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The Speech-Language Pathology Situation in Palestine: Focus on Stuttering

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Abstract

Stuttering is a formidable communication disorder and, despite extensive studies, there is still considerable disagreement and controversy over the possible causes, diagnosis and treatment. The situation of stuttering assessment and treatment in Palestine is far from satisfactory. There are only two available centres in Ramalla and Beit Jala. However, for many people these centres might be difficult to travel to because of the distance and the cost of travel. Competent speech pathologists are not always specialised in stuttering and most of the people have no access to speech pathology clinics.

Keywords: Stuttering, Stuttering situation in Palestine

1. Introduction

Stuttering is a formidable communication disorder which interrupts and breaks the fluency of speech. It is a type of pathological fluency failure. Despite extensive studies and many publications, it "remains one of the most puzzling and least understood of the communication disorders"; (Mower, 1998, p. 89-97). Stuttering is a speech disorder which can be either developmental beginning in childhood or acquired. (Howell, 2004; Yaruss, & Quesal, 2004). Mower quotes a statement from Siegel (1993, p. 111) which indicates how little we know about stuttering and its treatment. "Stuttering has opened many eras, and, after two or three decades of al theory, seems to have retained most of its mysteries intact .We still do not know what causes stuttering. We cannot confidently partial out the contribution of environment and genetic factors. We are still in some quandary concerning the basic definition of a moment of stuttering and its relationship to normal disfluency. We are still uncertain why some children recover from incipient stuttering and others do not. Within the framework of a learning theory we are far from understanding how punishment and reward contribute to the onset of maintenance of the disorder or to its remediation. We cannot provide a satisfactory account of why some of our more successful ally oriented methods work so well or so fleetingly".

Many researchers try to give a satisfactory definition for stuttering within the framework of the theories or hypothesis they stick to concerning its aetiology. It is out of context here to deal with this in detail, but a few of these definitions will be discussed briefly. According to the international classification of disease (World Health Organization, 1981, p. 86-87), stuttering is 'a disorder in the rhythm of speech, in which the individual knows precisely what he wishes to say but at the time is unable to say it because of involuntary repetitive prolongation and/or cessation of sound''

Wingate (1964 & 1969) describes stuttering as a fluency failure of dysfluency. In the 1964 article he gives some remarks on the definition of stuttering up to that time; "The definitions of stuttering vary at different levels. Some take stuttering as straightforward characteristics of speech; others deny this; others focus on aetiology; others take the combination of these features as their basis for stuttering definition". Wingate indicates some criteria for defining stuttering. He indicates that it is a speech disorder and in its definition the speech features must be indicated as the most important characteristics. They must be universally demonstrable; they must form the main features of the stuttering disorder wherever the stutterer comes from. These stuttering features should be the discriminating features of stuttering. In addition there are some other features which can be considered secondary and tertiary which may be a part of the stuttering of some stutterers. His standard definition of stuttering is presented in three parts. Part One involves the classic characteristics of stuttering. They are the discriminating features of this speech disorder and are called the primary features.

After his analysis he came up with the following description of stuttering. "The term stuttering means:

1. Primary features: These are characteristics of the speech events. They involve repetitions or prolongations of the short speech elements: sounds, syllables and monosyllabic words.

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These features are not ready controllable and they are frequent.

2. Secondary features. These are not evident in the speech of every stutterers so they are called secondary features which involve escape and avoid features, to get rid of the primary features.

3. Associate features. These features involve attitudes such as "fear, frustration anxiety and the like". In the 1969 article he continues considering stuttering as phonetic transition. He indicates that the primary features of stuttering, part-word repetitions, prolongations and broken words, are phonetic transition; a failure in the continuation of the speech event. He gives an example of prolonging a sound as not being able to produce that sound but inability to move from this sound to another automatically. Onslow (1993) considers Wingate's definition of stuttering as symptomatic definition on the basis that the listener decides what he hears is stuttered or non stuttered speech . He refers to another symptomatic definition of stuttering by the World Health Organisation (1977, p. 202) of their "International Classification of Disorders". "Disorders of rhythm of speech, in which the individual knows precisely what he wishes to say, but at the time he is unable to say it because of the involuntary repetitive prolongation or cessation of a sound".

