My leg muscles are tensed." During exhalation muscles are relaxed. Text: "Leg muscles are relaxed."

During exercises with arm and leg muscles we must focus on the sensations of *tensing and relaxation in the muscles*.

Logopedic relaxation

We shall refrain from a general description of the methods of relaxation (which includes autogenic training) since they are widely discussed in the literature and are well known.

Logopedic procedures are essentially *adaptations* which preserve the course and structure of the original exercises devised by *Schultz*, but therapists usually make use of only two types of sensation (heaviness and warmth).

Autogenic training is considered today as a non-specific method of treatment, which acquires meaning only if applied together with other methods.

Our *method* differs somewhat from those described in the literature and applied by others.

— We consider the exercises involving the whole organism and the speech organs to be equally important (the framework within which this process takes place is relaxation; the series of relaxation exercises are expected to exert an influence on the individual, on the organism, as a whole);

— there are special exercises for organs and muscles that participate in the production of speech;

— the formulas are said by the stutterer themselves;

— the procedure is a logopedic oriented, didactic method, carried out in treatment steps.

Reasons for the logopedic employment of our relaxation method

There is no attempt to eliminate the causes of stuttering. Our method contributes to alleviating the secondary effects of stuttering, to loosening the psychosomatic frames of symptoms.

It helps adjustment when coordinated with target formulas derived from the exploration material.

It is not a technique, but a treatment process in which the therapist takes part with the whole of his/her personality, and in which reciprocity plays a significant role.

It is a psychosomatic curative procedure, focusing on the regulation of muscle tone. Even by itself it is physiologically relaxing, remedial. Its psychological effect is a pleasant emotional state, tension-free composedness, which does not, however, mean a lack of tone, rather it leads to termination of needless strain. Verbal formulas tend to normalize the tone of striated and smooth muscles, vascular tone, as well as vasomotor reactions.

Through concentrative relaxation the stutterer attempts to bring the disorganized external and internal functions of the body into mental-physical harmony.

Relaxation is the repose of the body, of the senses, a mental tranquility, without the suggestion of passiveness (it increases the tone of activity through the reduction of excess actions).

We classify our method as one of the procedures regulating *psychological tone*. By tuning this tone, by incorporating new elements, we aim to establish psycho-vegetative balance.

The method is effective when applied together with other procedures, and given the client's willing and active cooperation.

For the stutterer *relaxation* means becoming independent as well as a responsible action. Relaxation experience helps the stutterer to grow and to mature, to learn to control his/her emotions.

Relaxation is introduced at the end of the examination steps, in the course of which client and therapist have come to know one another. Thus, mutual acceptance, necessary for treatment, is brought about (or is not, as the case may be). The method, suggestive influencing, works only if the stutterer wants to be cured.

It is particularly important to begin relaxation in a semi-dark isolated room with comfortable temperature. Later, with the development of the so-called internal silence, fewer conditions will suffice. The exercise can be done in a *lying down or sitting position*. In the former case, the client rests horizontally with his/her head slightly raised. The arms lie beside the body with palms turning inward, the fingers are loosely extended, legs are slightly apart, shoulders are slack, teeth are closed but not tightly, eyes are closed. Clothing, shoes, socks should not be tight. The bed should be soft and comfortable, the telephone disconnected.

No one should be permitted to enter the room during the exercise. However, if it is unavoidable, the client should be informed prior to beginning the exercise. The client should not have to leave at a set time, but be able to work without the pressure of time. All his/her muscles must be relaxed, his/her head comfortably supported. If the client is seated (and we prefer this, because it facilitates exercising and also because the client chooses active cooperation despite his/her problems, as opposed to the reclining position which favors passiveness and regression), then his/her arms rest on his/her thighs or the arms of the chair, his/her hands hang loosely between his/her thighs without touching. Knees and feet are kept slightly apart. The head is comfortably supported. The exercise should be scheduled two hours before or after eating, in order to eliminate influence by disturbing stimuli. Clients frequently complain that their mouths go dry, or too much saliva is produced, they have to cough, change position, etc. When discussing relaxation, we tell the client to do whatever relieves their discomfort and continue the exercise.

Client and therapist should take care that when they say the text and formulas of relaxation,

- they speak in a slow rhythm;
- they insert pauses between separate phases;
- the volume of speech is pleasant;
- recital is even, monotonous;
- they pay attention to breath flow (to exhalation, specifically) during speech;
- the therapist's behavior expresses suggestiveness, calmness, assurance;
- the therapist's speech is well-articulated, avoiding emotional excesses;
- the therapist behaves naturally;
- the therapist does not read anything;
- there are no disturbing odors (eau de cologne, perfume, smoke);
- the therapist corrects the mistakes (in the learning phase).

In addition to concentrating on the formulas of the relaxation text, the client must strive to form a mental image of the sensation content of the text. The exercises should focus on one sense at a time, the complete material is taught from one session to the next.

Upon completion of the exercise the therapist queries the stutterer and notes his/her observations regarding the success of the performance of certain parts, development of appropriate sensations, thoughts that disturb the exercise, recurrent images, etc. These observations are appended to the exploration material and interpreted. There may be unexpected failures in learning. People find different things easy or hard to learn. For example, frequently, the client definitely feels warmth in certain parts of the body, but not in others even after long practice. In

such cases, we should not begin to take a new material, or we should hold a break of one or two weeks until the sensation is fully developed.

During relaxation the client's face becomes slack, the lips are slightly parted, the skin is flushed, there is no eyelid tremor, breathing becomes slow and even, cardiac action slows down (visible pulsing of the cervical artery), body tone is relaxed.

The result of relaxation exercises is such modification of consciousness in which the client reaches his/her characteristic, most relaxed state of muscle tone, and thus concentrates on sensations of the given organ. Thus, *with the change in muscle tone, psychological tone changes, too.*

Three stages are distinguished in relaxation treatment. The basic exercise is not directly related to speech. Its purpose is vegetative tuning, preparation for subsequent stages. Thereby it becomes the method of instruction of autoconcentration and somatic introspection, the continuously applied means of direct or indirect awareness of somatic processes, developed through practice.

Intermediate exercise, which follows vegetative tuning, focuses on body parts and organs that play a part in speaking (breathing, jaws, mouth, neck, larynx, vocal cords), thus the verbal character of the exercises is enhanced.

In the course of *advanced exercises* the nonverbal character of relaxation exercises disappears. Based on the material obtained in the exploration, the stutterers themselves define the formulas of intent for their exercises. It is fundamental in the choice and content of these formulas that they promise the best solution to the difficulties of the client.

We give some pertinent information about the basic and the intermediate exercises in the following (the advanced stage is discussed later).

- in the basic and intermediate stages the client performs relaxation exercises. This, usually, means procedures that aim to establish a psycho-vegetative balance with the help of psychotonic tuning;

- basic and intermediate relaxation exercises are constructed to create mental homeostasis. They are a series of concentrated relaxation exercises involving the muscles, blood vessels, breathing, abdominal organs and the mouth-larynx-neck area (they evoke, with the help of a general, internal order, the process of de-contraction);

- relaxation exercise is one of the few psychotherapeutic procedures, where physiological events, underlying psychotherapeutic experiential events, can be traced;

- good performance of the basic and intermediate exercises results in the so-called organismic switch to equilibrium, which means that with practice the client becomes capable of regulating, controlling, his/her somatic and psychological functions in accordance with his/her intentions and adopted expectations;

— the continuous word stimuli (formulas) we employ, cause impulses which may either have a direct vegetative effect or arouse interest, in the case of the latter attention will turn towards the content of the formulas and psychological functions will converge on attention.

In general the following basic exercises are distinguished: development of the sense of weight, development of the sense of warmth, exercises concerning the heart, exercises concerning breathing, solar-plexus exercise, cool forehead exercise.

Here we employ only four of the six basic exercises for treating stutterers. The heart and forehead exercises are left out unless their use is specifically indicated by the client's complaints.

In the following we present the three stages of our logopedic relaxation treatment.

The basic exercises of logopedic relaxation

Before beginning the exercise, we prepare the client by arousing his/her attention and interest. The first step is to describe the goal and methods of the exercise in simple words. Too much information is to be avoided, because it only tends to increase the client's sense of insecurity. It must be stressed that the exercise is a well-known one applied in the case of many children and adults, that practically everyone can do it, because it's easy to learn. Furthermore, its success depends on how the client works. The talk should be bilateral with many questions from the clients and answers from the therapist. Having satisfied the client's curiosity, we begin to work.

The following exercise is employed only in the case of stutterers who are restless, suspicious, afraid to close their eyes, worried. After preparation and instruction, the client, who is sitting in a chair, facing a blank wall, is told to look at a spot on the wall without closing his/her eyes. When the eyes become tired and he/she feels it would be good to close them, then he/she can close his/her eyes and begin the exercise (the neutral spot on the blank wall is important because it does not stimulate, it evokes no associations).

We ask the reclining or seated client (as mentioned above, we prefer the latter position) to let him/her self go completely and act as if he/she were getting ready to go sleep, to forget about daily tasks, events, problems, about where he/she is, to pay no attention to external things, noise, voices, to shut out his/her thoughts, and to pay attention only to his/her chest, to its movement up and down, to its rhythm. We tell the client not to expect the exercise to go well the first time. We call this the "turning inward" exercise. When the performance of one exercise can be relied on, we move on to the next.

Instruction: "Say the words three or four times after me as I say them, then alone." (Only in eight cases out of the 500 I have treated did stuttering occur while saying the relaxation text, and only at first.) Before beginning the exercise, we ask the client not to desire the results from the exercise, but to try to achieve the effect by the repetition of the words and then observe the effect passively.

Text of other formulas: "I'm calm, I'm calm, my whole being is calm, there's silence." This is called the "establishment of calmness" exercise.

— *Exercise with the right hand* (left in case of left-handedness). Text: "My right hand is heavy, my right hand is heavy, it's as heavy as lead, my right hand carries the weight of my body."

— *Exercise with the left hand*. Text: "My left hand is heavy, my left hand is heavy, it's as heavy as lead, my left hand carries the weight of my body."

— *Exercise with right leg*. Text: "My right leg is heavy, my right leg is heavy, it's as heavy as lead, my right leg carries the weight of my body."

— *Exercise with the left leg*. Text: "My left leg is heavy, my left leg is heavy, it's as heavy as lead, my left leg carries the weight of my body."

These are the "weight exercises", which are followed by the "warmth exercises".

— *Exercise with the right hand*. Text: "My right hand is warm, my right hand is warm, blood throbs hot in my right arm."

— *Exercise with the left hand*. Text: "My left hand is warm, my left hand is warm, blood throbs hot in my left arm."

— *Exercise with the right leg*. Text: "My right leg is warm, my right leg is warm, blood throbs hot in my right leg."

— *Exercise with the left leg*. Text: "My left leg is warm, my left leg is warm, blood throbs hot in my left leg."

— *Solar-plexus exercise*. Text: "The pit of my stomach is getting warm, my belly is getting warm, the warmth spreads through the pit of my stomach and my belly."

There are no breathing exercises here. For explanation see chapter on breathing exercises.

These *basic exercises* last for approximately five minutes. What is important here is not clock-like precision but the quality of the sensation. The therapist must refrain from helping the client. In any event, clients soon learn time relations. Completion of the exercises is followed by *retracement*. Text: "The feeling of warmth has ended." Move your arms vigorously, take a deep breath, open your eyes, stand up!

Retracement is important, otherwise the hypnoidal state may persist and lead to unpleasant after sensations, reducing the effect of relaxation.

In teaching this part of the exercises so-called auxiliary illustration, specifically, visual and situational examples and references may be used to help clients understand the exercises. For example, "Try to be as relaxed as if you were lying on the beach sunbathing, with no one around." Or, "Think of the forest where you once took a walk. You're now in that forest, walking, with plenty of time, you're happy." (It is a general experience that the therapist's powers of creating a suitable atmosphere, his/her empathic ability are very important in bringing about the client's "regression".)

Teaching the elements of the basic exercises (there are eleven in all: introversion, feeling of calmness, feeling of heaviness, feeling of warmth, warmth of the stomach) takes two-three weeks. Each element is practiced for five or six minutes. However, with the addition of new elements, in order to save time, it is advisable to reduce the frequency and duration of practice of earlier elements. Consequently, when we begin to practice experiencing the feeling of warmth, first the time devoted to introversion, followed by the "I'm calm" formula, is reduced to one minute. After a while these states, feelings, develop quite fast, taking less time than was necessary originally. The stutterer learns to pay attention to him/her self, furthermore, the performance of this task is also ensured by the other exercises. The same holds for the heaviness and warmth exercises. When we begin teaching the sensation of warmth, the formulas of the sensation of heaviness are repeated only three times, after a week only twice, after another week only once, and finally after the third week only the first part of the formula needs to be said. It is important to pause between the individual exercises, because that is when the client fixes in his/her mind, "raises into consciousness", the effects produced by the formulas. This is not possible when the text is said fast and mechanically, because then the individual elements become indistinct. Each formula expresses what the given exercise is expected to accomplish. When saying the text, these expected effects must be given greater emphasis. In the basic exercises these are *calmness, heaviness and warmth*.

When, in retracement, we reach the stage of saying only the first line of the formulas, we can activate performance of the exercises, i.e., clients can do them anywhere, in any situation, *under any conditions* (in school, on the job, travelling, before a test, etc.).

Following the basic exercises, *voicing* is taught. (For more detailed treatment, see the part on exercises promoting speech confidence.) The essential thing is to do this exercise in the state that develops after performing the basic exercises. The goal is to make the client experience the sensation of voicing, lack of obstruction, *continuity of airflow*. The time allowed for the practice is 3 minutes at the most (we must pay attention to hyperventillation and pauses).

To summarize, after retracements, the order of basic exercises is as follows: introversion — pause — I'm calm — pause — my right hand is heavy — pause —

my left hand is heavy — pause — my right leg is heavy — pause — my left leg is heavy — pause — my right hand is warm — pause — my left hand is warm — pause — my right leg is warm — pause — my left leg is warm — pause — my stomach is getting warm — voicing.

Intermediate exercises of logopedic relaxation

We can begin the instruction of intermediate exercises when the client performs the basic exercises, their retracement and activated forms, efficiently. The instruction is prefaced with a suggestive introduction wherein the function of breathing, the lungs, jaws, lips, the vocal cords and the larynx is explained. It is very important that the explanation be adjusted to the client's age and education, as well as be interesting. It should be kept short and simple, avoiding technical terms, and be illustrated. We should lay special emphasis on the role of each in speaking. The simple mechanism (symptomatology) of stuttering should be similarly described.

Before each of the intermediate exercises the client is told to "recall" the image of the part of the body involved (an image of his/her own or someone else's lungs, chest, jaws, mouth, neck, larynx, vocal cords, as seen in the mirror, a picture or a drawing). Evoking this image helps to define, stress the significance of and reinforce the exercise. After long practice, image recall of the appropriate part of the body will automatically reel off the exercise (this will acquire significance in the client's independent work, and in the preparation for difficult situations that cause blocks). Image recall enables the client to review the critical situations, and, by doing the appropriate exercises, focus on probable expectations and achievements.

Intermediate exercises follow one another in three stages.

— *Breathing exercise.* Text: "My breathing is even and relaxed, air flows unimpeded from my lungs."

— *Exercise with muscles of the jaw and the mouth.* The jaw is lowered, so that teeth and lips are parted, muscles are not taut. Text: "Muscles of the jaw and the mouth are relaxed, muscles are soft."

— *Exercise with the neck and the larynx.* Text: "Muscles of the neck and the larynx are relaxed, they are swinging, air flows easily between them."

Here, too, it is important to *emphasize relevant parts* of the formulas. In the three stages these are: even and relaxed, relaxed and soft, relaxed and air flows easily between them.

The practice period of the intermediate exercises is longer (4 weeks) than in the case of the basic exercises. The reason is that the latter involve separate body

parts (legs, arms), whereas the former involve organs embedded within the body, so there is no immediate effect. These exercises demand great attention and concentration from the client, and a great deal of help from the therapist. In this part clients ask many questions concerning the result, the sensation. Many clients do not consider the exercises efficient and good, because they compare the effects accomplished here to the rapidly achieved and characteristic sensations of the basic exercises.

Each of the intermediate exercises is practiced for five minutes. As in case of the basic exercises, "retracement" begins only after the exercises are completed and firmly established, and the effects of the verbalized formulas are distinguishable. Pauses are important here, too. The retracement course of the intermediate exercises is: image recall, even breathing, pause, image recall, relaxation of the muscles of the jaw and the mouth, pause, image recall, relaxation, swinging of the muscles of the neck and larynx.

Following this the exercises can be activated. All exercises, including the basic exercises, are performed continuously. Beginning with the intermediate exercises, the client takes the lead in structuring, controlling, supervising, evaluating and correcting the individual exercises. Concomitantly the therapist is relegated to the background. In view of the fact that the goal is to help develop an autonomous system, it is necessary to ensure, at this stage already, the client's self-direction and independence.

The precondition of starting the advanced exercises is the steady, efficient performance of basic and intermediate exercises, in retracement as well as in activation.

Advanced stage of logopedic relaxation: intent formula exercise

Basically, relaxation methods, which include autogenic training, do not use verbal techniques. However, verbalization, systematic treatment of the client's complaints, feelings, difficulties, conflicts, are an absolute necessity in the later phase of therapy. This means dealing with everything that, as a result of stuttering, has become superimposed on, incorporated into the personality and achievement, everything that widens the range of symptoms and aggravates complaints.

In the advanced phase of treatment (meaning the second year of our complex treatment) nonverbal procedures are replaced with formulations of intent.

Application of intent formulas is indicated when the need to dissolve blocks in speech behavior, or contact disorders caused by speaking, arises.

Intent formulas are based on current information obtained from the consecutive interactional, explorational talks between client and therapist. Topics of these

talks are conscious and ideational, they correspond to that medium which, owing to consciousness, is characterized by the mental components of empathy.

Explorational talks are based on information derived from three sources:

- during the first year of treatment, preceding the present phase, data is accumulated, which provides the basis for establishing interactional relation;
- biographical exploration (relationships, affiliations, formal and informal associations);
- current or permanent conflicts, tensions, events, awkward situations, failures, successes, etc. that the client is cognizant of, which are brought about by chance acquaintances or in chance circumstances of everyday life.

The first and second sources provide the orientational framework of the stutterer's system of affiliations, the third provides the units of explorational talks. We call them units because they are condensed expressions of the client's difficulties. They have no continuity, rather they come into relief against the background of the influence of the individual's characteristics. We do not aim to carry over the discussion of a topic from one session to the next, a new topic may be introduced at each session, however, we must note that the changing mantle of the phenomenon conceals the same characteristic tendencies.

What explorational talks reveal are not the causes of the symptoms of stuttering, but the modes of maintenance, fixation of these symptoms. In the course of explorational talks the therapist helps the client to recognize those of his/her own emotional, affective reactions, as well as the external influences and situations, which act unfavorably on his/her adjustment and achievement (meaning not only speech, since speech is only a part of this achievement network).

In the course of explorational talks the stutterer reveals facts about him/her self, which tell of the actual or permanent difficulties, clusters of conflict, that maintain complaints. However, these may not become manifest immediately, it may not even be possible to explore them on the first occasion. The client's defense mechanism acts to drive some intolerable biographical fact, namely, the conflict, from the conscious mind, tries to transform it, consequently, the client does not even mention it (repression, avoidance).

The so-called intent formulas serve to dissolve the difficulties expressed (discussed) by the client. This constitutes the last episode of our relaxation therapy. These intent formulas are not the same as the formulas. The latter contain general material applied equally in every case. The former, however, are chosen and phrased by the stutterers themselves in such a way as to provide the greatest chance of solving a the given task, complaint, difficulty, etc. The client will use these when he/she deems it necessary. Since this as well as the other relaxation exercises are "incorporated", i.e., are "always on hand", the client can use them at any time, in any situation.

In the intent formula we work through the psychological symptom of blockage, the behavioral trait of insufficiency. The fact that the client has always said something other than what he/she felt and would have liked to say, shows that he/she maintained a "to be something else" process which inhibited the development of identification. As a result, the stutterer's contact, realization and speech behaviors became blocked, leading to the "what I am and what I would like to be" dilemma. Intent formulas must balance this difference.

Real unsatisfied desires, psychological deficiencies, unfulfilled lives are the reasons underlying the symptom of insufficiency. The client's symptom is founded on actual fact (stuttering), and the symptom formation was started by a contact disorder caused by speaking. Working through this and phrasing the intent formula takes place as part of the explorational talk between client and therapist. The objective is to reduce, equalize the difference in the idea, feeling, of "what I am and what I would like to be". The conversation is based primarily on information derived from the client's psychological life space. The questions raised by the client are discussed by client and therapist in the course of the dialogic exploration(s) (the medium of discussion and interpretation is the self). Since these discussions involve concrete events, the conclusions of analyses (expressed by the client) must also be directly applicable to the client's life.

