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ABSTRACT

Recent investigations in the field of speech pathology are focusing increasingly on possible relationships among the pathological natures of those speech disorders having an emotional base (e.g., stuttering, stagefright, reticence). The psychological and sociological context of reticence--the avoidance of social and verbal interaction--should be of particular concern to teachers of public speaking, since existing pedagogy either ignores this problem altogether or, by insisting on every student's full participation in the "recitation-criticism" aspects of public speaking courses, actually penalizes reticence or intensifies the problem. Teachers of public speaking have in the past often assumed that everyone is trainable to some extent in communication skills and that strength of will is sufficient to remedy any human difficulty. What is actually needed, however, is a clinical approach to this disorder that can be readily applied in the public speaking classroom, and a revision of the "recitation-criticism" teaching methodology. (JM)

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The Problem of Reticence

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SPEECH AND PERSONALITY

The field of speech pathology has recently come of age. Articles have proliferated on the etiology, diagnosis and treatment of organic and functional speech disorders. There is an implied inference that the dialogue between the speech pathologist and the public speaking teacher is ended. This is far from so! Much early research conducted by the speech therapists centered on the pathological aspects of speech disorders. However, recent investigations have increasingly been focused on the psychological and psychiatric involvement in pathologies of speech.[1] Travis states:

> Speech pathologists have manifested in both practice and research an ever-quickening interest in psychotherapy. To them have come those suffering from troubles in communication without organic impairment of either the sensory or motor speech equipment. Voice and speech drills have not always been too effective with these cases. The recognition of emotional disturbances as etiological factors in these disorders have forced speech therapists to seek the promising help of psychotherapy as developed by psychiatrists and psychologists.[2]

In dealing with abnormalities of speech behavior, some definition of "normal" appears to be necessary. To provide one appears impossible in the context of the ever-increasing association made between speech and personality. Recognition of the connection between psychology and speech disorders led to a search for possible relationships between personality patterns and disorders of speech and communication. Speech disorders and personality disorders are now widely acknowledged to be related malfunctions. This attitude is implicit in such definitions as, "a speech disorder is a disorder of the person as well as a disorder in the reception and transmission of spoken language,"[3] or ". . . speech is a peculiarly *human* function and its disorders reflect all the complex troubles of humanity."[4] Confirmation from psychiatrists can be found in Becker's[5] statement that speech is the most significant projection of human personality, so intrinsic that it cannot be studied or treated without a holistic involvement of personality. The implications here are obvious. If there is any disorder at all in a speaker's personality, it will, in some way, be reflected in his verbal patterns. Scher[6] refers to "verbal dysrhythmia" as a main symptom of personality disorder. Thus speech therapist and psychotherapist alike agree on the relationship between speech and personality. Berry and Eisenson sum up:

> Speech may be considered defective if the speaker is excessively self-conscious or apprehensive about objectively

small deviations in his manner of speaking. In a broad sense, any speech deviation, however small, becomes a significant defect if it interferes with the speaker's social adjustment.[7]

The awareness expressed by Johnson of the semantogenic involvement in etiology of speech pathologies is confirmed again by psychologists and psychiatrists.[8] It appears that a social definition is made of a 'deviation' and a human becomes involved as a total personality. It is this very admission of the psychological and social context of speech problems that re-opens the dialogue between speech pathology and public speaking. Examining the real potential of the psychological etiology means that a relationship can be hypothesized between stuttering, the domain of the speech pathologist, stagefright, the province of the speech teacher, and reticence, which no one works with at all.

All of these can be connected by a concept which designates normality as the set of 'neurotic behaviors' accorded positive value by society, as opposed to equally neurotic, but not necessarily more serious behaviors denigrated by society. Thus, the fluent, smooth, quick-witted speaker given high value in both the speech classroom *and* the social situation may be suffering from anxieties equivalent to those of the shy, withdrawn person who is often ignored. Speech behavior as a facet of total personality would be one of many responses to threat-inducing situations. Some would be motivated to take control: others to withdraw. Some would be positively evaluated in their behavior and thus reinforced, others would be negatively evaluated and induced to withdraw.[9]

A variety of social and psychological connections have been proposed for deviation in speech communication patterns. Brady[10] notes that a primary symptom of schizophrenia is reduced or modified verbal output. Freedman, Ebing and Wilson[11] add that quantity and quality of verbalization and vocalization must be considered in any diagnosis of schizophrenia. Schachter, Meyer and Loomis[12] generalize that any failure to use speech for conventional purposes of communication may be considered a sign of mental illness to a greater or lesser degree. Rowley and Keller[13] refer to social approval as the influential factor in verbal effectiveness or failure, while Rogler and Hollingshead[14] demonstrate a relationship between movement in social classes and disturbances in speech. Speech, as a projection of personality, is evaluated by society against implied standards. Individuals assume a role based largely on the reflection of their personality back from society.[15] That means that abnormal speech must be considered a function of normal speech in any deviation where a physiopathological diagnosis cannot be made.