The symptomatic definitions have been noted by Ingham (1984) as having certain terms which cannot be observed such as "fluency". Such speech events are very difficult to observe. Another point lies in the fact that stuttering is not a straightforward set of speech events. "People do a lot of different complicated things when they stutter. Perkins (1984a, p. 431) considers stuttering as an internal event which only the person who stutters can give an objective description of; "Temporary overt or covert loss of control of the ability to move forward fluently in the execution of linguistically formulated speech". The shortcoming here is that sometimes it is difficult to distinguish stuttered and non- stuttered speech even though they have the same features - Perkins (1990a) himself indicates that this is not easy through this approach to distinguish between stuttered and non-stuttered speech in children. Ingham (2004) indicates that vocal blocks are the most important characteristic of stuttering causing a disruptive to speech due to the fact that the stutterer is unable to talk at the time of the vocal block. In addition, abnormal movements characterize the behaviour of the stutters such as the facial musculature including the eyes, mouth, and lips. Bloodstein (1987, p. 9) argues that stuttering can be judged by experienced observers as "whatever is perceived as stuttering by a reliable observer who has relatively a good agreement with others". This argument is perceptual but it is not an objective one (for more criticism of this definition see Onslow (1993, p. 17). Bloodstein (1987) stresses the point that each clinical situation needs different ways of definition. Ingham (1984) reviewed the definitions of stuttering so far and indicated that broken words, prolongations and part-word repetitions of the initial sounds "are disfluency types that typify most stuttering". Van Riper (1971) suggests the following definition for stuttering "Stuttering occurs when the forward flow of speech is interrupted abnormally by repetitions of a sound, syllable or articulatory posture or by audience and struggle s". Shames and Florence (1982) added that "there will be emotional states. These can be on a continuum that extends from a generalised anxiety or tension about speaking to particular emotional failures".

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Barry Guitar (1998, p.10-13) gives a general definition to stuttering by indicating three types of behavior:

1. Core behaviors (adopted from Van Riper, 1971). They are used to describe the basic characteristics of stuttering: Repetitions, prolongations and blocks.

2. Secondary behaviors. The person who stutters develops these behaviors after becoming aware of stuttering. These indicate the types of reactions and behaviors of the stutterer to finish with stuttering. These behaviors begin as random then they are learned. They involve escape behaviors (such as eye blinks, head nodding, hand movement and lip tremor) and avoidance behaviors (such as changing the words which he might stutter on for other words) and avoiding situations (as telephone calls) and settings, all of which might create stuttering behaviors.

3. Feelings and attitudes. These represent a more advanced development of stuttering; when the individual who stutters starts to have negative reactions from his own such as fear, frustration and anxiety and from the people around him who he thinks that they criticize him for his stuttering.

In general, stuttering develops when "the articulatory system attempts to execute an underspecified utterance motor plan. Slower and incomplete retrieval of speech motor plans is the proximal source of stuttering: stutters occur when syllable motor plans stored in memory are concatenated to produce the utterance motor plan" Venkatagiri, 2004, p. 401). All the definitions of stuttering stated above and many others were suggested, but not one of these definitions has been adopted as a classic or satisfactory definition. Whatever a definition is suggested, specialists and researchers find holes in it. It is really a complicated issue especially with chronic stuttering among adults Bloodstain (1987), Wingate (1984), Smith and Kelly (1997), Van Riper (1971).

2. Stuttering Situation in Palestine

In Palestine the situation is very complex. The first speech-language pathology clinic, with a single clinician was established at the Bethlehem Arab Society for Rehabilitation. After that clinician resigned and went to work in Saudi Arabia, the clinic closed for some time but now there is another clinician working there. A further clinic opened in the city of Ramalla five years ago and is functioning at a satisfactory level. No other centres, as far as I know, exist in the West Bank and I am not aware of any clinics in the Gaza Strip. In September 1996 the Institute for Speech and Language Sciences was established at Al-Quds University in Jerusalem and started a Master's degree program in SLP. Unfortunately this programme failed owing to many negative factors.