The phrasing of intent formulas, their incorporation into the exercises, is started in the second year of therapy. By this time the client has completed the basic exercises of autogenic training and conducted a number of explorational conversations with the therapist. To be specific; by this time:

- the client has greater self-knowledge, a greater awareness of his/her actions, characteristics;
- the client has a positive experience of the results of treatment (so we can count on his/her incentive);
- the therapist is usually well-acquainted with the essence of the client's complaints, their motivational background (thus a part of the explorational material can be summarized).

What should *intent formulas* be like and how to phrase them?

- The intent formula should be brief and simple (three sentences usually suffice).
- The content of the sentences should show logical relationship.
- Intent formulas are practiced in the same way as the formulas.
- Texts should have rhythmic cadence (for easier learning, regression in thinking, thinking in terms of visual images).
- Intent formulas must not contain prohibition, only such positive goals as the client wants to achieve, with which he/she needs help and reinforcement of the self.

— Age limits to the application of intent formulas is always determined individually by the client's maturity and level of the incentive to cooperate.

— The substance of intent formulas must always be discovered by the client in the course of the dialogic talks, in addition, he/she must also phrase them (initially, in the case of the first intent formula the therapist exemplifies how it is done).

— The intent formula must be adjusted to the given situation (for this reason, in accordance with the different block and problem situations, or feelings, the client should phrase several intent formulas, one for every situation, which he/she will incorporate, with the therapist's help, in the exercises).

— By this time, both client and therapist must have a clear picture of the client's difficulties, complaints, which he/she wants to change because they obstruct the course of his/her life (we may ask the client which problem, complaint, he/she feels to be the most disturbing, and in the course of analyzing that complaint, make him/her phrase the first intent formula).

— It is standard procedure to work out, define as many intent formula to solutions as there are difficulties perceived by the client (naturally there are many common factors, therefore, too many intent formulas serve no purpose).

— In the first sentence, the idea, the intention to be grasped and attained should start out from a general premise, everyday human experience. The client must know and feel what is common, natural, what the norm is in human culture. Thus, his/her intention will become something very naturally desired, since "it's present in every person" (in this way the client's feelings, thoughts, objectives to be attained, become rid of their tension load).

— In the second sentence the client formulates the will of his/her self, i.e., what he/she wants to accomplish.

— In the third sentence client formulates how he/she wants to accomplish his/her goals (the 'how' can only be something the client has already learned in the course of treatment, thus he/she possesses the "means" by which he/she can now put them to work).

Case history: 17-year-old boy, whose first verbally expressed difficulty is, "I'm afraid to speak in front of others".

Since when?

— I started to stutter a very long time ago, but it did not bother me. The problems began when a new teacher came to the class.

— *You had no problems with teachers before?*

— No, everybody knew about my problem. They knew me and I knew the teachers. I think there was tacit acceptance of the situation.

— *Did the new teacher say something about you?*

— No, nothing. But once, when he turned unexpectedly to me and asked something, then, hearing my faltering response, I saw the surprise on his face, and, I don't know why, it disturbed me deeply.

— *So he didn't say anything, but listened patiently to you.*

— Yes, in fact, though my answer was correct, he didn't say anything, but went on to question the others.

— *Is this when your difficulties of speaking in public began?*

— Yes, I began to feel difficulties where I never had any before, with the new teacher too, though he never made any comments.

— *What did this event mean for you? What do you think about it?*

— I began to see something I had always suspected, but was not consciously aware of. I saw my stuttering in a new perspective. The event was like the "unveiling of a sculpture", and I began to remember earlier events, remarks which, now I know, concerned me, my speech, but were not, at the time, unpleasant or painful. I wasn't even touched by them. But this event made it clear for me what people thought about me, what they said or did not say; I became aware of my handicap, I began to think about it, I wanted to know about stuttering. I observed others, but above all I observed myself. I began to think and hesitate before speaking, which was so easy to start before. Now I began to weigh what will happen if..., etc. So I changed and turned inward.

— *Did it also affect your personal relations?*

— Only partly. The situation was better, it wasn't so extreme when I was with my parents and friends. It was only difficult in strange environments, in front of strangers, in front of several strange people, when all attention was focused on me, when I was left to myself, when I had to do the speaking.

— *What characterized your behavior after this?*

— Withdrawal, not showing myself, unobtrusive presence, I would have liked to disappear altogether.

— *Was this conscious or not?*

— Conscious, of course. When I didn't speak in public, I had no complaints, so it seemed expedient to choose this course, this behavior. It seemed a simple solution at first. The problem arose, and it still exists, when I had to speak, it was unavoidable, or when I wanted to take the initiative, with a girl, for example, and stumbled on my handicap. Here the solution I chose was no solution at all, but an obstacle I was unable to surmount.

— *What did you feel at such times?*

— I was sad, defiant and tense, alternately, because I felt, I knew, that this way I will miss my chance to do what I want, I will not achieve what I would like to because my wishes will remain unfulfilled or only partly fulfilled.

— *Do you still feel like this?*

— Yes, this is my biggest problem. Every public appearance is a great ordeal, another failure, another disaster for me, a setback.

— *But after a while you try again?*

— Yes, because with this impossible feeling of mine I will find myself in an unavoidable situation again, there's simply no other solution, because one has to speak, it's impossible to live without speaking.

— *You understand the problem, now try to phrase it in three intent formulas, as we have agreed (in a previous discussion), in the way you think best, in the way which will help you most to speak before others.*

— Perhaps the best would be, "everybody speaks", "I also want to speak", "with the methods I've learned, I can speak".

Treatment is then continued. After completion of the basic and intermediate relaxation exercises, the client remains in the same state of physical and psychological relaxation, and speaks about (talks out), anticipates and minutely describes — in order to free his/herself from it — the material, tasks, situation and experiences which pose difficulties along with their image recall, actors and emotional-affective influence. Since the stutterer experiences (experienced) these situations in several different ways, they can be worked through many times and in several different ways. Consequently, the client does not always talk about the same experience. Only the frame, the situation, is the same, not the content, which is always different. After each case the client selects and phrases his/her intent formula.

If new sensations, or ideas, are not found in a given material, the client is free to apply the intent formula (until the appearance of another difficulty) when he/she deems it necessary in other situations (either with or without the basic and intermediate relaxation exercises, but always along with the introversive exercise).

After talking out and relieving him/herself of the material representing a difficulty, client and therapist analyze the subjective evidences obtained. Unrealities with an emotional-affective basis and their consequent inadequate mental stereotypes must be acted on.

For example, a common factor in the clients' material is the mental stereotype known as the absolute solution of things or events. Clients believe that things have only one good solution, and they have to adjust to, or find, this single absolute solution. And, if they fail in this, their efforts, intent to change come to naught (it is quite likely, their opinion that there is only good or bad speech supports the development of this stereotype). This way of thinking leads "naturally" to a continuous sense of failure, thus, of course, no change takes place, and the goal, "what I would like to be", will be beyond reach.

Influencing breath flow

There are widely different opinions about the breath therapy of stutterers. The disorder of the respiratory function is prominent for stuttering, and is for this reason considered — incorrectly — its cause, therefore, direct treatment of the disorder is believed to be the single method of curing stuttering. This is a mistake.

Let us emphasize that *separate breathing exercises are not always indicated*. Basic and intermediate relaxation exercises exert a beneficial influence on respiration, too.

Regularity and the gradual development of the exercises, daily repetition of the formulas control breathing in a direct manner. However, if examination data so indicate, special breathing exercises can be introduced. A few of these are described below. We teach these exercises after the relaxation and before the speech fluency exercises.

Exercises of the diaphragm and respiratory muscles based on relaxation. The basic posture is a lying on the back position with the left-hand resting on stomach, the right on the chest. When client's breathing becomes free and easy, the formula is said: "My breathing is even, calm, continuous." This exercise takes four or five minutes. In the next stage posture remains the same. After a deep exhalation we inhale slowly pushing the stomach out (breathing through the stomach), the diaphragm moves downward. Then we expand the chest: the clavicles and the shoulders are slightly raised and the apex of the lungs fill completely with air. At the peak of inhalation we hold our breath for two or three seconds (to feel the strain), then breathe out without effort, let the shoulders drop, the chest muscles relax (feeling the gradual loosening, slackness). The text here is: "All my respiratory muscles are relaxed." When the next involuntary inhalation begins, the above are repeated. Usually ten or twelve respiratory cycles are performed at a time, with special attention to hyperventilation.

— *Instinctive individual rhythm.* This means that the therapist does not wish to enforce some predetermined rhythm of breathing but rather allows the client to find, without any activity, his/her own rhythm. No direct influence is exerted on breathing, since its disorder is only considered as a secondary symptom in the syndrome. In speech modification the therapist should take care that the client's attention does not fixate on the mode(s) of inhalation and exhalation. Before starting treatment the therapist should describe the physiology of breathing, its role in speech and in the case of stuttering.

— *Indirect influencing* is accomplished by singing, recitation of poems accompanied by movement.

— The *length of phonation using words* is gradually increased.

— *Use of support in breathing* (with hands placed on the lowest ribs). It promotes and unconsciously controls breathing if the client is called on to look at appropriate geometric figures and incorporate the image. Thus, for instance, an upright triangle means breathing through the stomach, while turned upside down it suggests breathing through the chest.

Spasm analysis

Our method of spasm analysis deals with muscle sense on the one hand (a) immediately *preceding* speech spasm, (b) *during* speech spasm, and (c) immediately *after* relief of speech spasm, and with the sense of the spasm of the vocal cords, on the other.

What we are investigating is the path leading to the spasm of the vocal cords, the muscle sense characteristics preceding it, and the subjective experience of the spasm itself, of the realized block. The area of investigation is primarily the *face* and, to a lesser extent, the *neck*, together with the muscle sense characteristics that accompany speech block and are localized there (other areas that speech block may also affect are left out of consideration here).

Treatment of spasm analysis in the literature:

- generally, it is called block analysis or self-analysis;
- subjective experience, i.e., what the client says, feels (as opposed to instrumental muscle examinations) supplies the material;
- desensitization is interpreted as an independent therapeutic consideration;
- recently, communicational research, in particular the significant difference in orofacial characteristics, have reinforced the importance of spasm analysis.

Our investigations show that stutterers define three different muscle sense characteristics in their subjective reports (stretching, contraction, surplus sensations), which are localized primarily on the face and, to a lesser extent, on the neck. That is to say, when speech is blocked, muscle senses come to dominate areas affected by speech and show different values during the block stage. This quantitative manifestation and distribution is a *spasmodic expression of the stuttering mechanism*, a peripheral sign accompanying the regulation of tone.

Indications and conditions of the application of the method:

- the method is suggested only in the case of stuttering, not in cases of concomitant speech defects (jabber, lisp);

— an anamnesis of several years is required (it is counter indicated if stuttering is recent);

— verbal definition, localization and the nature of the subjective experience of muscle sense in stuttering constitute the material;

— it is also suggested in the case of stutterers who do not experience muscle hypertension, in so-called symptomless cases;

— the sense characteristics obtained (stretching, contraction, surplus sensations) are treated uniformly, and they are always considered as manifestations of spasms;

— the method belongs to relaxation and speech procedures, the length of their application is decided on by the therapist;

— although the number and distribution of the sense characteristics is always different, the exercises are designed to cover the "functional whole" and not merely a restricted area;

— effects of this method are incorporated into our complex procedure; the method is expected to accomplish recognition and thereby *control of parasitic surplus sensations and movements*, as well as desensitization of the spasm experience.

Main steps of the spasm analysis method. Required steps preceding suggested method of application:

— the stutterer has to study his/her speech and the concomitant sensations, situations, circumstances when blocks occur, as well as the secondary symptoms, concomitant somatic signs, and take note of these, which he/she will then discuss with the therapist;

— the stutterer must spend a lot of time in front of a mirror on a regular basis (eating, studying, reciting his/her lessons, acting out situations);

— for approximately one month before starting spasm analysis, the stutterer must make daily tape recordings of his/her speech and play them for him/herself (he/she must come to know the external and internal relations of his/her way of speaking, the external and internal sensations, experience and the visual impression of stuttering, of blocks, and compare the differences between speaking out loud and internal speech).

The method of spasm analysis, including the so-called required steps, should take no more than two to two and a half months.

— working through conscious recognition and verbalization of muscle senses occurring in the various phases of stuttering (before, during and after) (ask client to make a drawing of the perceived area, too);

— observation and identification of characteristic sense signals and their combinations in the mirror during speech;

— when muscle senses preceding stuttering appear the client must stop speaking, and during the pause continue the experience, anticipating what will take place in fact;

— let us separate the block and spasm sensation from the articulation sensation;

— concurrent observation of the block complex (totality of muscle sense signals) and articulation in connected speech. It is particularly important that the client attends to the sensation of sound, and not to just hearing it;

— the client is told to note the errors he/she makes in voice, articulation and movement (this is based on a comparison with the tape recording making it a life-like confrontation).

Precise distinction of the individual muscle senses that occur in stuttering (individual senses, their combination and total senses).

— Task: "Stutter on purpose then compare it to unintentional stuttering. Note what it is you're doing wrong when you speak, when you stutter, and put it into words."

— The stutterer must observe what happens, what he/she feels in the speech muscles when he/she stutters: around the lips, in the tongue, neck, larynx, on the face.

— When the client discovers and puts into words what he/she is doing wrong, what he/she leaves out of the correct act of speaking when he/she stutters, he/she must compare it to his/her experiences gained in the course of connected speech. The result of the comparison is modification of incorrect speech behavior.

— The stutterer must observe and compare imitated and non-imitated stuttering.

— The stutterer must observe him/herself in the mirror when he/she is stuttering voluntarily — he/she must not stop speaking (continuous feedback); during observation speech must be greatly slowed down, so as to trace development of the presentiments of block formation. There is plenty of time for pinpointing what he/she is doing wrong in the planning and execution of speech.

— In intentional stuttering not one single block, but a series of blocks should be produced (once one series of blocks is formed, the client should not stick with it, but continue speaking, so that repetitions do not interrupt aural feedback).

— The duration of blocks should be monitored (without using instruments) in order to achieve their gradual reduction (in time and spasmodic violence).

— Movement senses, deviations of one side should be counterbalanced, "all senses should be transferred to the other side".

— Changing the direction of given muscle senses with the help of mental pictures.

— Correct and incorrect (stuttering) speech is compared again, the result of which is that the client learns to *erase*, to abandon what is not needed in speech production, to *remove* deficient block formation.

— At the first possible moment after the stuttered utterance the client must stop to analyze the faulty move then repeat the whole word (not the sounds) in a slow, continuous, so-called *gliding manner* (slowness is important in this situation, but the client should not normally speak like this).

— During the pause following the block the client must think over and plan the solution to the speech behavior task. This is comprised of two elements: one is by relaxing the larynx, the mouth, the mandible and the tongue; the other is to merely flatten the tongue and let the root of the tongue relax toward the larynx. After we have gone over and worked through and tested in practice every step of the examination, we close spasm-analysis with a condensed technical fixation on them. The client then uses it as a technical element of speaking or independently, as part of the basic relaxation exercises as a so-called combined element. Stages of the technical element:

- presentiment of stuttering;
- conscious awareness of stuttering;
- stopping in speech;
- waiting (during which time the following are done: creating a sense of neutrality — relaxation — placement of the tongue);
- exhaling breath, and starting to speak with only a very small amount of air;
- gliding manner.

The most frequently used therapeutic instructions are:

You must acknowledge that you stutter.

Don't act as if you were a fluent speaker (it reduces sensitivity to the fear of speech).

Stutter intentionally and willingly.

Always look into the eyes of the other, even when you stutter.

Do not forget that you are your own therapist.

Stutter openly without hiding.

Try to stutter as slowly as you can.

Speak in a solid, deep, "massive" voice.

Accompany your speech with many small gestures.

Do not repeat anything.

Pay attention to continuity, do not restart speaking, or the thought, from the beginning.

Resist the pressure of time.

Do not let the person, rank and position of the interlocutor influence you.

Distance yourself from the situation (emotion, tension).

Write a list of your difficulties due to your speech problem, and, when you have solved one, cross it out.

Spasm prolongation

General aspects

— This stage is closely related to spasm analysis, the promotion of speech confidence and speech analysis elements of our complex method.

— Employment of this stage is suggested primarily in the case of stutterers who show tonic symptoms.

— Effect of this stage is incorporated in the result of the complex method as a whole, i.e., *by itself it is of no use*.

— A precondition of performing the exercise is that the stutterer know the place and character of muscle senses that immediately precede stuttering (pressure, contraction, twitching, numbness, tautness, trembling, excess sense of discomfort).

— The therapist should tell the client that in the formation of a spasm there is a relationship between the force of the pressure and muscle contraction. The greater the pressure on the muscles, the greater the contraction, and the spasm remains. For this reason the client must not try in this way to “dissolve” the spasm by pressure, by effort, to “get the sound out”.

— In the course of the treatment the client must periodically practice this stage (homework).

Goal of the exercise

With spasm prolongation we wish to reduce conscious monitoring of the entire process of spasm development (muscle sense), the strength of the developing or fully developed spasm, spasm complex, disposition to spasm, or, in other words, to teach the client the conscious perception and monitoring of the fluency of speech.

Spasm prolongation modifies or interrupts conditioned spasm development.

Methodological steps of spasm prolongation:

When the client perceives muscle senses that introduce blocks, or stuttering, he/she must stop speaking (first of all he must grasp the I-felt-and-heard-a-spasm moment). If he/she cannot do this (and much practice is needed to be able to consciously perceive this moment), then he/she must stop the moment he/she finds him/herself "in the middle" of the spasm, the block (at first this is not always recognized either).

— *First task.* During the "waiting" period, after the client stops on perceiving muscle senses, he/she has to achieve *somatic-psychological relaxation*. To do this he/she has to apply his/her intent formula or the formula used in a relaxation exercise, namely, "muscles of the neck and larynx relax, swing, the air passes easily between them".

— *Second task.* In the state of relaxation the client is asked to exhale as if he/she were trying to warm his/her cold hands with his/her breath. To exhale only a little air is needed (this is important because a little air exerts a pressure on the muscles which results in muscle contraction). Breathing out should be even. This step is done several times during the practice in order to make the client feel the smooth, unobstructed passage of air.

— *Third task.* The warm exhaled breath is softly and gradually voiced. This step is done several times during practice. The client is asked to observe the transition from exhaled breath to soft voicing, the perceptible difference between them.

The voiced-voiceless ratio is changed in accordance with the exercise (the goal is to gradually decrease the voiced part).

— *Fourth task.* From voiced air, without pause, the so-called prolonged-gliding first sound of the utterance is formed (the sound has to be round and deep). Since a spasm is most likely to occur at this point, the client, paying attention to the muscle senses which indicate the development of a block, must prolong and glide the sound as long as the spasm or the chance of one exists.

— *Fifth task.* The client must start to speak by checking velocity. In addition to a conscious slowing down of speech, this also involves the production of softly and fluently formed vowels.

Summarized course of the methodological stages of spasm prolongation:

- perception of muscle senses indicating a block in speech;
- stopping to speak;
- achievement of somatic-psychological relaxation;
- breathing;
- voicing;
- prolonged-glided sound;
- checking velocity of speech.

Exercises promoting speech confidence

For a long time speech exercises constituted the best tested part of stuttering therapy. Their significance, however, has been reevaluated. The exercises presented below are not exercises in articulation, or in the technique of speaking, instead they treat *speech as the means of expressive behavior*.

The following are general rules for employing the exercises promoting confidence in speaking:

- it is important not to stress the independent role of speech;
- speech must always accompany movements, activities, be based on situations (because for every situation there is a linguistic complex, a series of linguistic signs, as a result of which speaking takes place with the help of a number of elements);
- do not teach unnatural ways of speaking, because it only enhances the client's feeling that he/she is different;
- do not regulate stuttering, accept it as a positive solution; *whatever solution* the stutterer uses, it is a good one, he/she must not think that there is only one good solution;
- do not correct, nor allow the stutterer to correct, his/her speech; lack of fear of speaking (even if not fluently), self-confidence are emphasized;
- do not give examples of reference for speaking; the client must *relate to him/herself*, to his/her achievements, interiorized speech patterns;
- always adjust utterance and the independent and collateral speech exercises to the client's somatic-psychological autoregulation developed in the course of relaxation;
- whenever justified, practice everything in question and answer situations (in pairs or groups).