Speech behavior is neither separable from personality nor trainable apart from personality as a whole. Any approach to speech training with alteration of behavior as the goal means a revision of total personality is necessary. Any alteration in treatment level or motivation will alter speech behavior. The precise nature of the personality change will not be so obvious. Masserman[16] demonstrated that conflict in motivations may induce coping behavior but heighten anxieties in subsequent experiences. For example, the needs moti-

vated by the grading system may induce a student to manage his fears and survive in the speech classroom, but impair his ability to function in future experiences. Attention to compensatory paralinguistic and kinesic behaviors has been noted by Szasz[17] and Sebeok and Hayes[18] as they demonstrated that the emotional state of the personality demands one sort of communication or another: if not verbal, then through some sort of bodily action not excluding hysterical or psychosomatic manifestations. A human may be able to mask a personality disturbance by controlling overt speech behavior, but the necessity to communicate the phenomenal self will produce a variety of other types of communication more indicative of the 'true' personality state. Quantitative and qualitative withdrawal from oral communication, therefore, may be considered as a sign of personality problems, requiring total treatment rather than symptomatic treatment in the form of speech training. The student who displays 'enthusiastic' gesture patterns and who receives an 'A' therefore may also require total treatment rather than reward in a speech class for manifesting neurotic symptoms.

Reticence is defined as, "avoidance of social, verbal interaction. Unwillingness to communicate unless prodded; disposed to be silent; not inclined to speak freely; reserved."[19] Teachers of speech and academic advisers are familiar with people who fit the definition. They are a small, but noticeable, proportion of the total student body. It would require a rather gross stretch of psychiatric nosology to classify these people as 'schizophrenic.' They do not show the symptoms of blocking and tension usually associated with stuttering. However, their behavior assists them to achieve the same ends as the schizophrenic or the stutterer, i.e. avoidance of the communication act. For this reason, their behavior can be considered pathological in terms of Van Riper's definition "speech is defective when it deviates too far from the speech of people that it calls attention to itself, interferes with communication, or causes its possessor to be maladjusted."[20] The fact that we have a definition of reticence generally applied to 'non-verbal' persons would indicate that our society negatively evaluates individuals who withdraw from communication. Ruesch and Bateson underscore this point as they state, "disturbances in communicative behavior of the speaker when he acts contrary to general expectations, when he says too much or too little, or when his expressions are unintelligible."[21] Where effective verbal behavior is demanded, inability to perform according to society's expectations would signal a deviation. In this dimension, reticence could be construed as existing on a continuum with stuttering and stagefright. As mental disturbance permeates all individuals, each of these 'verbal problems' would be complicated by whatever 'mental disturbance' overtones existed. At any event, the problem of failure to perform up to the expectations of society appears more complicated than simply revealing a resistance to the directed learning of the classroom.

It would be simple to declare a manifesto of 'civil rights' for quiet people: to declare that no one need speak in our society unless he wants to. The demands of our modern society preclude this easy

way out. Full utilization of the talents of human material, the integration of personalities into connection with "useful work" demands that each man contribute his share to his society.[22] Allowing an individual to take refuge from the challenges of life by refusing to participate in the communication level of the game would be to deny the whole concept of preventive mental health. Speech teacher and speech clinician alike assume the role of quasi-psychotherapist as they attempt to alter the behavior of the people who come to them, many of whom are inadequate in communication behavior *and* inadequate in total personality.