When it comes to therapy, I dare say that none of the therapist is competent in being able to differentiate between beginning stutterers and normal disfluent children. Stuttering is a very complex communication disorder; it needs efficient speech pathologists who understand the problems that face those who stutter and know how to work with them. Our speech pathologists function as general practitioners. None of them have devoted themselves to stuttering assessment and treatment. They handle stuttering from a speech behavioural point

of view after a short interview with the child or the adult. They diagnose the person as a stutterer or non-stutterer. They may use the same treatment method for a child and an adult stutterer. When the case is improved, even in a short time, they discharge the client or the client discharges himself because he no longer understands the manner of his treatment. He was usually given certain words or sentences to read for his treatment, and the clinician corrected him when he had stuttering or disfluency disorder. When stuttering relapses the client either comes back to the clinic or prefers to live with his stuttering rather than be treated by a non specialist clinician. Their assessment involves asking some questions without using any type of criteria to help them in for their judgement. As far as I know they do not use a case history or any other procedures in their assessment. They do not follow the right procedure in differentiating between early and advanced people stuttering in treatment. They use the direct method in treating children. Children think of the treatment sessions as if they were classes at a school with inexperienced teachers. They do not appreciate or like the way they are treated. Parents in most cases do not co-operate; they think of the clinician as a medical doctor who gives drugs to the patient to effect a cure. They think that they are responsible for the stuttering of their children and the clinician usually does not draw their attention to the fact that they are not. Adults prefer to live with their disorder rather than being in the hands of such inexperienced clinicians. Parents must realise from the beginning that things improve with their co-operation with the clinician in the assessment and treatment procedures and they are not responsible for the stuttering of their children. One has to remember that stuttering takes a long time to cure; and if fluency is to be increased at the early stages of therapy one has to work very hard at it. One has also to remember that therapy deals with stuttering behaviour and the attitudes and beliefs about stuttering. This really needs competent speech-language pathologists. One has to be very clear with his speech pathologist. He should to ask him from the beginning about what the therapy involves, about his experience and how many people who stutter he has worked with.

To remedy the situation for the assessment and treatment of this formidable communication disorder in Palestine, I recommend running a specialised course on assessment and treatment of stuttering for both clinicians who are interested in this field and parents who have children who stutter. It is important to invite highly specialised and experienced clinicians to teach in such a course. In addition we must start with an intensive and wide campaign to orient parents of children how to be aware of the fact that children through their early acquisition of connected speech pass through a period of speech disfluency and how to rear their children to avoid developing this normal disfluency into stuttering. We have also to draw the attention of adult stutterers the necessity of not concealing the fact that they stutter.

To my knowledge there has been no study in Palestine to find out the ratio of prevalence and incidence of stuttering among children and adults, and the ratio of males to females. Adults usually refer themselves to speech pathology centresand children are referred by their parents. However there are a lot of problems here:

1- In Palestine the two available centres are in Ramalla and Beit Jala .For many people these centres might be difficult to travel to because of the distance and the cost of travel.

2-The majority of the people in Palestine have no concept of SLP. Adults and parents of children with fluency failure in many cases go to medical doctors for the treatment of stuttering.

3-There are two main social classes: On one side, the educated and the rich people and, on the other, the uneducated rural and Bedouin areas. People from the rural and Bedouin areas may not care about stuttering especially in children. Many people who stutter in Palestine are low-esteemed, isolated from others and they are called "stutterers". The categorisation of these people as stutterers means that they are often mocked and laughed at. This is quite different from the situation in the western countries.

3. Conclusion

The situation in Palestine with stuttering is far from being satisfactory because most of the people have no availability to speech pathology, competent speech pathologists are not always specialised in stuttering, and people who stutter are mocked and laughed at and teased by the persons around them which create fear.

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