The *main steps of the exercises* promoting confidence in speaking are as follows (the material should be employed in stages, a step by step progress is suggested):

- “*repeating*” *infantile speech development*. The client and therapist are in *close physical contact* (body warmth, embrace suggesting security, rhythmic movement indicating situation of comfort) and move together in gentle rhythm (resembling rocking movement). In case of adult clients an intimate atmosphere is created. At the next stage this is supplemented with a soft “purring” sound heard only in exhalation (sound of comfort). The third and last episode is the so-called contact sound. The client and therapist look long into each other's eyes, studying, contemplating, smiling at one another; the child must be made to feel safe (relieving), they laugh without reserve, easily (“gurgle”);

- imitation of *inarticulate* sound sequences (not sounds);
- imitation of *articulate* sound sequences;
- imitation alternately of *articulate and inarticulate* sound sequences appearing then disappearing;

— “the *sound appears*”: The stutterer stands with legs slightly apart, eyes closed, shoulders dropped, mouth slightly open, the fingers of the right hand are spread and placed over the stomach, fingers of his/her left hand are spread and placed on the chest (the reason for spreading the fingers is to perceive the movement of as large an area as possible). During inhalation the stomach is gently pushed out, the body moves backward approximately 5-10 cm (feet are firmly on the ground, movement starts from the knees), during exhalation stomach is gently drawn in, body moves forward approximately 10-15 cm. This is followed by a pause of 4-5 sec and is then repeated. The result is a rhythmic sequence of movement. The client is to breathe through his/her mouth. Before beginning the exercise call his/her attention to the fact that he/she must not take deep breaths, but breathe as usual. Care must be taken that the rest periods are kept, otherwise rapid breathing may cause client to feel sick (hyperventilate). In the movement form of the exercise the basic posture is the same as above. After inhalation, when the client begins to exhale, he/she takes a step forward. It is important that the opening of the vocal folds and the taking of the step occur simultaneously. After a rest (of approximately 2-3 sec) the exercise is continued. (This must be done in a large room.) When performance becomes smooth, at the next stage, breath is exhaled in two phases, then in three, four and five phases. Then the exercise is performed with voiced utterance. At first, voicing appears at the end of the exhalation, then gradually the voiceless part is reduced;

— *the sound appears during exhalation*: The stutterer is already seated, and as a result of the forward movement of the body, he/she utters a humming, monotonous sound on exhalation;

- *the sound appears and disappears* (in one breath);
- prolongation of the sound (comparable to the prolonged sound of agreement emitted when we acknowledge something);
- *the sound is uttered* in different pitches with varying duration and accent;
- *rapid alternation* of pitch;
- *humming of a well-known simple tune* (without words, accompanied with movement, in a deep tone of voice);
- *humming of a well-known simple tune*, then changing the tune in some parts, its expansion with addition of new elements thought up by the client (no words are used yet).

Exercises with the jaw. The basic rule is that when the client forms and produces speech sounds, he/she must lower his/her jaw as much as he/she can. The

jaw must move up and down rhythmically, easily, without any strain. It is important that the lowering of the jaw concur with the production of sound (simultaneity). The result will be the production of somewhat deformed sounds and thus mannered speech, but, more importantly, tonic and clonic elements will be suppressed. The stages are:

- stutterers are taught to count with their mouths open, careful about the up and down movement of their jaws (to full width);
- avoidance of excess, so-called parasitic movements;
- basic exercise: counting from 1 to 10, to 20, from 20 to 100;
- when counting is satisfactory (effortless, unhurried, causing no fatigue, *retained in the memory*), we turn to *reading* (the basic rule here is that the number of syllables agrees with the number of jaw movements).

Reading is followed by spontaneous conversation:

- *imitation of speech* with strong articulation (a lot of supportive, expressive movement);
- *inventing simple tunes* (without words, but many movements);
- memorizing the *invented* simple tune and accompanying it with la-la, ta-ta, etc. syllables;
- addition of words to *invented simple tune* (at this point tune is changed, many new tunes are needed): at first the therapist selects a topic, later they define it together and the client invents a new tune (topics are natural, based on the client's characteristics and circumstances);
- *recitative speaking* to an always changing and invented tune (similarly to the operatic recitative). Stages of topic: given topic, defined topic, choice of situations;
- *speech*, tune and gesture variations together: simple tune with added words and movement (application of these elements should be greatly exaggerated);
- “*nonsense words*” and meaningful words are used alternately in speaking (with the condition that the word “nonsense” begins the word or sentence);
- imitation of a *foreign language* (strong accent, articulation);
- *shadowing* (the therapist's words are immediately repeated by the client and supplemented by an imitation of gestures, facial expression, and intonation);
- *doubled speech* (every sound, word is uttered twice);
- *alternating silent and audible speech* (at the beginning of the exercise silent speech prevails, but later proportional relations change);
- *idiomatic speech*;
- strong articulation, *increasing and reducing loudness*;
- speaking with a *constant shift of accent*;

— *interrupted speech* (brief, intentional breaks in speech);
— *imitating speech over a great distance* (strong articulation);
— *imitation of stuttering* (only properly prepared clients can do this, those who are able to face this burden);

— *hailing the moment* when the stutter (block) ends with increasing loudness;

— *association* (exercise starts with the so-called introversive exercise of relaxation, then the client is asked to give his/her associations of specified topics, ideas, to say anything that comes to mind without thinking about it);

— *technique of preparation to speak*: conscious linking of thinking and speech is placed in the foreground, with emphasis laid on the agency of internal speech. *With the conscious emphasis of internal speech we relieve, prepare the client for audible speech.* Going through the stages of internal speech helps level speech-behavioral, i.e., interactional, tension (other elements of therapy also play a part in this, e.g., logopedic relaxation to achieve equilibrium). Thus modulated tensions cannot disrupt the client's cognitive language control, since transformed verbal impulses are sent toward the periphery. Internal speech stages inserted between stimulus and reaction exert an influence on the inaccuracy of the thought processes (e.g., they anticipate difficulties arising as a result of modifications caused by speech problems), improving speech performance (peripheral function). This is achieved in two methodological steps. *The first stage is internal speech*: I understand the question, I organize what I have to say to form a sentence, and say it to myself. *The second stage is audible speech*: I repeat audibly, with strong articulation and jaw movement, the sentence I have said to myself. In the beginning the client must go through these stages regardless of whether he/she knows the answer or not, or whether the task is easy or difficult. The essential fact is the added element of mental effort inserted between stimulus and reaction (question and answer) helps the client to organize his/her thoughts and to put them into a final linguistic form. With practice this will take less and less time. At the next stage of exercise, two sentences are said after a preparatory phase, then three sentences. Afterward only conceptual, thematic units are practiced (naturally, the questions are also more complex), and, following the preparation for connected speech, the client gives his/her answer (articulation, intense jaw movement). Before speaking, the client prepares for speech as follows: "I know what I want to say, it's short and simple, I'll say it to myself, I have air, I'll say it slow and articulate well." He/she says this softly to convince him/herself and then begins to talk.

The courage to speak technique. The exercise is performed after the relaxation exercises. The client, by then, becomes capable of self-regulation and relaxation may form the basis of certain elements of the speech exercises presented below.

Prior to beginning these exercises, client and therapist must discuss them at length, so that the client has a clear understanding of the task and the situation, of what he/she is expected to do.

Once the client understands the task, the therapist withdraws and remains in the background. The therapist must not give examples of reference (i.e., client and therapist must not practice together, not even by way of illustration, it is important that the client be completely self-reliant). The client can relate to his/her own changing achievements through self-correction. The therapist must not avoid the stutterer's questions after the exercises, should he/she have any, indeed, it's a good sign if he/she does. The client must not conclude, in the course of the exercises, that there is only one good solution. He/she must be convinced that every solution is good (and, naturally, his/her performance will improve with practice and training, reinforcing the initial encouragement of the therapist).

The stutterer, sitting alone, performs the exercise in front of a large mirror (approximately 150 x 50 cm). The stutterer, engrossed, contemplates his/her own reflection (this is important, for at this point the stutterer becomes separated from external events and stimuli, given appropriate, helpful conditions).

The performance rate of the tasks is slow, because they are not done automatically, and there is a short rest between sections. Clients do not have to learn and repeat texts verbatim. The essence is understanding. Given that, it's up to the stutterer what he/she says and how he/she says it. Let him/her keep the most efficient variants. Also, underlying each part performed there must be real feeling (i.e., he/she feels what he/she says). Recitation is based on internal speech, and is characterized by persuasion and reasoning.

The stutterer says to him/herself: "I know what I have to do, now I will speak, it doesn't matter if I have problems, I'll prepare myself to speak, I have confidence in myself."

The stutterer says to him/herself: "I free myself of external circumstances. It doesn't matter that my friends, classmates, the teacher are all here now, I will not think of my everyday problems, I'll forget about them, only the task is important now."

At first the situation is not a question-and-answer one involving two people, but a one-person situation in which the stutterer says declarative, descriptive sentences.

In view of the fact that the use of a personal tone is suggested, clients quite often compose their sentences from the tensions they experience in the given situation (as if to transform them). For example, "I'm nervous. My face is flushed. My palms are sweating. This speech situation is difficult."

The stutterer says to him/herself: "I already know what I want to say, I have an idea, I will say it simply and briefly."

The stutterer says to him/herself: "I need air to speak, I'll be careful and plan what I have to say so as to take no more than one breath."

The stutterer says to him/herself: "Before saying aloud what I want to, I'll say it to myself." (This may be done several times, and even accompanied by rhythmic movement.)

The stutterer says to him/herself: "My speech will be strongly articulated, I will pronounce the vowels distinctly together with vigorous jaw movement."

There is one element of jaw articulation to one syllable.

The stutterer says to him/herself: "During speech my lips move forward a little, my speech becomes clear and distinct, my voice deeper, I follow, observe the movement of my lips while I speak."

Clients make up some of the declarative, descriptive sentences themselves. This exercise can be modified and expanded in several ways: it can be done in pairs, singing, as an associational, or as a situational exercise, by role changes, etc.

Movement provides the frame within which the entire exercise is performed, i.e., we rely on movements of the body, the head, on gestures, facial expressions.

For three weeks the exercises are performed daily, then they are done without a mirror, standing and in motion, during much activity.

Emotional speech. This exercise is performed in the presence of, together with, the important persons in the client's psychological life space (parents, friends, classmates, teacher), as revealed by the exploration and the family visits. At this stage conversation and the sessions no longer revolve around some neutral topic.

Adopting roles, role playing. This includes all the material that represent difficulties in the client's life. For example, "I'm a salesman (woman) in a store, whom you dared not ask for bread the other day. Tell me what you wish to buy."

After a while, clients move on from this open, unrestrained situation incurring no consequences, to saying words, sentences, telling events of their own choice, and incorporating them into the exercises. For this reason, from this point on we forgo the use of formal steps, suggested materials, and follow the principle of *self-regulation based on self-knowledge data*.

Speech analysis

The method of *speech observation* has already been employed in the above (spasm analysis, exercises to promote speech confidence), but only as an element of the treatment stages. Conscious observation of fluent speech, recognition of events that lead to incorrect speech behavior, of mistakes, and the development of self-correction, justify its independent application here. With the completion of a number of preliminary stages, the stutterer has come to speak fluently and with confidence, so *he/she must recognize* the inaccuracies of his/her speech and be able to *correct* them.

Although this exercise concerns the technical aspects of speaking, we must not forget that speech is a *means of expressive behavior*.

Speech analysis as a methodological step serves its purpose if:

- the stutterers accept their own voices, speech;
- recognize the phrases, solutions they use in speech;
- consciously apply previously learned speech-technique elements;
- the stutterers know which technical element to apply, where and how, in an appropriate sound and text environment (whether a typical or an atypical case of block necessitates the application of a permanent or a combined technical element).

Technical elements of speech are treated at length in the section about treatment steps.

An advantage of written reports is that, after a while, they help pinpoint the probable “sources of error”.

The speech analysis method is comprised of two stages:

- the stutterer speaks onto a tape recorder (for about 5 minutes, supplying the daily explorational material and his/her internal motivation), then plays it many times. He/she must recognize and analyze his/her mistakes by him/herself, make notes, then discuss them with the therapist;
- similarly to the above situation, the client speaks onto a tape recorder, and when he/she feels that he/she is doing something wrong, he/she stops talking (without turning off the tape recorder), and analyzes the development of the mistake, the incidents causing it. Then he/she outlines the *correct solution*, corrects the mistake and continues to talk (until the next speech event). After he/she is finished, the client plays the recording many times, makes written notes, which he/she will discuss with the therapist.

In the course of speech analysis, the client’s attention must be directed to the following points of consideration:

- the hardness, softness and “flow” of the sound, sound production;
- initiating the sound (“gliding”);
- pauses;
- articulation (“gliding manner”);
- sounding of vowels;
- selection of appropriate speech-technique element;
- putting together the combined speech-technique element;
- process of analyzing the speech event (precedent, consequence);
- combinations of the speech event;

- breathing;
- role of the tongue (“flattening”, drawing back);
- relaxation;
- presentiments (spasm analysis);
- arranging the movements of speech;
- “roundness” of the sound;
- melody, accent;
- speed.

Speech analysis is recommended after the speech confidence exercise, but it can be employed elsewhere and in combination with other exercises as well (it is also a favorite homework).

Speech in relaxation

At this level the client already employs every stage of relaxation exercises as well as conscious speech (which is the total effect exerted by spasm analysis, spasm prolongation, exercises promoting speech confidence and by the treatment steps of speech analysis), but so far there has been only partial linking of these two steps: in case of the relaxation exercises (voicing) and of the advanced relaxation (intent formulas).

For this reason, at this stage relaxation and conscious speech are linked to form an independent, directed stage of treatment. On the one hand the aim is to reduce spasm formations (considerably eased at this stage) that block the speech act, the vehicle of speech behavior. On the other hand, we aim to expand the scope of logopedic methodology, and to further refine adjustment on the part of the therapist, in order to increase the number of methods at the therapist's disposal to influence the various forms of stuttering. Thus the speech in relaxation step partly emphasizes speech (vehicle of speech behavior) in a relaxed state of consciousness pointing toward the “deep layer”, with its concomitant muscle senses, and partly, given an understanding of the speech malfunction, of spasm formation (an understanding of which the client acquires in the course of steps leading to conscious speech), helps to train the stutterer in conscious speech adjustment (prevention of spasm formation).

The effect of relaxation, namely, organistic switch to a state of rest, creates favorable somatic and psychological conditions for the client's conscious, volitional motivation, for diminishing the spasm experience. By expressing his/her muscle senses, the client verbally influences, diminishes the effect of conditioned responses to muscle senses that lead to spasm (block) formation.

This step cannot be used by itself, as it is effective only as a part of the

complex procedure, and it can only be applied after the completion of the relaxation and the conscious speech steps.

The theory of the speech-in-relaxation methodological step is founded on the author's experimental work on oral-sensory factors.

Methodological steps of the speech-in-relaxation treatment stage

Before employing these steps, the therapist must do two things: (1) he/she must discuss in detail with the client every expected methodological step (so the client will know precisely what he/she has to do); (2) the stutterer is asked, as part of the homework, to observe (for approximately one or two weeks) what brings about the speech block, what kind of sensations introduce development of the spasm, whether he/she experiences single spasms or spasm complexes.

The methodological steps

a) After the completion of the basic and intermediate relaxation exercises, the stutterer remains in the same posture (the speech-in-relaxation step must be done in the relaxation position and in the state of consciousness achieved by relaxation) and in his/her own words describes in minute detail:

- what the source of the spasm is, where it leads, how long it lasts, what he/she feels, what sensations introduce the spasm (which inevitably develops), whether he/she experiences single spasms, or spasm complexes, or one big spasm;
- what he/she feels after the spasm;
- what he/she would like to feel instead;
- what he/she would do to change, to end the spasm feelings.

Case history (21-year-old female university student):

"I feel that small pressure, numbness, here in the back part of my tongue, in a small area at first ..., then it spreads, ... it moves slowly forward, ... then my tongue stiffens, ... the tip more so, ... as if frozen, ... my whole tongue is one lump, ... I feel it is bigger too, ... it almost hangs out from my mouth"...

"I don't have these feelings after the spasm passes, ... then my tongue is mine again, ... not an alien body, ... it's sensitive and mobile, as if the ice had melted away" ...

"I like my spasm, I embrace it ... like an enemy I want to defeat it by its own methods, ... I take my spasm (according to a subsequent explanation, this means an exercise of will power), ... I don't let it spread, ... I warm, bend, gently rock my tongue ..., so that it will always be agile and obedient..."

"The air current opens my tongue, ... the air rushes through my mouth, I feel my tongue is soft, I smooth my tongue, I want it to be like this..."

Notes

- The stutterer should perform the exercises after relaxation.
- Usually, the stutterer does not know about these introductory sensations, signs, and will recognize them only after a certain period of observation (NB, some of the stutterers will not have anything to report even after a longer observation period).
- Since there is very little time between sign and spasm, they cannot always be clearly distinguished.
- Frequently, the stutterer recognizes the introductory spasm sign only when the spasm has already developed, i.e., when he/she is already "in the middle of a spasm".
- Voice intensity in describing feelings should be the same as it was when saying the relaxation formulas, namely, soft, whispered, slow, articulated and emotional.
- Description of feelings must be emphatically suggestive, pictorial.
- We have found the most frequent introductory sense characteristic to be: strain, tremor, numbness, pressure, pin prick, tautness (these may occur on one or both sides).

b) The moment the senses introducing the spasm are perceived, the stutterer must stop talking, he/she must never continue into the spasm, i.e., he/she must prevent development of the spasm.

Notes

- Since the speech performance of stutterers is always good (there is no spasm formation) in relaxation situations (and afterward), it would be difficult to practice this method of spasm formation here. Therefore sound places (speech) that according to observations and everyday experience of the client indicate a difficulty, a spasm formation, must be consciously recalled (every stutterer knows well which sounds cause his/her difficulties and where).

The current treatment material (exploration, confrontation) may provide the relaxation topic, with which the client can practice the method of spasm avoidance, but it is always determined by the given situation, case, or by the therapist.

- The client is to phrase his/her observations, because the expression of feelings and thoughts promotes conscious experience.
- There is a conditioned relation between the signs introducing the spasm and the spasm transmitting them. By stopping to speak after perceiving of the signs

transmitting the spasm, we break this conditioned relation, and with subsequent breaks we will not reinforce this conditioned pattern.

— Stopping also means that there is no spasm and so the stutterers no longer hear their own stumbling speech, in other words, there is no aural reinforcement of stuttering.

— Before treatment the stutterer always “entered” the spasm and then tried to overcome the obstruction by a continuous and gradual intake of air. (But since muscles react to pressure with contraction, this obstruction — air pressure situation could not possibly be solved in a “natural way”, thus the feeling of spasm increased “ensuring” the continued reinforcement, maintenance of the spasm.)

c) The client stops speaking before the appearance of the spasm, then he/she must produce a voiceless gentle airflow, a light current of air (similarly to the way he/she blows on his/her cold fingers in the winter).

d) The voiceless light current of air becomes a voiced sound (voice should be deep and soft). With practice and improving speech performance we change the voiceless–voiced ratio by increasing the voiceless light air current and decreasing the voiced part until only the former remains.

e) The transition from light current of air to voiced sound is the critical point, because the air current exerts a pressure on the muscles making spasm formation possible. (In such cases we usually suggest that the client produce a soft, slightly deepened sound, slow down airflow and allow it exert gradual pressure on the vocal cords.)

f) From the light airflow — voiced sound stream we pass onto shaping the first sound, which again is a critical point where spasm formation is possible, due to the fact that airflow and somatic-psychological readiness for action induced by treatment increase tension in the muscles.

g) For this reason we glide air very carefully, slowly, prolonging it, to produce (shape) the first sound (it is important that the client consciously monitor every single element, internal muscle sense, and produce sounds effortlessly with little stress of sound).

h) The first sound is glided until the client feels safely past the possibility of spasm formation, the airflow must be maintained until the sense of spasm has disappeared. (It demands a high degree of consciousness, very fine muscle sensation, to know how long the airflow, and thus the “support” of vocal cords by the air column, must be maintained, in order to feel the gliding pass, avoiding spasm formation.)

i) After the first so-called glided sound speech is continued using the so-called articulation technique.

Note

— Later on, after much practice, when spasm senses and their variants are recognized if they occur in the larynx, the vocal folds, at the back of the tongue, the focus of the spasm “must be moved forward” in the direction of lip movements (with the help of sensation and intent formulas phrased during relaxation), because articulatory movements make monitoring easier (this is supplemented with the so-called articulation technique used in front of a mirror).