It is generally assumed by teachers of public speaking that everyone is trainable to some degree in communication skills. However, over the years it becomes evident that a noticeably large number of students do not seem to profit from the training, and a few, in fact, seem to regress. While few speech teachers fail to recognize the existence of these 'failures,' the phenomenon has not been studied in an organized way. Muir, in a series of interviews with reticent persons, demonstrated the possibility between regression of speaking skill and the training given in the conventional speech class.[23] Several of her 'reticent' subjects traced their inability to cope with speech situations back to an unpleasant or intimidating verbal performance, sometimes in a speech class, often in classes where 'speech' was being taught by an untrained teacher.

In general, the therapy of the speech class is based on the classical Greek model which holds that 'strength of will' is sufficient to remedy any human defect.[24] This approach may be reasonably effective in training the speech of those who suffer from no disturbance of personality. For those who are moderately disturbed to begin with, however, public speaking classes may do considerable psychological damage, particularly in the potential induction of iatrogenic disturbances triggered by stimulating awareness of performance criteria (voice, gestures, etc.) over which the subject has no apparent control. The apprehensions thus induced may act in somewhat the same fashion as the etiological factors in stuttering, i.e. setting off hypertonic, apprehensive reactions about the malfeasance in question. Most studies of apprehension use objective evaluations as a validity criterion.[25] There is no available data using the subjective testimony of students about their own apprehension levels. It has already been noted that the drive to succeed in the broad academic game may temporarily permit masking of anxiety symptoms, but there is no reasonable guarantee that the result of the whole experience has not been a heightening of the desire to avoid communication. Muir's study poses this as a possibility.

Syllabic repetitions do not seem to become problems until a name, "stuttering," together with a pejorative connotation has been given to them, and anxieties triggered.[26] Denigrating comments about 'eye contact,' 'gesture patterns,' 'voice quality,' etc. may evoke similar apprehensions in some students, which would heighten the general anxiety when facing a public speaking situation. If the pattern were

carried to its logical end, a whole complex of avoidance-type symptoms could be set off.

If we were to assume a continuum of personality, we would also assume that a reasonably high number of students would be 'threatened' by a directive mode of speech criticism.[27] Direct criticism and the attendant directive therapy has not seemed to work so well in the psychological clinic.[28] Today the pattern appears to follow a non-directive mode in order to allay rather than heighten anxiety.[29] If the speech teacher could identify in advance which of his students would profit from a directive approach, there would be little problem. Since the tendency of the human, however, is to mask personality disruptions, the teacher can really never know that his directive approach is not causing hidden psychological damage. An analysis of diary reports of 300 subjects with 10 different instructors shows an incidence of physiological and emotional symptoms in response to criticism in about 15% of the cases. The anxiety level expressed here may represent a burgeoning core of personality-disturbed individuals whose potential is for regression unless given a very special sort of treatment.

Masserman reports that subjects confronted with conflicting goals may use their desire to achieve a greater goal to help them overcome anxieties about a lesser goal.[30] In the speech classroom this could mean that desire for 'survival' in the grading system would enable the student to surmount anxieties in the speech classroom. The question is, of course, what happens to anxiety levels in subsequent speech situations. If Masserman's evidence can be believed, we must assume that anxieties would be substantially increased.

As a first step in determining the potential for existence of 'problem-speakers' or 'reticents' the relationship between the various types of identified speech disorders and normal speech needs to be investigated. There is virtually no material dealing, with the problem of reticence *per se*, nor, indeed is it recognized as a problem. Lilly-white, however, points out that generally, inability to communicate is a disease; for example, the person who is *psychologically* incapable of listening is suffering from just as much of a defect as the person who sustains an organic hearing loss.[31] More relevant:

> Our very limited concepts of what we call 'speech defect' and disorders of communication have prevented us from seeing the relationship between clinical communicative disorders and disorders of communication in 'normal' speakers. It would be helpful if we could think of disordered communication as a continuum with difficulties arising from many different causes: some pathological, some psychological, and some social — all contributing to the failure to be understood or to understand. Such a point of view would enable us to make use of the techniques employed in the clinics and the laboratories of speech pathologists and audiologists for help in evaluation, diagnosis and treatment of the problems in communication outside as well as inside the clinic.[32]