The speech-in-relaxation methodological exercises are performed in the case of every spasm formation, but only in therapeutic and practice situations (at home), and as long as the client cannot consciously control the mechanism of spasm formation. Subsequently they are performed only if the client cannot otherwise overcome his/her speech-behavioral difficulties (in this case the client relies on solutions he/she has practiced and learned).

Logopedic confrontation

The behavioral approach in stuttering therapy is widespread, and behavioral procedures are successfully employed in specific therapeutic programs, as in the present case.

The confrontation procedure is related to learning theories, but it also rests on anxiety reduction procedures and counterconditioning. The last one is especially suitable in cases when the individual has problems of self-assertion (assertive training).

Confrontation procedure employed in stuttering therapy aims to influence the stutterer's behavior by way of talking over in a confrontation situation. It focuses on fear reduction in cases of sound, word and contact phobias. The main target is, however, the verbal confrontation of the variants of “speech phobic” behavior, of specific stimuli causing stuttering.

The procedure has no direct bearing on speech technique, for here stuttering is not regarded as a speech defect, but a “manifestation of internalized effects, of incorrect fixations in oral behavior”.

The therapist, in the course of this work, seeks to find and analyze the motives directly or indirectly responsible for speech fear. Recollection of the natural conditions of the experience makes it possible to link, for example, stuttering with the presentiment of stuttering. Therefore, due to conscious anticipation, the stutterer will avoid being intolerant or an anxious underachiever. He/she will be

able to tell whether or not his/her stutter concurs with the appearance of his/her fear of speech, or whether it introduces some topic that provokes anxiety.

The client and therapist discuss the influential effects until there is sufficient material for recognition, acknowledgement. Thus this supportive emotional exploration leads to a confrontation with previously suppressed feelings that constitute the basis of speech fear. Successive confrontations reduce conditioned anxieties, fears, and together they influence behavior.

The method is inefficient in the case of introverted, rigid stutterers, because their resistance, limited manifestations make confrontations leading to recognition impossible.

The *aim of the treatment* is to help the stutterer showing contact-pathic behavior disorder along the road to the intent of voluntary speech, to enduring secondary complaints, feelings, conflicts caused by the speech defect.

Operation of the method. The medium of the procedure is the conscious self, wherein the introspective stutterers, talking about themselves, by expressing their opinion and feelings about themselves, by confronting their own complaints and feelings, find relief in elaborative verbalization, as a result of which subjective evidences become devaluated, diffuse emotions, impulses become subjected to mental control. (Emotions are related to thinking, in other words, we can exercise mental control over our impulses, consequently, newly acquired skills influence, modify emotional tension).

The sphere of indication of the method. It is used for influencing secondary events, subjective resonances caused by stuttering, when inhibition can be eliminated in confrontational conversation, in the case of stutterers (from the age of 14) showing realistic adjustment, adequate behavior and intact intelligence.

The method is used as part of the complex therapeutic procedure, based on the material obtained during the examination phases, and particularly on logopedic exploration and the impression gained from the family visit.

Using this modified variant of the confrontation method, each *secondary difficulty* is treated in five successive sessions, and each time basic and intermediate logopedic relaxation exercises introduce the session. Each session lasts for 20 or 25 minutes, with only the client and therapist present. The confrontation procedure is employed in the second quarter of the second year of the two-year treatment period. By this time sufficient experience has accumulated, client and therapist have come to know one another well, and logopedic relaxation already ensures the internal equilibrium necessary for confrontation.

The so-called secondary difficulties accompanying the speech event are present in every client, though varying in number and extent. By secondary difficulties we mean complaints, speech behaviors (situation) linked to the speech event and expressed by the stutterer, that he/she finds hardest to endure.

Information is obtained from the stutterer's self report, and the regular recurrence of the complaint.

Before beginning treatment, the therapist tells the stutterer what kind of procedure he/she intends to employ and how, given his/her consent and cooperation, without which there is no chance of success. The therapist further informs the client that the goal is to help remedy his/her complaints, which in turn will diminish tension caused by the speech event.

*

The following is a *summary* of our experiences gained with the logopedic confrontation method.

The procedure is used as one element of the complex therapy of stutterers. It cannot be employed independently, and is linked to the therapeutic process only as a precondition of other treatment steps. Therefore, the *therapeutic process as a whole* is expected to exert a favorable effect.

Clients reported many different kinds of difficulties arising from speech events, but we have found them to belong to only a few basic stereotypes: rejection, helplessness and the lack of self-monitoring, inability to meet expectations, "residual feeling" (stutterer can meet expectations only after the event).

These data indicate that *stuttering is linked with certain personality characteristics*, which, through reciprocal actions, aid the appearance of symptoms (or stereotypes) and determine their severity.

In this part of our work we have dealt only with the most important difficulty, assigned as of primary importance by the stutterers (during the course of the treatment altogether four or five secondary difficulties are dealt with). The stutterer must try to analyze, identify and influence his/her other difficulties by themselves (naturally, if the need arises, the therapist is ready to discuss them with the client). The aim here is to *help the person toward self-knowledge, natural, independent growth*.

The method does not change the cause of symptoms, instead, it *influences one of the vehicles of symptom preservation*, namely, speech-behavioral blockage (discussed, confronted, ideated complaints are modes of fixation of symptoms).

Logopedic confrontation takes place on *two levels*: direct and indirect.

a) The indirect level of logopedic confrontation. Stutterers are trained in self-knowledge, self-observation. They must know what the characteristics of their stuttering are (mode of stuttering, muscle tension, its location, extent, accompanying muscle senses, synergic movements).

The stutterers must come to know when they begin to stutter (the time and place), they must be able to recall the speech situation(s), disturbing sensations, the feelings, thoughts accompanying the block, the pre- and postsentiments of the block, all the disturbing circumstances in which they usually stutter. This observation must include the listener, the interlocutor, his/her role, the topic of discussion, what is expected of the stutterers in the given situation (their performance), that is, a minute observation of the interactional situation between the stutterer and the interlocutor. These two steps make up the orientational frame of the confrontation on the one hand, and promote a consciousness of the motive and the "experience" of stuttering on the other hand.

Observation and working through the speech behavior situations that arise. This means the anticipation of situations in which the stutterer's speech behavior shows blocks, difficulties (consciousness and analyzing anticipated critical situations enhances self-knowledge).

Following logopedic relaxation the stutterer sits in front of a large (150 x 50 cm) mirror (in which therapist is not visible), and thoughtfully contemplates, studies with deep interest his/her reflection to "discover his/her face, gestures".

The stutterer makes tiny and gentle movements, first on his/her forehead, then around the eyes and the nose, and finally the mouth. At the beginning they are isolated movements, which then "take possession" of the entire face. It is important that the movements remain very fine and gentle, and do not become spasmodic, so that onlookers just barely perceive them, but the stutterer feels them and knows that he/she is in control. There should be no pauses, the fundamental idea being that the movement keeps "travelling". The exercise is performed in two or three sequences with pauses in between, and lasts for about one or two minutes.

Excess and synergic movements that regularly appear can be imitated. They are practiced separately by first going from small movements to big ones, then the other way around.

The *speech accompanying movement* element is introduced in the exercise described in the above step. That is we also say what we are doing. The sentences are kept short and simple. For example, "I gently contract the eye muscles, then slowly relax them, I feel the tautness of the muscles of the forehead, now I feel the muscles relax."

A tiny and gentle series of movements with the body and the arms. Again it is important that there is no pause between movements. The rest is done as above (movement and speech together).

Muscle senses accompanying and characterizing the client's *stuttering* are taken one by one. Each muscle phenomenon, sensation is reproduced and accompanied by audible speech. For example, "Here, in my neck the muscle is stretched, like this, yes, like this, now I feel it is taut, then I slowly relax it, I feel it is relaxed"; "Here, around my lips, every muscle is stretched when certain sounds are produced, now I stretch them intentionally, as when I stutter, then relax them."

The *demonstration of movement units* belonging to a given situation is accompanied by speech. For example, "Good afternoon" (nod); "How are you?" (arms spread, questioning look on the face). It is fundamental to have material which is easy to demonstrate and needs action by the arms, head, shoulders and the body, and can be done sitting down. Movements are not broad, they are gentle and expressive.

Technique of preparation for speech. (For description see Exercises promoting speech confidence, pp. 100-105.)

b) Direct level of logopedic confrontation. At this stage client and therapist must already have a precise knowledge of those unique, characteristic effects, situations, which promote, or enhance, stuttering. In addition, the circle of secondary difficulties awaiting elaboration must be marked out. This is one of the preconditions of beginning confrontation. The other is that the stutterer be versed in the indirect level of logopedic confrontation.

Following completion of logopedic relaxation and indirect confrontation exercises, the stutterer sits in front of a mirror (direct confrontation always precedes the so-called intent formula part of logopedic relaxation, because the client will use it as a source of material). The therapist sits beside him/her (but is not visible in the mirror) and asks the client to call to mind his/her critical situation in great detail, together with its objective elements, external and internal sensations, associations. The rhythm of speech is slow (in accordance with the thematic variations of the technique of undertaking speech), and the stutterer watches his/her mouth throughout.

The therapist does not interfere in the client's discourse, does not correct him/her or divert the stream of images, but allows him/her to unfold the topic, to change the subject, to digress.

Afterwards the client is requested to sum up in a few sentences what has been said: what, in his/her opinion, brings about this critical situation, why he/she cannot cope with it, what episode, or feeling, he/she think obstructs and inhibits him/her. The therapist in a subtle way, using rational arguments, must help the stutterer to grasp and study this point, idea, feeling from every aspect, in order to reduce subjective exaggeration.

Generally, there are two solutions to this. The first is, when in the course of summarizing the material, the client has sudden insight. We have noted in these cases that the stutterers speak little, but it is obvious they have discovered something they were unaware of before. However, this does not happen very often. The second is, when the solution, or the road leading to it, has to be discussed together. In this case too, the therapist stays in the background paying close attention to the weave of images, and only very rarely, at turns of thought he/she deems important, does he/she interrupt the client with a question: "Why do you

think so?"; "Try to explain it.", etc. These questions prepare, direct the stutterer toward forming more rational opinions, verbal expression of recognitions. It is decisive that the clients themselves discover (with indirect help from the therapist) and identify the *irrational fear of speech element*. In the course of the conversation, the therapist must create a situation, in which the *client is able to put into words a solution to the block*.

The session ends with the confrontational conversation. The next session (and subsequent ones) continues to deal with the subject of secondary difficulties, expecting the client to verbalize new feelings, episodes, by prompting him/her to draw new analytical conclusions.

In our experience, stutterers accept and like to do this exercise. They do not have to report the result, we do not suggest that the client try it, nor do we forbid it. Even so, in one or two weeks every stutterer tends to report, of his/her own will, his/her experiences.

Role play

It is well known that in "certain situations" the speech of stutterers is more likely to be blocked than in others. According to stutterer reports, this block is introduced by the appearance of a general feeling of tension, and the feeling that he/she will stop to speak and be unable, afraid, to say what he/she wants to.

Stutterers list the following situations as insurmountable, as causing the blocks:

- when they have to speak to their bosses;
- when they have to speak to their teachers or take an oral examination;
- when they seek somebody's attention, or are being courted;
- when they have to consult with someone on official matters;
- when they have to turn to a doctor with a problem.

These situations prove that every interactional partner involved in a conversation, fills the role of a superior for the stutterer, and the outcome of the speech act, which the stutterers initiated for themselves, depends on this superior. (Naturally, situations causing the block are complex, and we chose to examine only one of the elements, the interactional partner.)

Based on the above, we suppose a relationship to exist between the interactional partner (his/her role) and the block situation. Its course of development is as follows:

The interactional partner playing the role of the so-called superior, by fulfillment or nonfulfillment of the stutterer's expectations, will become a source of tension. This ambivalence (as regards outcome) puts the stutterer with a weak

ego in a situation of speech-behavioral instability, that is, it sets in operation all the disadvantageous, fixated somatic and psychological mechanisms during which time the stutterer shows symptoms. (Note, no conflict was reported to exist between the examined stutterers and their interactional partners filling the role of a superior, which means that the difficulty, disorder, revealed in interaction had some other source.)

The essential aspect of situations that stutterers find impossible to solve is the tension inherent in the ambivalence of waiting. Our methodological step of role taking reduces this tension.

In role play a working through takes place in the conscious mind. In the course of this the stutterer consciously takes the role of the person who represents the source of tension, and creating a dialogic situation talks out this tension (exploration material). Role play is successful if identification — talking out leads to the reduction of tension linked with persons transmitting the disorder, creating a state of balance between the role and the self, and, subsequently, a neutral balance between any role and the self (naturally, other treatment steps also take a part in this).

Employment of the method of role play is justified if the person, eliciting the actual disorder of speech behavior, who is responsible for the “particular situation” causing the stutter, can be named.

General points of view of employing the method of role play:

- the method of role play depends fundamentally on the data obtained in the explorations (the actors in the stutterer’s psychological life space, the stutterer’s relation to them as already expressed in the course of the exploration),
- there is not one, but many “particular situations” in which the stutterer’s speech is blocked, therefore, one person is associated with each situation as responsible for the block (which involves many role plays),
- the method of role play is suggested in the second year of our complex procedure, following logopedic confrontation,
- usually, the stutterers themselves select the roles of persons representing the source of tension in an order determined by the “degree of suffering”,
- the stutterer should try to place the same person (role) in many different situations, using different materials, expressing different difficulties (different linguistic signs, affective and mental events belong to each of the situations, which means increased opportunities for acting them out),
- the method of role play constitutes only a part of the sessions.

The steps in applying the method of role play:

- the stutterer must tell who the cause of the block is,

— the stutterer must unfold in detail what in the interactional person disturbed him/her (he/she reminds the stutterer of someone he/she dislikes; the stutterer disagrees with his/her ideas; he/she is unhelpful, indifferent; talks too loud; moves too much; he/she is tall and the stutterer is short; their spatial position is disadvantageous; he/she is very smart, cultured; his/her face is impassive; he/she has an overwhelming personality; he/she is attractive, like the stutterer would like to be; he/she is elegant, graceful; speaks fluently; lives well; he/she “talks so much, you can’t get a word in”; he/she is rigidly cold; has a frightening look; looks like a balanced person; he/she alluded to stutterer’s speech defect; he/she is impatient; etc.),

— the stutterer must say in the dialogic situation what he/she would have liked to say to his/her interactional partner (alternately taking the role of the partner and him/herself).

The following is an example of the application of the method of role play (the subject is G.D., a 16-year-old high school student):

— Mr Kovács makes me nervous and my speech is always blocked in his class (Mr Kovács is subject’s class teacher and teaches Hungarian).

— Mr Kovács always stands impassively in front of me, so close that I can see the color of his pimples, he stares at me, puts his hands behind his back, he gives no help, no encouragement, I’m afraid of him....,

— dialogic elaboration: “Well, George, I’d like to hear what you have learned — All right Mr Kovács — Let’s give it a try — All right — I’ll help you — All right, that will be great — Then let’s talk about Arany’s late poetry, you probably know everything about it — Yes, yes, I learned everything — Good, good, it was very good, George. You see how well George recited the lesson (teacher hugs and pats the boy on the back) — It was good to hear your recitation, there were one or two inaccuracies, but you showed a good understanding of the subject. I’ll give you a four*. Keep up the good work (pat on the back). (Note: remind stutterer to use nonverbal elements.)

Logopedic homework

The aim here is to achieve cognizance of such tasks and behaviors that the client and therapist attempt to modify together. Logopedic homework (LHW) serves this purpose with the addition that stutterers practice their homework at home or outside the home every day, completing or solving the assignments.

* The four is the equivalent of a two in other systems, or it is a B in Anglo-Saxon systems.

The following are examples of LHWs used as part of our complex procedure. LHWs are *exercises and assignments* that must always demand effort, preparation on the part of the stutterer, so as to enable the therapist to exert an influence on as yet unformed characteristics, modes of reaction, conduct, interactional situations.

LHW is part of the complex procedure. Its material is based on treatment, and is related to it. These sessions are based on the symmetrical relationship between client and therapist, their joint effort (the stutterer does not “endure” being taught, but works with the therapist). The effort element is important in itself, but we stress also its importance because it designates the course that LHW must continue to take. For this reason *LHW* is considered as an equally important, *indispensable* part of therapy.

Aim of LHW:

- to practice the learning of the curriculum;
- to prepare for leaving the therapeutic situation, for separation from the therapist;
- it is an aid, a means towards an autonomous organization of conduct, natural self-development;
- to prepare for testing what has been learned.

Arguments for LHW:

- effort embedded in activity, practice, becomes a permanent feature of the personality;
- treatment may be extended to psychological life space (i.e., it may deal with events that occur only in everyday situations);
- the number of sessions is small, LHW helps expand treatment.

In general, LHW exercises, assignments, are scheduled to take place in the middle of the first year of the two-year treatment program, because:

- the client and therapist already have a great deal of treatment experience behind them, and the client is prepared to work alone;
- the therapist, in possession of other treatment and examination data, comes to know the stutterer and the realizable goal, or possible goals;
- the client can begin to test, to apply what he/she has learned in real-life situations.

LHW is part of the treatment program, it is based on data obtained in logopedic exploration, family visits, our own logopedic examination and observations.

LHW may take the form of *practicing or assignment*. The former includes exercises (e.g., relaxation exercises), the latter includes tasks that represent some

difficulty, or block, in the stutterer's life space. Naturally other elements may also be added.

In the following we give an outline of our most frequently used LHW materials and solutions. Not all of them are used in every case. It is always individually determined what elements to use and when.

Practicing. The stutterer practices every day, without help. The home environment is appraised by the therapist, and the necessary conditions are discussed with the family. The exercises are made up of repetitive elements. Practicing should take no more than 15 minutes each day (with due consideration of age and personality), but it should be concentrated work. It is important that, before beginning the exercise, the client be in an indifferent somatic-psychological state, because it helps adjustment.

The practice part of LHW is checked during the session, which (if decided by the therapist) may be a group session, i.e., a group discussion of the observations, experiences of other clients invited to attend (three persons, with a difference of two years in age at the most). It is very important to discuss the information and experiences (correction, reinforcement) gathered in the course of performing the exercise, or the reasons for nonperformance. There is much to learn from it, especially for the therapist. All forms of disapproval are detrimental. The therapist must prepare notes on the practice part of LHW in the absence of the client, in order to record changes, to reconstruct events.

Main exercises are:

- *technique of articulation:* essentially it means speaking with exaggerated jaw movement and articulation in front of a mirror;

- *logopedic relaxation:* essentially it is an organistic switch to a rest tone, in which the client is capable of affective self-direction;

- *performance of written assignments, observations:* the purpose is to make clients become conscious of themselves, especially in affectively determined situations; to become cognizant of the characteristics and habits of their mothers, fathers, siblings, friends and teachers;

- *keeping a diary:* for an expression of the resonances of the stutterer's private world;

- *mirror exercise:* essentially it requires stutterers to spend much of their time in front of a large mirror (e.g., study, eat, etc. in front of it); to observe, to get used to themselves, to their gestures, speech — recognition of a change is a decisive factor;

- *speech confidence exercise:* technique of preparation for speech (for description of method see pp. 100-105).

Assignment. This is introduced if we see that in a given life space the client has difficulties, he/she underachieves, lacks the motive for action, interaction, and believes that he/she may be influenced to change in a more regulated, rational situation (the task) (given his/her determination, of course).

In this case the client does not have to practice daily. In general, he/she has to solve one or two tasks a month (after a preparation). The assignment part is performed in a group situation, the actors (real and imagined) of which are always different, with increasingly difficult tasks.

The preparation, selection of topics and discussion is always done individually. We may depart from this practice and do it in a group situation if there is a special reason. The therapist must be cognizant of the client's level of tolerance and psychological endurance. The *client is not required to report the performance* of the task at the following session. If on another occasion a similar topic arises the therapist can refer back to the action, the phenomenon, which influences speech. In the majority of cases, however, the stutterers readily report on their performance of the task, since it forms an important part of their lives.

These assignments often mean an intervention in the stutterer's life, therefore, great circumspection and tact is necessary. As in psychotherapy, in general, here too, the therapist must not give advice in any way. Instead, in the course of the conversation, he/she must *create a situation* in which *the client finds the solution him/herself*, or is able to select the appropriate solution from among the many possible ones.

The main assignments were:

These assignments focus on awakening the motive of initiating speech. What is essential is that the client is deliberately directed toward speech-behavior situations which are critical in his/her everyday life (these critical situations are revealed in the exploration).