Lillywhite may have an extended role for the speech pathologist in mind. His statement also takes cognizance that the wide nosological range of identified speech problems requires the combined diagnostic talents of speech pathologists, psychologists, psychiatrists, and teachers of 'normal speech!' If we accept the premise that many speech disorders result from societal evaluation, there would be no lacuna between normal and abnormal. Any 'normal' speaker enrolled in a public speaking class may be considered a potential 'defective.' That is, any identified pattern may develop to the point where it interferes with his communication and requires special treatment. The public speaking teacher thus finds himself in a new role, that of clinical diagnostician. He may be called upon to do therapy also, in a given case. If so, his whole classroom necessarily takes on the aura of a clinic. Each student would have to be treated as a unique personality with equally unique communication patterns. Diagnosis would reveal those who would benefit from directive training in the form of performance criticism as well as those whose anxiety state would permit only non-directive approaches. Also, such restructuring of the classroom would enable the speech teacher to coordinate his efforts with those of the speech clinician or psychologist to assist rehabilitation of released subjects. If properly trained, the teacher of normal speech could play a significant role in reinforcing clinical gain, in addition to his own clinical role of improving the speech patterns of 'normals.'

Training would involve attempting to derive insights into the factors contributing to 'disordered communication' requiring involvement in a number of fields. Psychological problems and speech problems can be temporary or permanent, chronic or acute. Insights that apply to both temporary deviations in normal speakers and chronic patterns in diagnosed communication defectives must be sought. Above all; an understanding of verbal behavior in general and its relation to personality in general is necessary.

Several authorities believe that communication behavior is so direct a function of personality that any maladjustment, temporary or permanent, would be projected in some way through deviant communication. Johnson speaks of a "language of personality maladjustment,"[33] and Barbara refers to a "neurosis in speaking."[34] Under the general heading of "Language of Maladjustment," Johnson discusses two kinds of individual, classified according to verbal output. Admitting the difficulty of arriving at an accurate estimate of what might constitute a normal amount of talking, Johnson says:

> Among the definitely maladjusted there would appear to be a disproportionate number of these over-verbalized and under-verbalized individuals. Both appear to have great difficulty in expressing themselves with any considerable degree of satisfaction either to themselves or to their listeners.[35]

He goes on to classify verbose individuals into three categories: 1) "those who talk mainly to avoid silence," 2) "others who use language chiefly to conceal truth," and 3) "those whose incessant talking appears to serve the function of a great nervously twitching proboscis

with which they explore unceasingly in search of certainty." Of people who talk very little, Johnson says, "as a broad generalization it can be said that they have progressed more deeply in stages of demoralization."[36] Apparently he feels that the person who is still speaking offers some hope for therapy. He considers the person who withdraws from speech a more severe case. He says, for example, of the stutterer:

> A person's speaking time is a fundamental indicator of the degree to which he is handicapped by the communicative difficulty . . . the importance of a particular individual's speech problem is felt by him in a peculiarly basic way in the extent to which he restricts or inhibits his communication with other people.[37]

We are concerned with stuttering not only because it is a verbal deviation accorded low status by society, but more important, because of its effect on the individual stutterer. We are not distressed by 'syllabic repetitions.' In most cases, a simple directive, corrective remark remedies the 'defect.' In a few cases, the context of the directive reinforces tension and a stuttering syndrome is induced. Stuttering inhibits communication with others. It is one of many ways in which persons whose personality needs impel them to withdraw or avoid the communication meet this need in their communication behavior. The vector is not certain. Sometimes communication disorders result from personality problems. Sometimes the disorder is conditioned or present and a personality disorder results. Once the personality disorder has been rooted, however, treatment solely directed to speech phenomena is generally useless.

Szasz sets up a "games theory" model for understanding such personality disorders which offers a wide range of explanations also for avoidance of communication each of which involves personality problems.[38] A human being who seeks to mask his emotions or hide his values and/or suffers threat from the existence of potential responses to his communication may elect to withdraw through stuttering, through manifest stagefright, through monosyllabic responses, through maintenance of a phatic level of communication, through compulsive iteration, etc. Regardless of the specific method elected, it serves as an explanation to the individual for failure to cope with the role-demands of society. Reticence may thus mean more than low quantity in verbal output, but rather denote a nosologic category for any communicative disorder which results in reducing the effectiveness of the individual in the normative verbal intercourse demanded by his culture. The psychiatrist may conveniently classify these deviations as 'mild schizophrenia' or 'manic-depressiveness.' However, few persons with mild personality disorders will ever see a psychiatrist. Their problem must be treated in the normal routine of their daily existence if it is treated at all. The fortunate ones may perhaps learn to stutter and be referred to a speech clinic for help. Those who deviate in an unclassifiable format will be labelled "weird" and rendered permanently unable to contribute their verbal share to society. Even worse, they will be prevented the privilege of self-actualization

simply because they are unable to integrate their own personality with society.