The preparation is individual. The steps of the assignment should not all be difficult to solve, because it would make it impossible to bridge the distance between ability and expectation.

The assignment part is linked mostly with the so-called target formula material of logopedic relaxation.

A few, more frequently used intermediary steps in inducing initiative to speak:

- to approach an acquaintance living in the same house (with an indifferent question);
- to phone (an acquaintance and give a message);
- to approach a stranger on the street (with a conventional question);
- to go into a shop and ask about some merchandise;

- to approach a girl (boy) in school who does not attend the same class;
- school lessons (before doing these lessons, the therapist should visit the school and discuss his/her professional opinion with the teacher, and win over the teacher in order to reduce chances of failure): undertaking a task, demonstration of the intent to volunteer, answering questions from his/her seat, in front of the class, role play (choir, recitation);
- to make friends accept the client's intentions (by reasoning, and not by use of force or authority);
- to participate in decision making (the outcome of which is ambiguous, therefore the client must work for it);
- to go into a store to buy something (at first it should be a simple task, like buying a bun);
- to go into a department store and to demonstrate the intent to buy something, try on a pair of shoes for instance, then say thanks and leave;
- to undertake official business (e.g., renewal of library card);
- to go into a coffee shop, sit at a table and order something.

The so-called intent formula part of logopedic relaxation which the client performs before difficult situations to create a favorable internal psychological tone, also belong here.

If therapist considers it necessary, or, preferably, if the client requests it, the therapist should take a role in performing certain elements of the assignment (e.g., accompanying the client on the shoe-buying assignment and providing support by his/her presence in the background).

INTENT FORMULA EXERCISES OF THE STUTTERER

One element of intent formula exercises: time pressure

In the course of analyzing and developing intent formula exercises, stutterers mention a number of difficulties that have to be met. Since the sense of time pressure is the most frequently mentioned, we have decided to devote a separate chapter to it.

One of the tasks of treatment is to slow the stutterer down, including his/her reaction characteristics, and thereby help a learnt, conscious monitoring of speech behavior, and therefore adjustment. One of the possible variants, forming part of our complex treatment procedure, is discussed below.

We must note two things concerning the so-called time pressure phenomenon manifest in the stutterer's speech. Firstly, logopedic literature only describes the phenomenon and narrows down its analysis expressly to a question of articulation. We find this approach of "separating a part from the whole" unacceptable. In our opinion, speech is not an isolated characteristic of human life, even if, indirectly, it is linked to the whole of personality and influences the development of other aspects of the personality. This proves the correctness of interpretations, therapeutic procedures that consider the whole personality of the stutterer, on the one hand, and the approach to stuttering as a speech-behavioral disorder, on the other hand.

Secondly, logopedic literature still lacks an explanation of the developmental mechanism of the time pressure phenomenon. In our opinion, it is based on the to-speak-or-not-to-speak dilemma of the conflict theory: of these two opposing intentions, communication is the one realized, therefore, the stutterer wants to get speaking done with fast, because it gives no satisfaction, on the contrary, it poses a difficulty (i.e., an identification with some problem he/she always tries to hide), it is a physical, psychological task beyond his/her abilities (the stutterer does not say what he/she would like to, but what he/she can).

The above show that we do not consider time pressure an articulatory question, but as something derived from the basic conflict of the personality, from

the communicational block and its resultant reactive neurosis. Thus, *speech always reflects past and present*, active somatic, psychological and environmental events, which the stutterer experiences as permanent motivations.

Logopedic literature no longer holds the idea of uniform manifestation of stuttering tenable. Today we speak about stutterings which exhibit varied symptom-formations and take different forms, and we interpret the phenomenon of time pressure along the lines of this view. The foregoing raises two questions of fundamental importance.

One: Is the examined phenomenon present in every form of stuttering? In our experience, the phenomenon of time pressure is found primarily in stutterers who emphatically exhibit behavioral symptoms.

Two: When does the stutterer experience the sense of time pressure: only while he/she talks or even while he/she does not talk? According to our experience, this inner urge is present before and during the speech act, but it is not active during non-speech (stutterers could not report it).

The facts mentioned indicate that there is a *direct relationship between psychological state and speech*, that is to say, underlying every verbal manifestation, speech-act intent, there is a motivational background of varying intensity and depth.

Conditions of appearance of time pressure are viewed as a unit, because, in our opinion, they are complementary and the existence of one presupposes the existence of the other, i.e., they form a functional unit, therefore, they are not divided into external and internal conditions.

Treatment of the sense of time pressure is successful only if done together with other treatment steps of our complex procedure.

The reasoning underlying the time-pressure treatment step is as follows. If time pressure in the stutterer increases, then the speed of articulation will also increase, as a result, conscious monitoring of speech will decline and the frequency of stuttering will increase. If, however, time pressure in the stutterer diminishes, conscious monitoring of speech will increase, i.e., the stutterer will have time to apply what he/she has learned, which means that the frequency of stuttering will decrease. For this reason, in this part of the intent formula exercises our goal is to affect a slowing down in the stutterer (specifically, of his/her reaction characteristics, speech behavior), with speech and articulation serving only as a medium of transmission.

Similarly to every intent formula, the sense of time pressure is also based on dialogic exploration material. In this case, the aim of the dialogic exploratory conversation series is to make the stutterer dissolve the feeling of time pressure by distancing him/herself from events. To achieve this, client and therapist discuss and analyze this subject together, the situations that bring it about, its motives, through a multitude of examples taken from the exploration material. Afterwards,

the stutterer selects the material and defines the intent formula(s) by him/herself, which he/she then uses to counterbalance the sense of time pressure (inserting it among other elements of our complex method).

The reasoning underlying the treatment step of distancing is as follows. The stutterer's tolerance, storage, of stress is low, therefore, excitement, anxiety, enhances the feeling of pressure, which leads to poor adjustment, i.e., deteriorates speech behavior (specifically, this means that the speed of articulation increases, conscious monitoring of speech diminishes, blocks become more frequent). For this reason, a so-called adjustment, or preparatory, period is inserted between the question (stimulus) and the response (distancing the two elements), in order to regulate the stutterer's inadequate adjustment to stress, to slow down the reaction characteristics of behavior, to promote speech confidence (i.e., to amplify the intent to speak in Sheehan's conflict between speaking and not speaking).

In the course of the conversation series of exploration stutterers mention the following main situations as evoking the sense of time pressure (order is irrelevant):

- when the stutterer wants to (has to) give a quick response;
- when interactional partner speaks too fast;
- when several people speak simultaneously, when people speak in quick succession and the stutterer has to join in the conversation quickly;
- when several people speak to the stutterer at the same time (simultaneous speech actions);
- when the stutterer has to answer question concerning his/her person (introduction, family status, family data, profession, home address, workplace, education);
- when the stutterer experiences intense emotional effects (positive and negative);
- when the stutterer is anxious, excited (there are many and varied motives in the background, but "they may find out", "what if" and "what will they think of me" motives are conspicuously frequent);
- when the interactional partner changes the prosodic elements of speech too fast and unnecessarily;
- when the stutterer has to talk with an interactional partner who changes his/her nonverbal signs too fast;
- when the stutterer has to talk with someone in superior rank or position.

Common to the above situations is the fact that the sense of time pressure always appears in interactions, and that the verbal-nonverbal characteristics, expectations, roles of the interactional partner (pressure to hurry, quick responses, "the superior") exert an influence on the stutterer.

In the course of the exploratory conversation, the main theoretical steps in the formulation of intent influencing the sense of time pressure are:

- making the stutterer comprehend why he/she must distance him/herself from events;
- detailed, cognitive analysis of the emotions, events, interactional persons, affecting the stutterer's speech-behavioral performance (based on the stutterer's exploration material);
- training in distancing, in the course of which the therapist assigns tasks and the client carries them out (e.g., recognizing the impatience, emotional expressions of stable interactional partner, and observing and changing the stutterer's own reactions to them; affective recognition of elements hidden in certain situations that have an influence on the stutterer, recognition of "danger"; a step-by-step solution of situations having an influence on the stutterer),
- incorporation of processes and meaningful intent formulas in the stutterer's behavior, and their conscious, deliberate application.

One element of intent formula exercises: concealment

Therapeutic practice has raised the need to investigate the question of concealment. In exploratory conversations stutterers regularly and repeatedly use this expressive term as indication of their experience of a speech problem and related feelings. Realization of this fact led us to examine the question.

Logopedic literature does not describe, nor use, the concept (however, its variations are well known, e.g., contact difficulties, inability to assert oneself, etc.). This is a deficiency, for concentrated in the idea of concealment we find all the important behavior traits characterizing the stutterer (contact-pathy, anxiety, introversion, insufficiency, inclusion), thus it provides the speech therapist with treatment approaches. The significance of the idea of concealment lies in the fact that since it is a manifestation of the affective set organized from the behavior characteristics of stutterers, it can be made use of in the analysis and interpretation of the stutterer's characteristic symptom. Our goal here is to present a further method for influencing the divergent symptoms of the stutterer.

Concealment is not stuttering-specific, since it can be found in many conditions with different symptoms, as well as in healthy individuals, furthermore, it does not occur independently, but is a sign representing a combination of symptoms. Concealment is fundamentally determined by age, gender, social-cultural development and maturation. We also find concealment to be an efficient form of adaptation among animals (mimicry).

Concealment is the result of a developmental process. For people to mature, to be able to develop, they must be capable of change biologically, psychologically

and socially. Stuttering obstructs this changeability. Its permanence inhibits development, which in turn arrests the sense of personality as a whole. As a result, differences between age-dependent abilities and requirements will create states of deficiency (owing to inhibited development, the stutterer is unable to meet requirements, age-group developmental phases are left out, and due to the accumulation of deficiencies the stutterer will lack motivation). These deficiencies lie in the background of stutterer concealment, which are not related to speech only (for speech is not a separate part of human existence), consequently, the stutterer suffers emotional, verbal and nonverbal damage.

What is stutterer concealment? It means verbal and nonverbal performances falling behind age level and not meeting requirements (of the situation), which have a long history and, hence, exert a continuous influence on the quality of the capacity to act. In other words, stutterers conceal themselves not only when they speak or in speech-related events, they conceal their entire being (speech and personality are linked).

Concealment occurs in cases where stuttering has a long history, where it is secondary, where it has psychological symptoms and where contact is greatly limited.

Concealment makes treatment difficult. In such cases, the stutterer is hard to approach, he/she activates his/her intentions with difficulty, cooperation is problematic. Appraisal of this condition deserves special attention at the onset of treatment.

In order to ascertain concealment, the therapist must have several talks with the client. In the course of these, the therapist must decide whether it is a temporary concealment (caused by surplus tension evoked by the situation, for example), or a permanent one characterizing the personality. Repeated observation of the following indicate concealment:

- short answers;
- absence of answers (behind which the therapist feels that the client would like to answer, but can't, or is afraid to);
- evasive answers (these too are shorter than expected);
- increase of reaction time (slow answering compared to the situation, to "habit");
- uncertain, ambiguous answers;
- "I couldn't say it the last time" (answers an earlier question);
- the client confers his/her right to speak, initiative, answer onto the therapist, then expresses only an acceptance of the therapist's actions;
- poor nonverbal communication;
- "screening" (covers mouth, face, eyes with hands during speech and nonspeech);

- avoidance of eye contact;
- “darting look” (looks briefly at interactional partner, then looks away and back again, etc.).

Three variations of the idea of *concealment* are revealed in the exploration series.

One: client begins by saying that he/she would have liked to disappear, cease to exist, hide somewhere, etc., at the time when, and continues by describing how the experience(s) came about that led to this. He/she also says that this is a permanent feeling which makes him/her timid, withdrawn, seek concealment during speech as well as nonspeech, because he/she can never say what he/she would like to. (This variation occurs in cases when the stutterer is still under the influence of what he/she has said before, the unpleasant experience is still fresh, or the exploration situation, topic, revived this experience.)

Two: summarizing the train of thought of the exploration, the client him/herself verbalizes the sense of concealment. It follows from the logical sequence of thought that the stutterer realizes at some point of the conversation that he/she is concealing himself because of his/her speech defect.

Three: it starts out like the second variation, but there is no cognitive identification. In this case, the therapist helps by summarizing the more important elements of the earlier events of the exploration, then asks the client to find the common idea. This idea is quickly identified by clients, and they add immediately, “I felt something like this too, only I’ve never put it into words.”

All three variations are important and useful from the point of view of therapy. Next, the meaning of concealment should be discussed, so that stutterers know precisely what it is. We suggest discussion of the following two topics (in a dialogic form):

— Concealment is a part of life. In different cultures in the world norms are set up, because the world, life, can function only if guided by some kind of an order and principles. Naturally, not everyone fits in, or agrees, with these norms, orders, averages. Consequently, those who do not fit into these categories and deviate from the average, must consciously think, act, behave differently, in other words, they must conceal their thoughts, actions and intentions. This means that concealment is a common human trait, an efficient form of adaptation by people who live in communities (by way of illustration, the therapist lists examples from the world of art, politics, religion, literature, as well as from everyday life and the client’s own life).

— Concealment is a part of human behavior, it can (and must) be used as a way of adapting to the environment, but if it becomes a dominant behavior characteristic it indicates a functional disorder in the personality because it inhibits

the development of the capacity to act. The explanation for this is that in his/her life the client experienced a great deal of speech behavioral failures, and, as a result, has become unsure of him/herself, withdrawn, timid. We must change this. What we are doing in this part of the treatment is a means to this end. Withdrawal is a disadvantageous attitude, because it confines the stutterer's wishes, ideas, abilities, as a result of which he/she will be unable to carry out his/her actions.

An additional question that belongs here is that stutterers, by way of justifying their characteristics, often argue in favor of concealment. We must therefore discuss that though concealment involves seemingly less conflict, effort and difficulty, its advantages are transitory and it represents a lower level life style, because it restrains development (when, in fact, development, psychological strengthening need obstacles to be overcome, which then gives self-confidence, faith, ego-strength).

It is frequently asked whether the therapist should deal with specific questions in order to reduce concealment, in view of the fact that interpretation of the idea of concealment itself (which also has personal implications) may result in self-revelation and give the impression that the problem of concealment has been solved. But there is no real solution because it is the result of a reduction of situational stress, of target questions touching on personal problems, and such a result can only be temporary, because it is not backed by analysis consequently the therapist is not exempted from applying the other methodological steps. However, it has the advantage that it accelerates the process of influencing concealment, and the therapist can count on the client's cooperation, which will lead to real and permanent results.

Following this, the therapist may start the conversation series (deciding its duration and scope according to individual needs) by focusing on the client's concealment stands. At the end of each thematic and conceptual unit, the client verbalizes the intent formula he/she finds most appropriate for the problem discussed. This, of course, does not mean a solution to the client's concealment complaints. A number of conversations may ensue and a number of intent formulas may apply in the given case (what must be taken into consideration here is the strength of inhibitory mental patterns, feelings, that maintain concealment; quite often the situations, feelings, causing the complaint, cannot be ranked, because clients link every feeling and thought with verbal expression, consequently, so long as verbal expression is blocked, the feeling of stress remains strong). Furthermore, as already mentioned, we consider concealment as an affective set organized from behavior traits characterizing the stutterer. Thus, these behavior traits are discussed in other stages of our complex method as well. Here our job is primarily to increase the capacity to act of the stutterer. It is important, among other reasons, because we can thus move the stutterer from the passive state of mind induced by concealment.

To summarize, our goal in *influencing concealment with intent formulas*, is to increase the stutterer's capacity to act, and at the same time talking out and interpreting the preceding exploration series serve to reduce the intensity of feelings derived from inhibitory events that cause and maintain the complaints.

The following material is taken from the exploratory conversation with a 21-year-old client. We dealt with the question of concealment in four sessions. In each session the client verbalized one intent formula to dissolve the sense of concealment. The present material is a *verbatim transcription of the first session*.

— *In your opinion, do you show, express, your characteristics, thoughts, feelings, intentions?*

— Now that we're talking about it, I begin to understand the question; I think not.

— *What do you mean?*

— To be precise, I can only say it's because of my speech. I always have to modify what I want to say and myself too, so I'm not who I am. I can't show my real self because of my speech, because often I do not say what I want to, but simply what I can at that moment, in that particular situation.

— *Is something restraining you?*

— Yes.

— *What?*

— I think it's the fear that comes before speech, which doesn't mean I'm actually speaking, only that the thought, the intention is there, and I can feel it in my whole being, in my body. That's when it appears, what we're talking about, concealment, that it would be nice not to be, because then this feeling would not be either.

— *Can you verbalize what restrains you?*

— My speech and, well, fear.

— *What do you think it is you have to conceal?*

— I think it's my speech, when I have to speak, say something, and of course it also matters where I speak, with whom and when. Well, when I speak, when I have to speak, because I don't like to do it of my own free will, only when it can't be avoided, then I feel something's happening to me, something unusual, irregular, not right, as if I were doing something abnormal that differs from the norm, from the accepted conventions of the world, as if I were an alien, who doesn't belong here. It's all very embarrassing, because I know what the other person thinks, but does not say, that this person is incomplete, it's obvious, everyone can see it and hear it. I know the amazed faces, the look of wonder on those who see me, and this has been going on for a long time, and well, I would really like to hide, to conceal myself.

— *You said, it is very embarrassing, would you explain that?*

— Since this embarrassing situation happens often, I often have something to conceal, and slowly this whole thing has become characteristic of me, a very

unfavorable characteristic, the essence of which is fear, uncertainty, which is stronger than my intention to overcome it. It's something I carry with me everywhere, I can't leave it behind, perhaps this is what causes the block, because this feeling always precedes my intent to speak, perhaps this is why I become rigid and hesitant, which then makes not only my speech, but my movement too, uncertain, clumsy, therefore, I make many mistakes I would not otherwise make. For example, I'm sitting on a chair in a strange place trying to seem practically invisible, that I'm there and not there at the same time, it's embarrassing, my presence is not as natural as I would like it to be, and I know it, I live it. And I often imagine what I would do in such situations, but in reality I can never solve the task in the way I imagined, and so I became introverted instead.

— *I see, I understand your problem. Can you tell what it is concealment prevents?*

— Do you mean work, studies?

— *Yes, that too.*

— Almost everything. In the beginning, a few years ago it would have been easier to distinguish things, for example, it bothered me more in strange places than at home, but today there's no difference, as I said, it's become a characteristic, something that a person always carries with themselves, it's there, and at most there are situations when it becomes very active, like exams at the university, role playing, new situations, when one must make a switch because old habits are no longer valid, then it comes out more, well, in everything.

— *In what ways have you tried to overcome these difficulties?*

— I did two things, they probably weren't right, but I was serious about them. One was that I always encouraged myself saying that it's just a matter of willpower, and, of course, I couldn't do it. I'm weak, and it's hard to do alone. The other, however, was that I gave myself small things to do, for example, if I was in a bad mood, which is often, then I forced a smile on my face, I would have liked to give the impression that I'm all smiles. I tried things like this. Perhaps, if I had a better understanding of this whole thing, of the mental part of the whole thing, it would have been possible to get hold of it. After the first step, perhaps the rest would have followed, but there was nothing to hold onto.

— *Now you said something very important, remember what we talked about before this conversation?*

— Well, maybe one thing, that everyone conceals themselves in some way.

— *Yes, yes, and what does it mean?*

— Maybe that it's not, not something strange, that everyone's doing it, so it's a general thing, characteristic, right?

— *Yes, and the other?*

— The other is that maybe this thing, this concealment is related to speech. It has occurred to me too.

- *How?*
- If I remember correctly, it went something like this: speech is not an independent characteristic of a person.
- *Yes, essentially, and?*
- Well, if I'm right, the two are related, it's in speech, in human speech, it's a human characteristic.
- *Is it only the present that's in it?*
- No, no, I think also memories, and of course the present, then what the individual has learned and perhaps inherited.
- *When did your speech defect begin?*
- When I was about 3-4 years old.
- *And it has been with you ever since?*
- Yes, but I'd be happy to give up such a companion.
- *So, you don't like this "companion" of yours.*
- It's not a companion, it's an inexpressibly hated characteristic.
- *Did it cause you much trouble in the past years?*
- It's hard to even speak about it.
- *Then it still affects you?*
- Yes, unfortunately.
- *Given the above, how do you see your concealment?*
- How my concealment follows from all this?
- *Yes.*
- I see, everything that happened to me over the years is still effective, still exists, yes, I've felt that all these old things hold me back. That's what you mean, isn't it? That my concealment is caused by the many previous failures, but in that case, drawing the logical conclusion, the solution is success, my success, if its cause is the opposite.
- *Yes, you're right, but what success are you thinking of?*
- Well, everything that was before, that will come now, that is the result of the treatment, right?
- *And what do you think is the basis of success?*
- I think if I work well, do what I'm told to do here.
- *This too is important, but at the beginning of the conversation you said that if you had a firm point...*
- Oh, you mean a hold?
- *Yes, what is the hold in your life?*
- Regularly performed tasks, work, I guess.
- *As you say that is correct, this is one of them, what's the other?*
- What is it you're thinking of?
- *We've touched on it at the beginning of our conversation.*
- Oh, that people conceal themselves, in general.
- *Yes, if this is general, then?*

— Then it's not such a special thing, it's a form of adapting, but it should not be, if I remember correctly, or as you said, dominant, well, exclusive, distinctions must be made.

— Yes, yes.

— You mean that with some people one has to conceal oneself, but not with others, then I can let go.

— *Name a person, someone in your life with whom you don't have to conceal yourself.*

— My mother, my sister, maybe.

— *Are they your confidants?*

— Yes.

— *Could you elaborate on this a little?*

— Maybe that we relate differently to different people, we show them different things of ourselves, so our concealment is always different, so...

— *Very good.*

— Well, concealment is a subtle characteristic. It's not always bad, in fact, it should be used appropriately, in the right place with the right person, then things will go better, but if someone is always concealed, then there's nothing, I won't accomplish anything.

— *Very good, I'm glad to hear your reasoning, this is exactly what I was thinking of.*

— Thank you.

— *There is a poetic expression of this idea by Attila József, it goes something like this: From my affairs I hide you, my God, how much I love you. Do you understand it?*

— Maybe that there is a kind of love when a person loves another so much that he/she wants to spare the other the difficulties, and so conceals the problem, and carries his/her burden alone. A nice thought.

— *Yes, and your interpretation is very nice. At the beginning of our conversation you said that you would like to know more about concealment. What do you think about it now?*

— Basically I have a better opinion of it now and I also know more.

— *But it's not only that you know more about concealment, is it?*

— No, of course not, I also know more about myself, about my concealing self.

— *Would you then try to express the substance of our conversation for the intent formula?*

— Yes, I'll try, wait, you mentioned a poet before, let me mention another, Madách.

— *Of course.*

— Then as he says, "I practice my qualities, I say what I want, give what is my self".

One element of intent formula exercises: feeling of comfort

During the exploratory conversations stutterers often conclude the discussion of an activity, attempt, task, by saying, "I didn't enjoy myself there either", "I couldn't make it with this girl either", "I wasn't at my best then either", etc. The precedence is an important intention, which the stutterer would very much like to accomplish, but which he/she feels he/she was unable to realize as planned or as he/she would have liked to, or was unable to realize at all. Since such events occur frequently in the stutterer's life and matter much because they have operational consequences, we must deal with this question, too, in the course of treatment.

During the exploration we asked stutterers why, in their opinion, they were frequently unable to accomplish their intentions. Their answers were the same: "I don't know exactly" and "probably because of my speech problem". That is to say, the mode of experience of the phenomenon is not conscious, but an affective set. This observation suggests the therapeutic method whereby cognitive analysis of the phenomenon of the lack of comfort feeling would divest the mental content adhering to it, influencing it, of its operational effects.

On the basis of our therapeutic experience and exploratory conversations, the above qualifying statements of the stutterers may be interpreted as follows. Stutterers have preimages with which they approach situations, actions (specifically, they imagine how they will behave, sit, what they will do, they practically plan the situation, they even formulate the thought of what they will say to the partner in that particular situation, in fact, one client phrased even the answer he expected to receive). The reason for doing this is that stutterers know from experience that often they cannot solve and control events and situations as they would like to. Given the preimage, however, they think they can exclude or filter out the uncertainty or disturbing factors, and this way the course of events is known beforehand and under control, nothing will surprise them for they control the events, and not the other way around. The problem is that no matter how well the stutterer is prepared for these situations, imagination and reality do not overlap (in reality there are always complex, dynamic changes, for which static preimages do not prepare the stutterer), therefore, the expected result does not ensue, or if it does, it differs from what was imagined. Thus the joy, the feeling of satisfaction derived from accomplishment, is incomplete. Since this is a recurrent experience, owing to the permanent feeling of deficiency and because there is no result to the lack of positive reinforcement, the stutterer becomes unsure, unwell physically and psychologically, consequently a deficiency of comfort feeling develops which impairs achievement and psychological functions. (By comfort feeling we mean a somatic-psychological condition of performance characterizing the individual, where the quality of performance is consistent with abilities.)

The so-called preimages indicate the operation of the self-regulation of the personality, which serves to counterbalance psychological insecurity. This psychological inflexibility tends to continuously produce and maintain problems, since the stutterer wants reality to conform to his/her own subjectively organized system of conditions, concepts (this is one of the basis of the stutterer's poor self-knowledge). This inflexibility is motivated by the content of preimages, which, in turn, is explained by the course the stutterer's life takes: due to his/her speech-behavioral disorder, the stutterer leads an isolated life, which involves a decline in the capacity to act, poor human relations, less shared experience, thus less human practice, experience and adaptation. All these strengthen self-truth, the subjective feeling, idea, of self-evidence and reduce reality and mental control.

The above concern the person, the characteristics of the stutterer, but comfort feeling also involves the environment where the stutterers realize their intentions. Internal deficiencies coincide with external conditions (the environment brings out and strengthens the individual's characteristics), the coincidence which initiates the process of development of insecurity and its stable presence leads to deficiencies in comfort feeling.

To conclude, we may observe that the activity, the intentions, of the stutterer, who uses, thinks in terms of preimages that contain self-validations, can be successfully realized only if they concur with preponderantly favorable, motivating, supportive environmental and human conditions. Thus the stutterer's feeling of comfort is dependent on many supportive conditions (which form the "basis" for the feeling of security of the stutterer). Consequently this dependence on conditions is an obstacle to the feeling of comfort. To solve this problem we must, in the course of dialogic explorations, exert an influence on the stutterer's condition dependence with the help of the intent formulas. The fact is that objectivizing self-truths improves the stutterer's comfort feeling, because he/she receives an increasing number of positive reinforcements of his/her thoughts, actions, thereby increasing his/her self-assurance. Below the practical realization of this is discussed.

The reason behind the statement of intent formulas is to have the stutterers themselves devaluate certain conditions of the preimage. Hence, the stutterer must collate conditions of the preimage with important elements of the actual event (at first, they discuss it with the therapist). The stutterer must recognize and analyze the difference. The purpose of verbalizing intent formulas and the exploratory conversations preceding them, is to enhance cognitive behavior based on self-knowledge.

The next step is the statement of intent formula, the material for which is derived from topics of the exploratory conversations (naturally, the therapist has at hand a number of data concerning the deficiency of comfort feeling, obtained in earlier exploratory conversations). His/her first sentence contains a reference to this: "Am I right that your affairs, intentions, do not always end as you would like

them to?" The question is discussed as often and as thoroughly as the case demands. Again we emphasize that, in addition to the present methodological step, other elements, effects, of our complex method also play a part in changing the deficiency of the stutterer's comfort feeling. But since in the stuttering syndrome this constitutes one of the modes of symptom preservation, we must deal with it separately.

Phrasing an intent formula to improve comfort feeling starts with a discussion of two fundamental concepts (these concepts form the theoretical framework for further discussions). One is clinging to the preimage (to its content). Here we must discuss why the client clings to the preimage (in essence, the stutterer is afraid that if he/she digresses from the preimage, he/she will become insecure, helplessly defenseless, because there is no other solution). The other concept is the ability to change. Here we must say that the client has to learn a behavior, a way of thinking that is adjusted to continuously changing events, thoughts, conditions, situations, because this is the only way they can adapt. (In both cases, examples are taken from the client's material.)

This is followed by an analysis of an event which had an unsuccessful outcome for the stutterer and which is selected by him/her. We ask the stutterer to tell what preparations, adjustments, he/she has made for this selected event. After recounting the event he/she tries (at first with the therapist's help) to verbalize, to select from the story the expectations, subjective conditions with which he/she entered the event, which belong to the concept of preimage. When this is done, the same is performed in the case of a concluded event, i.e., the "result". Then the two are compared, in the course of which the stutterer arrives at a recognition of the differences, and thus divests certain conditions of the preimage of their subjective self-evidence, and approaches reality (in the first few analyses recognition appears as an affective set, e.g., "it's so obvious, yet I didn't realize it", then, as a result of growing self-knowledge and practice, the material of the analyses becomes much more sophisticated).

The *examples* below serve to illustrate the methodological steps described above and in the following.

a) The client attended an evening party and, qualifying it, said, "I didn't enjoy myself there either".

Content of the preimage (sequence is irrelevant both here and in the case of the result): "I'd like to be among smiling people."*

"I long to be loved a little."

"I'd like people to show an interest in me."

* These statements are taken verbatim from clients' exploration material.

"I'd like to be made to feel important."
"I'd like to feel peoples' warmth for me."
"I'll be a little late, by then the party will be lively."
"I'll go alone, it's easier to mingle."
"I'll wear casual clothes."
"I'll drink no more than the others."

The concluded event (result):

"They talked but little to me."
"They were moderately nice to me."
"I could only dance a little, they cut in soon."
"The music was too loud."
"I often had to help the hosts" (to make food, wash the dishes, etc.).
"There was too much smoke."
"We had to sing" (people began to sing at dawn).
"My dress got grease on it."
"I went home alone."

Confrontation of the preimage and the result (verbatim transcription of tape-recorded material):

"Yes, yes, I see, it was naive, full of exaggerations, yes, but I'd have liked to make sure, because so many things had happened to me already, yes, one must try to be realistic, what I did was not that, yes, there really is too much wishing, longing in this, yes, I did not pay attention to what is important, well, I'm grateful for this recognition, I promise, it was interesting, this is probably not the way to do it next time."

b) The client is meeting a woman, then describes the meeting: "I have not managed to become friends with this girl either."

Content of the preimage:

"I'd like to belong to someone."
"I'd like to meet a woman with a strong will, on whom I can depend."
"In the restaurant I'll sit with my back to the entrance, so that she'll have to say the first words."
"I'll put the flowers on the table so that it's easily seen, it makes a good impression."
"I'll sit comfortably, with my legs crossed, to look relaxed."
"I'll read to occupy myself."

The concluded event (result):

"The girl did not smile."

"She didn't let me hold her hand."

"She quickly passed over the significance of the flowers..."

"Her voice was polite."

"She didn't let me pay her bill."

"There were too many people in the restaurant, it wasn't an intimate place."

"She greeted a friend, and that bothered me."

"She was busy that night, and that bothered me."

Confrontation of the preimage and the result:

"Well, it's interesting, very interesting, put like this side by side, I must say it's very exciting, these two things, which are actually one thing, well, I know that you think I'm always like this, oh, I should answer, answer myself, I see, all right, if I think about it, it's true, this is not unusual, I always overshoot a little, perhaps when I'm at the target, for that I'd need a big target to hit it, I want to make sure, this is the reason for overdoing it, that's why I have such, well, unrealistic expectations, then I fall on my face so to speak, so there, only it's difficult to face this now, because, then there are the many differences, it really is more a question of technique, there's the important thing, but it has its reason, so what is the lesson to be learned, well, with more simplicity and more realistically, no, to stay with the question, this was not good strategy."

c) The client looking for work, went for a job interview, and describing the event, said, "I was in a poor shape then too."

Content of the preimage:

"I'll be casual, so that they won't notice how much I want and need the job."

"I'll give many pieces of information about my work."

"I'll emphasize the professional recognitions I have received."

"I'll be there at the appointed time, so that I won't have to wait."

"I'll hand over my business card."

"I'll dress conservatively, that's good in any situation."

"I'll have newspaper clippings to show I'm well known."

The concluded event (result):

"There were many people in the waiting room, several people were called in for the same appointment."

"There was a committee of three persons."

"I had to wait a long time."

"When I entered the room, they didn't speak to me for a long while, they were arranging papers."

"They did not listen to my prepared speech."

"Strangers were coming and going."

"I switched to German on one occasion, but they stopped me."

"The phone rang several times in the room."

"The light was strong in the room."

"The heater was turned high in the room."

Confrontation of the preimage and the result:

"Well, this is very surprising, this confrontation, and why deny it, it's a perfect hit, and it's very simple like this, and now, I realize it just now that this way I'm my own worst, if I have to carry so many unnecessary things, unnecessarily I make my own life difficult, there is too much trimming and the meaning is lost, it's like a beautiful bride, with whom you can't do anything afterwards when the decorations are removed, this is very enlightening, of course, there are reasons in the background, because we've talked about this before, this is not accidental, but returning to what I said before, it's surprising how easy to understand the thing becomes, the things, if they are put together, I really must pay attention to what I'm capable of."

Confrontation of the preimage and the result usually shocks stutterers, the difference between the two sets of data affects them. It's advisable to renew at this point the dialogue and to phrase the intent formula. It always depends on the given situation which part of the confrontation material the therapist selects to start the dialogue. Sometimes the end of a topic, sometimes a key sentence, and sometimes silence offers the link for starting the conversation.

In the following, continuing the analysis of case b), the process of phrasing the intent formula is presented in a verbatim transcription of the tape-recorded material.

— *Earlier you said you'd like to belong to someone, is that right?*

— Yes.

— *Would you elaborate on this?*

— Yes, yes, of course, it's easy to answer this, because it's an everyday problem of mine, not only now, but before too, well, almost always, my whole life I had difficulties making friends, only it's more difficult with girls.

— *Do you think that you've had difficulties in making friends aside from dating?*

— Yes, but it's more a problem with girls now.

— *Does that mean that your relationships are unsuccessful?*

— Yes, if I try to date, to love someone, then I have problems, because then one must speak, I have to express myself, If I want someone to get to know me, I must speak, it takes courage. Yes, I'm full of blocks.

— *What kind of blocks do you mean?*

— I am the block.

— *I see.*

— Often I'd like to avoid myself.

— *How do you think you'd do that?*

— Make bypasses, solutions, prepare for the situation, prepare plans.

— *Could you be more exact?*

— Well, what we did before, what we talked about, about what I do before starting something, when I have to solve some task, I mean, I prepare for it so the thing has a small "dispersion", oh well, I have to do many things for things to come together, to get started.

— *And what is it you do when you're preparing for something?*

— I usually say that I'm composing it beforehand.

— *What does this mean?*

— I prepare myself for the task, I make plans that this goes here, that goes there, and then I only have follow a fixed course.

— *And does it work out?*

— Not really.

— *Then why do you do it?*

— Because I don't really have any other choice.

— *Does this preparation have a theoretical basis?*

— Yes, I have my standards, and one must stick by them, if something is not one hundred percent good, then there's no relationship, for example.

— *I see.*

— Then it does not get started.

— *But this way you make things difficult for yourself.*

— How?

— *If you only have conditions, it's very hard to find someone to fit them.*

— Yes, I'm strict.

— *With whom?*

— With others.

— *I don't think so.*

— Well then who?

— *With yourself.*

— Why?

— *You're punishing yourself, isolating yourself, you shut out even the possibility of a relationship.*

— Well, maybe.

— *How do you determine if someone is unsuitable if you don't get acquainted with the person?*

— By having a look, a little conversation.

— *Isn't that too little for getting to know someone?*

— Yes, it is.

— *What are your intentions when you meet someone?*

— That she will be the right person for me.

— *Good, but that needs time, you can't exclude the chance of getting to know the person from the start.*

— Yes, that's true.

— *Try and sum up what we have talked about so far.*

— Yes, well, that I shouldn't make such severe judgements, that I should give the two of us time to develop, I mean the woman and myself.

— *And.*

— Not to measure always by my standards.

— *And.*

— Well, fewer conditions, biases, but I should have a relationship, acquaintances, and make a choice that is suitable, but not beyond reach.

— *Yes.*

— I should let things take shape, and not hinder the other person.

— *With what?*

— With myself.

— *Specifically.*

— With my characteristics.

— *Specifically.*

— Not with all of my characteristics, only the important ones, only the important conditions, there is a need for standards, you can't put everything aside.

— *Good.*

— In other words, the unnecessary things, the burden, must be thrown out of the sinking ship, to relieve the ship.

— *A nice simile, and what must be thrown out here?*

— Things that are not good, do not fit here, the excess, my conditions, things that I have surrounded myself with so far.

— *Yes, yes, do you remember the confrontation earlier? Based on that try to summarize what you have said so far.*

— Yes, well, nothing came of my preparations which means they are unnecessary, the whole thing is, because at other times too, there is no need for it, none, because what was expected of me there, what I'm doing here, it's different, well, I was poorly prepared, or I misjudged the situation, well, it was simpler there than I imagined it to be, that's my exaggeration, it's a magnified thing in me. The whole thing is a yearning, that means it has to be done differently, more simply,

think and act and follow this road, without turning off, and then these situations won't be difficult, my little conditions will not be blocks, behavior must be simple, this must be practised with people, and then perhaps my turn will come, too.

— *Thank you, you've expressed this well, to be precise, you've also said this well. Now try to express this as an intent formula.*

— Now?

— Yes.

— "Things, affairs can be solved with fewer conditions, I leave off excess conditions, I live and think simply, naturally."

Exploratory conversations in the course of developing an intent formula to improve the feeling of comfort, as well as confrontation of the preimage and the result, have uncovered a close relationship between the stutterer's poor ability to change and his/her sense of reality, that is the development and maintenance of the deficiency of comfort feeling is also the result of an inadequate, inaccurate judgement of the situation. There are two basic variations (common to both is that the stutterer's judgement of the situations and tasks is based on his/her inflexible attitudes to change, to adapt, failing to conform to his/her abilities, characteristics). In the first variation the stutterer enters situations, undertakes tasks, that do not demand special effort on his/her part, i.e., he/she underachieves. In the second variation (and this is the more frequent one) the situation or task exceeds the stutterer's abilities, i.e., he/she overachieves (both variations, especially in chronic states, maintain reproduction of the deficiency of comfort feeling).

One element of intent formula exercises: difficulty in changing

The stutterers' difficulty in changing, inability to switch indicate adjustment disorder: they cannot activate, modify their characteristics, acquired knowledge, according to the situation and time, corresponding to their abilities and expectations.

Underlying the difficulty in changing we find a decision-making dilemma and an emotionally determined thinking process.

Change, or switch, is always preceded by a decision. The stutterer full of uncertainties will always postpone making decisions (the solution) because of his/her dilemma, so the ability to make decisions, i.e., to change, has no chance of developing (at the same time, there is not really anything the stutterer could switch to, for his/her need for security, overcompensating behavior is tied to many conditions which make change impossible). Furthermore, stutterers are character-

ized by decisions made under stress, actually for the sole purpose of relieving stress. There is no rational goal, control or motive, the decision is the product of internal insecurity (with commensurable results and use, in addition, endurance and correction of the consequences cause the stutterer many problems).

Stutterers, owing to their obstructed development, have an emotional view of events, which pervades their thinking. Instead of rational thinking, they are characterized by an emotionally determined self-governing mental process, instead of pragmatic logic based on facts, their thinking is influenced by emotions shielding subjective certainty. This is manifested in behavior as follows. The intention to change always appears as part of a situation or an event and through the mediation of participants, and the adjustment to, the mental evaluation of, the situation is determined by the stutterer's relation to the participants. Facts play no part, the important thing is whether the individual concerned is nice or not nice, beautiful or not, good or bad, attentive or rude, etc. The accumulative and regular recurrence of these subjective and extreme comparisons determine the stutterer's decisions and thinking.

Exploratory conversations have revealed what it is the stutterers know about their difficulty to change and what they mean by it. Some of the stutterers know about it, perceive their difficulty and the fact that they should modify their behavior, thinking habits, but are unable to execute the behavioral solutions because they lack the activating characteristics. Other stutterers do not know about this difficulty and use reproductive stereotypes based on behavioral automatisms adopted without control, unconsciously (therefore, usually they do not even have to make choices).

Stutterers derive their inability to change from the spasm sensation, and regard it as its fixation variant. The logic behind this attractive, but unacceptable thought is that both the spasm and the inability to change are unavoidable, unalterable, therefore they are the same (inductive reasoning).

The difficulty to change is not an exclusively stuttering specific trait, it occurs in other syndromes as well either as a central or a peripheral sign (anxiety, problems of self-esteem, depression, affective disorder, etc.).

Based on exploration material, the characteristic difficulties, which stutterers would like to change but cannot, are described below (sequence is irrelevant):

- they do not want to leave home (because then they do not have to show themselves, to speak, reason, give an opinion, adjust to others, accept others);
- they do not want new friends, acquaintances (because they cannot present themselves in interactions as they would like to, therefore, they will give a false picture of themselves);
- they do not want to change their opinion (making conclusions means a lack of problems, and thus there is no need to face another decision-making situation);

— they do not want new styles in clothing, haircut, to switch to a new sport (because it would entail re-examination of all that was before, by not changing stutterers avoid the difficulty of re-identification, of developing a new characteristic);

— they find it hard to cope with the greater or lesser difficulties of everyday life, of official business, they do not want new jobs, schools, or professions (for reasons as above);

— partner relationships (love, marital) are discussed separately (there is an irrational attachment to the partner, despite negative emotions, not as a source of affection, as an inspirational plus enriching the self, but as an object, or medium, filling the void that would arise if the object were lost, because filling the void, i.e., replacement of the object would cause difficulties for the above reasons).

The following is a *verbatim transcription of the recording* of the first of the eight sessions, in the course of which five intent formulas were developed by a 17-year-old client. It shows the development of an intent formula to influence the difficulty to change.

— *Do you mind talking about yourself?*

— Yes, yes, well it depends on who with, but actually that means only very few people.

— *Your parents, friends, I think.*

— Yes, but I have only two friends, like that, well, with them, my parents, occasionally, I think we already know one another very well, maybe they are tired of helping me.

— *What do you mean?*

— Well, this speech thing, I've had it a long time, they've taken me everywhere with it, they've always tried to tell me what to do, that's what I mean.

— *And now they don't want to help, or is it that you have had enough of their help?*

— The latter...

— *I see, and your friends?*

— They're different, they live more in today's world, there are things to talk about, we go to the same school, and before that to elementary school, so it's an old friendship.

— *The three of you?*

— Yes, and I don't think we need more.

— *Why do you think that?*

— Well, it's like this, we feel fine together, so we don't need anyone else, others wouldn't understand us, our customs.

— *Have you discussed this?*

— No, no, not specifically, but I think it's all right like this and the others didn't say anything either, so I think we can, will go on like this.

— *Will it always be like this?*

— No, eventually, sometime, maybe, things will change.

— *What are you thinking of?*

— Well, things like marriage, dating, other interests, work, moving, so on.

— *Do you think it's normal that the three of you bar yourselves from forming new relations?*

— I don't think that's exactly the case, because, now that we're talking about it, I think my friends are doing it for me, or for me as well, they adjust to me, well the fact is that they take my speech defect into consideration, and since they know that it's not good for me to meet strangers, well, they help me like this.

— *Does this mean that your friends would like to get acquainted with others?*

— I guess so.

— *How about you?*

— No, no.

— *Why not?*

— I don't need others.

— *Does this mean that you want to live alone all your life?*

— Well, put like that it sounds drastic and on hearing it, no, I certainly don't want that, and if I think about it, it's a stupid thing, but I can't really do anything else now, alone I think, maybe if I'm finally cured here, then, sure, I will change, I will decide...

— *I see, and this intention of yours to shut out others concerns only friendships or something else as well?*

— Well, everything I think, I don't like racing about.

— *Could you be more specific?*

— Yes, well, I have my schedule, which means mostly that I do what I have to, but nothing more if possible, not because I'm lazy, but because it's not in my schedule, so ... well it's school, friends, sometimes, but mostly I'm home.

— *Don't you have anything else to do?*

— Why should I, it's best to be at home, I like my room, my things, the tape recorder, video recorder, books, TV, I have no problems with my parents, sometimes I ride my bike.

— *Don't you wish for other things?*

— I do, I think I know what you mean, sure, and this contradicts what I said before, friendship, friends, well, it would be nice, and not only boys, girls too, of course, I see that others have girlfriends, but I told you, this does not fit into my schedule, I did not have one before, well, I think that this is a continuous thing

linked together, from the kindergarten on, that there are girls too, because this way, at my age, it's no novelty, as I feel it, it's unreachable, I don't feel strong enough for this.

— *This is an important thought, but where would you be able to, as you put it, grow stronger?*

— Well, in company, among people.

— *Yes, and?*

— And, and I'm not among people.

— *Where are you?*

— At home.

— *Why is that good for you?*

— Because it's safe.

— *Why is it safe?*

— Because there are no surprises there.

— *What do you mean?*

— Well, the things that disturb or surprise me, new things, people, when they ask questions and I have to answer, I don't like that, because I don't know what to say or do, how to answer, should I change, if so, is it good, for me change is like an earthquake, everything shifts out of place.

— *And is what you have now good?*

— Actually it's not.

— *What would be good for you?*

— Well, what I said before, a relationship, relations.

— *What prevents them?*

— That I don't change, I'm at home.

— *That's a precise description.*

— Yes, I think I am my own worst enemy.

— *What should be done?*

— It should change, but it's so difficult to do.

— *But you long to change, don't you?*

— Yes, of course.

— *Then what should you do?*

— Change.

— *What?*

— My present situation.

— *Be more specific, if you can.*

— Step outside the home, make a move towards new relationships, towards girls, to speak ... right?

— *Yes, that's correct. All right, now try to sum up the substance of our conversation up to now.*

— I'll try, but may I think about it a little?

— *Of course, let me just add, think of only the main, the essential elements, what you consider important.*

— All right, let me try, maybe it won't be a muddle, well, I spend little time among people, I have few friends, and the one, I mean the ones I do have, because there are three of us, help me even when they shouldn't, with my problem, and then, the important thing, I'm a homebody, though it's true that I'd like to go out, especially with girls, to make friends, with boys too, and what I have now, what I'm doing now is no help, because, well, I don't have the courage to dare change this and other things, for there are other things to change too, that's enough, well, it really sounds quite interesting.

— *Yes, you described it well, now try to verbalize the intent formula.*

— Yes, yes, let me think a little.

"I open the gates of my soul,
and bravely make friends".

(Note: Unknown to the client, we looked up the two friends mentioned in the exploration and asked them to help their friend to make friends.)

CONVERSATIONS WITH PARENTS OF STUTTERERS WITH A VIEW TO SELF-CORRECTION

In earlier investigations we have traced parental behavior characteristics across two generations. Our question was: are there any behavior characteristics in the stutterer's family, permanently influencing the stutterer, that span generations. To answer this question, we have examined not only the stutterer's parents, but their parents as well. The assumption was that the stutterer's parents and their parents show transmitted behavior characteristics, in other words, there is a relationship, a similarity, in the behavior characteristics of the stutterer's parents and their parents.

Our investigations proved that the behavior characteristics of the stutterer's parents and their parents influence, block, the development of hereditary factors and acquired abilities, as well as interiorization, causing a disorder in the stimulus and model of behavior learning.

Based on our findings, we consider the extreme fluctuation of the personality traits of stutterers as the essence of their parental characteristic. Since constant shifts, change, is the substantive character of the parents, other characteristics of the individual seek to counterbalance this (functional equilibrium). This permanent dilemma results in contradictory behavior, emotions (the parent's behavior is "unfathomable"), causing a continued disorder in the interiorization and socialization process of the stutterer.

We do not believe, of course, that the behavior characters of parents and their parents are the exclusive cause of the development of stuttering. It is only one important factor among many, one that preserves a predisposition spanning generations (this reasoning makes the behavioral "hereditariness" of the development of stuttering easier to understand).

The continuity of behavior characteristics of generations can only be influenced if the parents (the family) are also included in the therapy of the stutterer.

Transmitted behavior characteristics typical of stutterers' parents (parents and grandparents):

1. What is your present psychological state like? (bad)*
2. What characterizes your home atmosphere: arguments or peace? (alternation of the two)
3. Are you prepared for life? (yes)**
4. Are you able to control your emotions? (no)
5. Are you able to adjust to others over a period of time? (no)
6. What determines your behavior, decisions: emotions or reasoning? (emotions)
7. Do you experience conflicting emotions in quick succession? (yes)
8. Do you experience periodically recurrent fixed anxieties? (yes)
9. Are you aware of your own unfavorable characteristics? (no)
10. Do you lose your temper easily and often? (yes)
11. Is your family closed or open? (closed)
12. Do you have any emotional, behavioral inconsistencies? (yes)
13. Do you pay much attention to keeping yourself and your environment clean, in order? (yes)
14. Do you persist in your principles, customs, characteristics? (yes)
15. Are you inclined to be suspicious? (yes)
16. Do you divide work among yourselves at home? (no)
17. Do you experience extreme changes of mood? (yes)
18. Do you have prolonged bad moods? (yes)
19. Is your psychological balance easily upset? (yes)

Goal and conditions of self-corrective conversations:

— since in stutterers' families there is little discussion of affairs, events, feelings, opinions, conflicts, and little listening to one another (due to which there is a great deal of accumulated tension), our primary task in the conversation series is to bring the couple (and thus the family) closer together, to prompt regular conversation, to strengthen family cohesion. Thus, after our initial help, parents should initiate settling their own affairs, *want* to ensure the functional balance of the family and to create the necessary conditions;

— development or reinforcement of the need for conscious conduct, so that instead of being controlled by events, haphazardly, the parents, family members become capable of influencing events, their personal affairs, *at will*;

— regular contact between family members will shape, develop, the ability

* Significant replies in the questionnaire are given in parentheses.

** Interpretation of this in the conversation series was: is there order in the person's life?

to decentralize, so that parents, family members become capable of, will *want* to, pay attention to the others, to have regard for the thoughts, points of view of the others;

— regular conscious control over their own affairs will develop the problem sensitivity of parents, family members, so that instead of ignoring their problems they will *want* to find a solution to them;

— the goal of the self-corrective conversation series is *conduct based on self-knowledge*.

Generally, three or four sessions introduce the exploratory conversation series. Only so many are needed to help parents over the initial resistance to bring thoughts, feelings, into consciousness, and to show the method of practical realization, enabling them to attempt a solution and influencing of their affairs without delay. After the first few sessions regular monthly appointments are made.

The *basic concept of our conversation series* is to achieve parents' cognizance of the actual events, facts in their lives and of the data derived from the collation of their self-image with their feelings, of the difference between "what I am and what I would like to be", because this motivates parents to want to change and to perform self-corrective actions.

The goal of dialogic conversation is *recognitive understanding*, that is a re-examination by parents of their accustomed patterns of life style, thought and behavior, reaction modes, as well as the solution(s), and a verbalization of these with the therapist's help (some of the recognitions and solutions are not new ones, in which case the therapist's task is to reinforce these and to urge their realization as fast as possible, in order to strengthen the intention).

Since the medium of conversation, of the analysis, is the conscious mind, the conversations, analyses, the solutions must also be concrete (who, when, why, how, antecedents-reactions, reality-unreality, I felt it was like this or that, or it also happened like this, what was the mistake, what have I done and why, what I have not done and why not, what I will do, will I be able to carry out what I undertake, etc.).

Self-corrective conversation is applicable in cases where there is still a "usable", if partial or faulty, readiness to cooperate between husband and wife, between the parents (to "settle" things). Lack of cooperation, retardation, psychopathological conditions are contraindications.

A case of self-corrective conversation series

Since the medium of self-corrective conversations, analyses, is the conscious self, we begin by selecting from the questionnaire of so-called transmitted characteristics and discussing with the parents, first the most appropriate concrete questions (Nos 3, 11, 16), then the real life situations raised by them. According

to our experience, an analytical discussion of concrete, recurrent problems of everyday life shifts parents, family members towards one another, towards the intention to discuss other questions, feelings (under the continued supervision and support of the therapist).

We shall not deal with the other so-called transmitted characteristics here. In subsequent sessions we talk over problems raised by the parent, with which he/she needs advice or support. Discussion of the subject of the preceding session is not continued (except at the parent's request or if the parent is asked to identify, express the common factor of a set of events).

The following is an analysis of an example of the third characteristic in the questionnaire (concerning order in the subject's life) (case of A.K., 38-year-old mother).

— *Tell me what your average day looks like.*

— From morning until night?

— *Yes, from the time you get up until you go to bed, in as much detail as you can, what you do.*

— Usually, I get up at 5, alone, automatically, though I only start work at half past 8, but I have so many things to do that I must get up early when everyone else is still asleep. What I didn't do the night before, I finish in the morning, I get things ready for everybody, then get ready myself, prepare breakfast, wake my husband, he can never wake up by himself, of course he goes to bed late so he can't get up. He's often late to the office because of this. Then I wake the children, and take one after the other to the bathroom. Then somehow we get ready, and since the kindergarten is where I work, I take the smaller child with me, and walk the other across the street to where the school is. My work is mechanical, needs no initiative, I'm not very interested in it, but I've been there so long, I've gotten used to it and accept it, I work in the archive of a ministry. Then at work I think about how I'm going to pick up the children, what I have to do on my way home, and so on. Then I leave at around half past 4, and get everything done as I planned it, and arrive home around 6, then I check the homework, watch TV, help the children take a bath, tell a bedtime story and play a little with them, but not everyday, because I have a "thousand things" to do in the evening. My husband usually comes home around 7 or 8, and joins in things then, mostly dinner, watching TV, his books. Then I put the children to bed, do the light laundry, then go to bed and read about half a page and fall asleep (I've been reading the same book for about a year now, I always fall asleep over it).

— *What is your weekend like?*

— That's when I do everything I was unable to during the week, clean the house, do the laundry and the ironing, and Sunday afternoon I take the children out somewhere. We plan it together with the children, my daughter decides one week, my son the other.

- *Couldn't your husband help you?*
- No, he says he doesn't know anything about it.
- *Have you tried to teach him to do a few things?*
- Yes, that's the cause of all our quarrels.
- *What do you mean?*
- When I've had enough, I start to quarrel with him and the children too.
- *What do you want to achieve by this?*
- That I can't go on, something has to be done...
- *Does it have any results?*
- No, because the main thing always gets lost, it's only my screaming that they notice, and my husband withdraws even more.
- *Have you ever tried to talk this over with your husband when you were calm?*
- Once or twice, but he said he wasn't brought up like that.
- *How was he brought up?*
- He had everything done for him at home, he was an only child.
- *Have you tried to teach him, to show him how to do something in a nice, humorous way, in a better period?*
- No.
- *Do you mean to say that you only ask him to change without teaching him what and how?*
- Yes, you could say that...
- *What do you expect from your husband?*
- To help do some things, to take part in the family's work.
- *To do what, give an example.*
- Everyday things, like playing with the children in the afternoon.
- *Does your husband work so much that he can only get home in the evening?*
- No, he plays chess in the afternoon.
- *Do you think that he should stop playing chess?*
- No, only play less, so that he'd have time for the family.
- *Be specific, what would your husband have to do?*
- Go to the school in the afternoon and bring home the older child, help in doing his homework, and then I wouldn't mind if he went to play chess in the evening.
- *So you accept your husband's recreational needs?*
- Yes, within reason.
- *How do you consider telling him?*
- Maybe in a better phase.
- *Yes, that's good, but do you think it can be done in one sentence, with one request? You have already tried this, though only once...*

— No, I realize that, I'll have to prepare things better for this, since he'll have to give up something that he probably loves doing.

— *I agree, then what do you have to do and how?*

— Not when I'm mad, I realize that, not quarreling, but quietly, by reasoning, and maybe remind him of what he told me before we were married, about how he imagines our life together.

— *Do you think you have enough determination to try and make your husband understand?*

— Yes, I hope so, I was probably impatient, couldn't find the right time and place, I'll try it again so that I wouldn't have to do everything alone, because I've bungled, we've bungled something...

— *What do you mean?*

— Up to now I believed that I can do everything better and everything is best done as I do it...

— *Why aren't you so sure anymore?*

— Because I see that I can't do it alone, and my things aren't going so well..., there's too much quarreling.

— *Who quarrels with whom?*

— Look, apparently I do, because I'm the one to bring things up, I accept that, but I'm forced by the situation.

— *And who's responsible for the situation?*

— Yes, essentially I am.

— *What do you have to do, what would you suggest you do?*

— What I said before, we must finally have a talk...

— *Is that all?*

— I have to change my bossiness.

In subsequent sessions dealing with this third characteristic, the parent verbalized the following thoughts as those which prevented order in her life, in her family:

— lack of time:

— disproportionateness ("I accumulate a lot of things to do for Sundays and Saturdays");

— "I do not weigh how much I take on myself";

— "I do not save my strength";

— "I do not discuss things with my family, and often confront them with a ready situation";

— "one thing absorbs all my attention";

— "I forget things";

— "I don't think ahead".

She verbalized the following thoughts with regard to the *11th characteristic* (closed or open family):

- “I have no time to make friends”;
- “everyone just says their thing”;
- “you have to conform too much in a friendship”;
- disappointment (“I once had a friend...”);
- “there are few people you can trust”;
- “making friends costs too much money”;
- “there are too many problems, this isn’t so important just now”;
- “it’s better alone, there are no surprises”.

She verbalized the following thoughts regarding the *16th characteristic* (division of work, tasks, in the family):

- “this is the woman’s job” (quote from husband);
- “I failed to introduce customs properly”;
- “I don’t know how to go about it” (quote from husband);
- “I wasn’t brought up like that” (quote from husband);
- “I like to do things myself, because then they are sure to be done right”.

For methodological considerations we have treated the three transmitted characteristics separately, but, naturally, in the course of the conversation series this should not be done too strictly. Parents should be allowed to talk according to the dynamics of their stream of ideas, at the same time the therapist should repeatedly return to ideas he/she considers important.

Treatment results show that the self-corrective conversation series bring parents, family members closer together, and enhances the parents’ self-knowledge, self-control. We have found that results are more favorable in cases where both parents participate in the conversation.

The self-corrective conversation series provides an opportunity for ensuring the function of the family and thus for improving the circumstances of the stutterer.

REVIEW OF THERAPEUTIC RESULTS

Analysis of the efficiency of treatment and aftercare

We have conducted a follow-up examination of 50 cured stutterers to show the effectiveness of our complex method. The purpose of this follow-up examination was to discover if our therapeutic results withstand the test of time, of events.

The cure was measured by favorable changes in the individual symptoms of the four leading groups of symptoms, presented below. The author compiled a list of symptoms from the exploration series, the psychological and physical examination of the stutterers, his experiences of family visits and his own observations, and classified them into four groups. The phrasing of the symptoms represents the substance of the perceived symptoms, of the phenomenon. On the basis of this list, at the end of the first three months of therapy each stutterer was rated either as showing symptoms or as symptomless. This examination, using the same signs, was repeated at the end of therapy and one year after the end of therapy, then in 1985, 1986, 1987 and 1988.

We carried out six follow-up examinations of five cured groups between 1970 and 1980. The follow-up examination covers a period of 8-16 years.

Data of the follow-up examinations

Group	Number of subjects	Time of therapy	Follow-up examinations of					
			first at end of therapy	second 1 year after end of therapy	third in 1985	fourth in 1986	fifth in 1987	sixth in 1988
					carried out after			
A	8	1970-72	1972	1973	13 yrs	14 yrs	15 yrs	16 yrs
B	9	1972-74	1974	1975	11 yrs	12 yrs	13 yrs	14 yrs
C	10	1974-76	1976	1977	9 yrs	10 yrs	11 yrs	12 yrs
D	12	1976-78	1978	1979	7 yrs	8 yrs	9 yrs	10 yrs
E	11	1978-80	1980	1981	5 yrs	6 yrs	7 yrs	8 yrs

In the following we present in detail the symptom groups characterizing stutterers.

Behavior symptoms

1. Low toleration of unexpected, new situations.
2. Struggles with decision-making problems.
3. Incapability of endurance, effort.
4. Feeling of isolation (few contacts).
5. Narrow sphere of interest.
6. Not open to life.
7. Lives without any plan, purpose.
8. Low initiative.
9. Avoidance of role playing.
10. Low tolerance of failure.
11. Tendency to complain.
12. Avoidance of problems, difficulties.
13. Feeling of suffering many injustices.
14. Occupies peripheral position in group.
15. Poor sleeper (episodes of night terror).
16. Problems of concentration.
17. Using help from others to solve own problems.
18. Introverted life.
19. Feelings of inferiority.
20. Experiences physical-psychological "feelings".
21. Cannot live together with complaints (stuttering).
22. Preoccupation with unsatisfied desires.
23. Struggles with problems in relationships with the opposite sex.
24. Considers themselves sick.
25. Preoccupation with unrealistic feelings, thoughts.
26. Life is not what they would like it to be.
27. Cannot love deeply.
28. Thinks too much about their problem.
29. Often in a bad mood.
30. Cannot control temper.
31. Cannot maintain eye-contact.
32. Has tormenting dreams.
33. Feels lonely.
34. Has feelings of fear.
35. Shows sharply varying moods.
36. Has anxieties.

37. Can only give the correct answer, or solution, after the event.
38. Has compulsive ideas.
39. Inability to make compromises.
40. Is a daydreamer.
41. Considers the speech defect an obstruction in life.
42. Intends to be cured.

Motor symptoms

1. Wrinkling of the forehead.
2. Blinking.
3. Tensing the muscles of the mouth.
4. Lateral movement of the jaw.
5. Movement of the nose.
6. Movement of the outer ear.
7. Movement of the tongue outside the oral cavity.
8. Arched clinging, movement of the tongue.
9. Tensing the neck muscles.
10. Movement of the shoulders.
11. Bending the arms.
12. Movement of the fingers.
13. Separate movement of the fingers.
14. Movement of the body.
15. Touching some part of the body with the hands.
16. Movement of the legs.
17. Movement of the feet.
18. Standing up from a sitting position.
19. Movement in a standing position.
20. "Fiddling" with some object.
21. Seeking support with the hands.
22. Synergetic actions.
23. Irregular breathing movement.
24. Change in the tone of voice.

Somatic symptoms

1. Sweating.
2. Blushing.
3. Heart palpitations.
4. Trembling hands.
5. Micturition.
6. Disposition to diarrhea.
7. Disposition to stomach aches.

8. Disposition to headaches.
9. Hot flushes.
10. Feels changes in weather.
11. Ejaculatio praecox.
12. Problems of orgasm.
13. Dizzy spells.
14. Feelings of disgust.
15. Feelings of weakness.
16. Frequent faintings.
17. Vegetative paroxysms.
18. Difficulties of relaxation.
19. Muscle-senses throughout the body (trembling, tension, so-called surplus sensations).
20. Oro-facial excess movements.
21. Spasm sense (in the throat, stomach).
22. Frequent illness.

Speech symptoms

1. Fear of speech (fear of speech initiation because of block, stuttering).
2. Fear of speech situation (fear of joining in a conversation, speech situation).
3. Speech is accompanied by inhibitory feelings, thoughts (fear of block, without it actually occurring).
4. Disorder in the coordination of verbal and nonverbal systems (they do not complement one another).
5. Inaccurate sentence structure (inaccurate thinking).
6. Feeling that there are things left unsaid (usually, due to inability to say them).
7. Lack of forethought before speaking.
8. Use of "strategies" to make speech situations easier (these are created by the client, but by the end of therapy they also use strategies learned in the course of therapy).

Summary of the results of the examinations and follow-up examinations

Symptoms	Before therapy	At the end of therapy	1 year after therapy	in 1985	in 1986	in 1987	in 1988
Behavior	1643	81	391	167	68	27	16
Motor	514	21	80	92	16	10	7
Somatic	422	56	145	146	58	22	9
Speech	400	11	62	37	26	18	12
Total	2979	169	678	442	168	77	44

A summary of the data of follow-up examinations shows that there is a significant reduction of symptoms as a result of therapy. In other words, our complex method, developed for the treatment of functional stuttering, efficiently influences all symptoms of stuttering and withstands the effect of time and events.

The first follow-up examination shows an increase in the number of symptoms in every group of symptoms. Interviews with the clients revealed that every one of them had stopped doing the exercises. This was the reason why former clients were called in for a so-called reinforcement treatment and were asked to do the exercises regularly at home. As a result, the follow-up examination in 1985 again showed a decline in symptoms (except for somatic and motor symptoms). All subsequent follow-up examinations showed significant improvement in all four symptom groups, i.e., the number of symptoms showed a steadily declining tendency.

The above prove that there is a causal relation between continuous practice and the decline in the number of symptoms, i.e., between continuous practice and the permanence of therapeutic results. This means that so-called reinforcing treatments are necessary for preserving of therapeutic results.

We have found that within a more or less short period of time after the conclusion of the therapy stutterers discontinue their exercises at home (note: this question is not given sufficient attention in the literature, and the author himself has not realized its significance before). The reason for this is that since the speech symptoms did not reappear our former clients were able to speak fluently in every situation, therefore, the immediate motive for practice seemed unimportant. The other symptoms exert indirect influence on the personality, consequently what they signal does not rise to full consciousness.

In view of the above we consider the employment of so-called reinforcing treatment periods necessary, because (a) positive treatment results will be stable only if they are regularly reinforced (prolonging therapy is not advised because of client's infantilization), (b) positive, permanent changes in other areas of the personality follow the improvement of speech, positive changes in speech symptoms, only slowly, and (c) they allow regular control of the reproduced neurotic symptoms (prevention).

The most important finding of our follow-up examinations is the fact that the stutterer is fundamentally and steadily characterized by behavior, motor and somatic symptoms, and only to a lesser extent by speech symptoms. This finding explains the background of the reproduction of neurotic potential, of somatic-psychological functional disorder.

In our view, neurotic potential emerges in the course of development of stuttering in reciprocal action, therefore, it is not the cause, but the consequence of stuttering. Its course of development is as follows. Reactive neurosis brought on by stuttering amplifies some of the factors and mechanisms of the basic character-

istics of the personality, which were in harmony up to then, and which continue to operate even after the cessation of stuttering and the end of treatment. Since the personality always acts in a complex psychological energy field, simultaneous life events continue to maintain a neurotic disposition (constitution and experience) against the background of the personality's mode of reaction. The result is that the phenomenon of stuttering is tied to certain personality components, which favor, through interaction, the manifestation of different symptoms independently of the speech symptoms.

Data of our follow-up examinations show the following symptoms to change little compared to other symptoms, and, therefore, to characterize stutterers in the long run:

- weakness of the capacity to act (change in the quality of communicational capacity, from communicational deficit to reduction in communicational capacity);
- vegetative dystonia (the stutterer's somatic and psychological activity is a function of many conditions, consequently, adaptational balance, the functioning of the personality is unstable);
- inaccuracy of motor organization (in the appearance of which speech-behavioral achievement tension is a determining factor);
- insufficiency (the fact that the stutterer always says something other than what he/she feels and desires indicates the maintenance of a process "to be something different" blocking development of the sense of identity, which means that the stutterer carries the dilemma of "what I am and what I would like to be");
- inaccurate anticipation (based on fear of stuttering, when the stutterer wants to get done with speaking as fast as possible, then noticing his/her mistakes, corrects them and repeats what he/she was saying, whereby the communication is slowed down; this is an inaccuracy of the expression of ideas, of structuring verbal content, of progress of thought);
- emotional-affective control (it shows the magnification of the subjective self, the "I feel" event, in other words, the stutterer perceives experiential material as subjective evidence, and is, therefore, characterized by subjective assimilation of experience which is maintained by unsteady tension regulation, by neurotic potential).

According to our *follow-up examination*, stutterers are steadily characterized by their behavior, and to a lesser extent by their speech, motor and somatic symptoms. Our treatment results resist the effects of time and life events, they are stable if the stutterer continues to do his/her exercises on a regular basis. This means that in order to maintain even performance, the stutterer must, throughout his/her life, focus attention on him/herself (not on his/her speech), which serves to preserve mental health.

General aspects of aftercare

At the conclusion of the treatment, when the client is symptomless or his/her symptoms have diminished considerably, and is thus in a positive physical-mental state, the therapist tells the client that he/she must continue with the exercises at home if he/she wants to maintain achievement, because *practice and maintenance of results are related*.

The client must be informed that a so-called *natural relapse* may occur after the conclusion of therapy. The explanation usually lies in the loosening of a close client-therapist relationship. Frequently relapse occurs, especially as regards behavior symptoms, if the environment (family, school, workplace) "fails to properly follow therapeutic events", i.e., it continues to produce symptoms (and preserve symptoms).

The therapist, based on the treatment experiences of the given case, prescribes the exercises to be done at home. These exercises must only contain material the client is familiar with and the therapist has supervised (often, clients discover "treatment elements" for themselves, which the therapist should not discourage, unless it impairs treatment).

At the end of treatment it is the therapist's duty to propose regular meetings with the client, the purpose of which is to reinforce and supervise work performed at home, or to help solve new problems. Given the client's consent, an appointment for the first so-called *reinforcement treatment* is made. We have found the best time to be the end of the third month following discharge and after every third month a meeting is suggested. Under normal circumstances, such frequency of subsequent meetings is sufficient. Theoretically, each of these sessions lasts 2-3 hours.

Aftercare must rely on treatment status, the completed material and the treatment plan.

In the course of aftercare, the therapist must examine the client in the same way as at the beginning of treatment (but, in view of the fact that the therapist already knows the client, his/her questions, his/her probing, may be purposive).

Exploration constitutes a salient part of aftercare. In the course of doing exploratory work the following questions are important:

- what has happened to the client since his/her discharge (make the client tell of actual events, as well as his/her attitude to them, his/her opinion about them, learn whether they coincide with the client's desires, help his/her growth, etc.);

- has the client's psychological life space changed (family, school, workplace);

- is there a change in the client's relation to relevant persons in his/her psychological life space (parents, husband, wife, siblings, children, colleagues, friends);

- is there a new person in the client's psychological life space (attraction, aversion);
- does the client have complaints (are they new or have old ones returned);
- does the client perform the prescribed exercises (it is important to query the client closely about this),
- what is the client's opinion about his/her new complaints, why have they appeared, what causes them (this provides important information on the consciousness of conduct),
- is the client responsible for the emergence of new complaints (errors in conduct, decision-making, has the client applied the methods learned in therapy),
- current (as well as past) physical-mental condition of the client.

The therapist must decide, on the basis of information obtained in the exploratory conversation, whether or not to change treatment. If he/she does, he/she must explain what changes he/she intends and why.

If one so-called reinforcement treatment session is not enough (because interpretation of complaints takes longer, or demonstration and learning of a new methodological element becomes necessary), then client and therapist should meet again the following day.

If necessary, the therapist should visit the client's family, or request to meet the client's relatives personally, in the course of aftercare.

The main methodological steps of aftercare

The following are therapeutic solutions we use in aftercare to influence symptoms generally characterizing stutterers.

In the case of a *low capacity for action*, the goal of exploratory conversation is to discover if there are any realizable tasks in the client's life, that is, to find out if the *individual is motivated to exert effort*, to perform. The reason being that the problem of not undertaking enough tasks, or a lack of tasks, lies at the heart of this symptom. Concrete life events and the actors therein are the subject of dialogic exploratory conversations. Thoughts and emotions inhibiting effort are interpreted in this concrete psychological life space. On the basis of conclusions drawn from them, the client is asked to formulate the tasks stimulating his/her achievement, volition, coordination, the actions to be solved.

This process of logically thinking through the client's life events serves to strengthen the capacity of rational understanding.

The following exercise serves to influence *the symptom of inaccuracy of anticipation in thinking*. Its stages are:

- the client must be sure he/she has something to say;
- that he/she wants to talk about it;

- if so, he/she must first phrase it to him/herself;
- it should be short and simple;
- he/she should say it by using one of the methods learned.

The essence of this exercise is to insert a waiting, a preparation, period between stimulus and reaction, when the client has time to “build up” the content and form of what he/she wants to say.

We find behind the *insufficiency* symptom the client’s real unsatisfied desires, psychological deficiencies, unfulfilled life. The symptom was brought about by the client’s actual quality (stuttering), the process of symptom formation was initiated by a communication problem caused by speech. Here our aim is to reduce the difference between “what I am and what I would like to be”, to close the gap between the characteristics and desires of the client. This is done within the framework of exploratory conversation between the client and therapist. The material and the actors in it are taken from the client’s psychological life space. Client and therapist discuss the questions raised by the client in the course of dialogic exploration (the medium of discussion and interpretation is the conscious mind). Since concrete events are discussed, the conclusions of their analyses (formulated by the client) must also be objective and immediately realizable in the client’s life.

A “common denominator” in the clients’ exploratory conversations is the mental stereotype of the so-called absolute solution of things, events. Clients believe that things have only one good solution, and they must conform to this single, absolute, good solution. If they fail to do so, their efforts, intention to change will not succeed (probably, their opinion that there is only good speech and bad speech also plays a part in the development of this mode of thinking). A “natural” consequence of this mode of thinking is a continuous sense of failure, and thus there really is no change, and the goal, “what I would like to be”, remains unattainable. For this reason, the positive life events, successful solutions, accomplishments of the client are given special attention in the exploratory conversations.

Analysis of the background of the symptom of *unstable emotional-affective regulation* has shown that in their past (because of their speech defect) clients stayed outside a number of human relations situations (friendship, love, roles). This isolated way of life deprived the client of identification with many important persons, events, emotions. The result is a deficient *interactional self-knowledge*, experiential material, a slowing down of the development of the personality.

Therefore, the therapist’s job in aftercare is to guide clients toward varied interactional relations in order to acquire as much personal interactional experience as possible (in each session the client is asked to analyze his/her successful and unsuccessful attempts).

Autogenic training, as well as the intent formulas based on it and are applicable for a wide range, is a very efficient method for influencing the symptom of unstable emotional-affective regulation.

Given this symptom it is always advisable to discuss the following topics in the course of dialogic exploratory conversations:

- return of past fears (beliefs, loss of assurance connected with speech, persons, situations);
- bias (against a background of subjective evidence clients tend to form quick judgements and categories of good or bad);
- overview, distancing, independence of the emotional-affective tone of events (they are to counterbalance the exaggerations of emotional instability);
- getting lost in details and inessentials, and sublimation (due to a readiness to yield to psychological temptation there is no steady mental-behavioral composedness, consequently, the thinking and action of clients tend to be impulsive and governed by minor details).

Our suggested method in the case of the symptom of inaccurate application of the so-called *articulation techniques in speech*, is:

- reducing the rate of speech;
- well formed, strong articulatory movements (in case of vowels);
- uniform enunciation time of vowels in words (regardless of their position in the word);
- speech based on conscious, monitored, self-observational experience.

The symptoms, *vegetative dystonia* and *inaccurate coordination of movement*, are not dealt with separately and methodically in aftercare. We have found that these symptoms are related to the above discussed symptoms, the improvement of which entails improvement of these two symptoms. Should this fail to take place, we then, naturally, begin to treat them (in consultation with a doctor).

Comparative examination of the lives of cured and untreated stutterers

In our follow-up examinations conducted over a period of 16 years we sought to find out, given positive treatment results, what changes in life (performance) characterize stutterers cured by our complex procedure. Furthermore, if the client, the cured stutterer, is able to maintain the even quality of his/her functional capacity only with regular practice, then what changes in life and performance do untreated, uncured stutterers show.

Structure of the examination

We have based our study of the changes that took place in the lives of cured stutterers in the case histories of 50 clients who participated in our 16-year-long follow-up examinations.

The data of untreated, therefore uncured, stutterers was obtained from 50 persons, whom the author began to treat between 1984 and 1988, but who gave up soon after and have not completed treatment since then (11 women and 39 men between 18 and 43 years of age took part in the examination, their scores on the Hungarian adaptation of the Wechsler Intelligence test corresponded to age and performance requirements).

Data was collected individually in an exploratory conversation in 1989.

In the exploratory conversations we were interested in four areas: school, family, work, physical-mental health. In each area we sought answers to preformulated questions (these questions were directed at the physical-mental accomplishments of the personality).

The data of the two groups were collated and interpreted proportionately to the statistical frequency of its occurrence.

The following table shows the four areas examined, the *answers to preformulated questions and the frequency of their occurrence*:

<i>School</i>	<i>Cured group</i>	<i>Uncured group</i>
Elementary school education	8 (17, 19)*	17 (15, 16)
Vocational school education	19 (20, 18)	26 (26, 25)
Secondary school, vocational secondary school education	16 (9, 11)	7 (9, 9)
College, university education	7 (4, 2)	0 (0, 0)
	50	50
Occupies executive position (only those with college or university education)	7	0
Occupies middle managerial position	9	2
Employee	35	48
	50	50
Has doctorate	1	0
Speaks foreign languages	5	1
Has second diploma, vocation	3	1
Innovation, invention, creative product	3	0
Study tour abroad	4	1
Publications (regularly)	1	0
Lectures (regularly)	2	0
Social functions	4	2
	23	5

* Parents' education, the first number refers to fathers, the second to mothers.

<i>Family</i>	<i>Cured group</i>	<i>Uncured group</i>
Lives in marriage	42	32
Cohabits	4	6
Unmarried	4	12
	50	50
Total number of divorces	2	10
Divorce was preceded by long negotiations, dispute, legal proceedings	1	5
Marriage dissolved because of former stutterer, stutterer	1	3
Spouse has speech defect (stutters)	1	0
Military service (total number of men: 36)	31	17
Unfit for military service	5	19
<i>Work</i>		
Satisfied with workplace, with job	36	21
Dissatisfied with workplace, job, but will not quit for other reasons	11	9
Dissatisfied with workplace, job, and wants to change soon	3	20
	50	50
Total number of workplaces of subjects	121	215
Reprimand	1	4
Award	13	2
Property acquired by work:		
family house	7	5
condominium	9	2
piece of land	6	3
car	29	16
<i>Physical-mental health</i>		
Received treatment for nervous complaints for a brief or extended period	2	9
Still has nervous complaints	1	11
Took medication for nervous complaints over extended period	0	5
Still takes medication for nervous complaints	0	8
Received treatment for medical complaints, though examinations revealed no changes	2	12
Received psychotherapy	1	0
	6	45
The "break", the "nadir" in his/her life is caused by:		
his/her speech defect	0	19
financial problems	7	5
marital problems	1	4
problems at work	1	0
health problems	1	9
	10	37

Solves conflicts him/herself	34	1
Believes in God	6	3
Keeps a diary	2	0
Examines his/her conscience every day	2	0
Examines his/her conscience occasionally	14	2
Was responsible for a traffic accident	0	2
Active in sports	11	2
Nurses his/her grudge	1	4
Committed violent action	0	2
Is regularly in touch with parents, siblings	26	15
Has a very close friend	23	14
Satisfied with his/her life	45	22

Discussion

School

The greater part of the subjects (43-49) in both groups did not continue to study after finishing secondary school, only very few of them went on to higher educational institutions, not one of whom belonged to the uncured group (7-0).

More than 50 % of the cured group finished elementary school and vocational training school (27), the rest (23) finished secondary school and university.

The overwhelming majority of the uncured group finished elementary school and vocational training school (43), the rest (7) finished secondary school only.

In the cured group the subjects' education is higher than their parents'. In the uncured group it is the same. Education and position at work are directly related.

In the cured group only those who finished secondary school and university (23) decide to study further while in the uncured group only a very small number of those who finished vocational training school make the same decision (5).

Family

Most of the members of both groups live in marriage, though 12 subjects in the uncured group are unmarried.

The divorce rate is very high (10) in the uncured group.

Work

Subjects in the uncured group changed jobs more often than those in the cured group before finding the "right" one (cured subjects had two, uncured subjects had four jobs on the average).

Twenty subjects in the uncured group were dissatisfied with their workplace and decided to look for a new one soon.

The amount (value) of possessions acquired by work was greater in the cured group.

Physical-mental health

Uncured subjects had more nervous complaints than cured subjects (45-6).

Speech, somatic, financial and marital problems were the cause of a "break" in the life of uncured subjects (37), and financial problems in that of cured subjects (7).

Cured stutterers do more on a regular basis for the preservation of their physical and mental health than uncured ones.

Summary

Cured stutterers, i.e., those who received treatment, clearly showed better performance and fewer problems in each of the four areas examined, than did uncured stutterers. This means that treatment helps the full development of the stutterer's abilities, improving his/her chances for a higher quality of life.

Data about the lives of cured stutterers show that they are capable of meeting every standard posed by society. They can work and study and reach high levels of achievement, they live in families, they are physically and mentally functional entities (able to solve their conflicts).

Successful treatment helps stutterers to lead a richer and more creative life, their lives are characterized by physical and mental achievement. The lives of untreated stutterers are characterized by a low-level development of abilities and low performance.

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The accumulation of theoretical and practical knowledge in related branches of science have led to a better understanding of stuttering. This process has also led to an increase in the scope of objective information on stutterers. The recognition of the fact that a multitude of causes are responsible for stuttering which is manifested in a multitude of symptoms, has raised the question of the need for a complex method of treatment for differential therapy which combines several professions and approaches, in order to enable therapists to adjust to the nature of the phenomenon. This type of therapeutic approach has the most to offer for stutterers today.

Our procedure is not speech-centered, it does not directly focus on the speech defect itself. In our view, stuttering is not a speech disorder, but a manifestation of interiorized influences and events, of erroneously fixated speech behavior. Consequently, our procedure does not offer to change the cause of symptoms, but the medium responsible for maintaining the symptoms, namely, the speech behavior block (complaints are modes of fixation of symptoms).

The procedure for the treatment of the various manifestations of stuttering symptoms, was developed in the course of two decades of psychological and speech therapy work, and each of the procedural steps is backed by theoretical and practical experience.