Barbara also discusses in great detail the relationship between personality traits of 'neurotic' persons and the characteristics of their speech.[39] One classification is "the man of few words," the resigned speaker, of whom he says:

> Unable to face himself most times in a realistic sense, one of the resigned person's active neurotic solutions is to remove himself from the conflicting situation by assuming the attitude of being the on-looker or non-participating spectator. He represses or denies many of his real feelings and desires by placing inhibitions and checks in the path of their expression.[40]

Society often reinforces such withdrawn behavior with the classification, "good listener." The premium on "good listeners" as sounding boards for the excessively fluent might also be examined in terms of the development of an authoritarian hierarchy in which verbal quantity alone determines the acceptance of ideas. Muir, for example, detected a trend among classified 'reticent' persons toward variance or clash in their basic value structure with those of the modal group of which they were ostensibly members.[41] That means that a prevailing style of values exists in national cultures, an assumption definitively documented by Charles Morris.[42] Examination of micro-cultures or sub-cultures within the American culture might also indicate that sub-styles emerge and those individuals who are members of a sub-culture by propinquity or ascription may avoid threat to his value structure by electing a reticence pattern. Thus the total culture is denied the contribution of their ideas, and they are denied the opportunity to release the tensions they feel.

While 'normals' may be reticent on occasion, the chronically reticent may have adopted a permanent game behavior because of inability to cope with felt or projected values in the group around him. Riesman refers to the ability of the genuinely other-directed individual to detect the basic operant value pattern in his social group with the metaphor of "internal radar."[43] If the individual is suitably other-directed, he will also have no trouble altering his behavior and values to suit those of the mode. On the other hand, the individual who still clings to an inner-directed set may feel values and behaviors hostile to his own and find it necessary to adopt a reticence mechanism to prevent discovery and threat to his value deviation. Stuttering, stage-fright, verbal withdrawal and various types of compulsive speaking may be variously elected. Riesman's hypothetical constructs were experimentally confirmed by Williams.[44]

Barbara also discusses two qualities of deviant speech behavior. The self-effacing speaker, he says:

> . . . is in constant dread of failing in the speaking situation. He is in a perpetual state of self-consciousness, tension apprehension and in fear of suffering stagefright or freezing at some particular stage of speaking.

His nervous mannerisms call attention to themselves, his voice often

lacks control, his speech is full of vocalized or unvocalized pauses. He has a fear of using words which may have connotations of violence, aggressiveness, presumption or arrogance. He avoids direct assertion and carefully selects his vocabulary.[45] The average speech teacher is familiar with this type. His behavior generally leads to the classification of "lazy" or "unwilling" and earns him a 'C' or less in the course.

The expansive speaker, Barbara continues, is one who has a compulsive need to talk and whose speech is egocentric, aggressive, one-sided and two-valued:

> In the speaking situation, the expansive speaker feels he should be and is the *last word*. In any discussion he fears mutual exchange of ideas, is usually stubborn, resistant, and highly reluctant to face issues squarely and honestly.[46]

Frequently this type of speaker is rewarded with high grades because of fluency alone! Highly developed performance criteria succeed in masking the personality disturbance that enabled him to develop as a "capable" speaker.

There are apparently two levels of disturbed speech behavior with which the classroom speech teacher might be confronted. These may be classified as 1) restricted verbal output, and 2) excessive verbal output. In either case, the disturbed speech pattern would be indicative of a disturbed personality pattern requiring special treatment. The frequency with which such cases are encountered may imply the non-applicability of a uniform pedagogy and the adoption of a clinical format for the teaching of 'normal' speakers.

Clinical Implications for the Teacher of Speech

If we accept the twin premises that 1) speech problems are related to personality problems, and 2) the bulk of such cases exist in the 'normal' population rather than in the clinic, some drastic revisions must be made in the assumption underlying speech pedagogy. Currently the speech teacher functions as a diagnostician, but does so in the framework of the classical view of speech as a separable human behavior capable of pedagogical manipulation in isolation through a variety of directive methods. The "canons" are interpreted to mean that it is possible to train speech in 'parts' or 'units' in which emphasis may be variably placed on sources of ideas, organization, language, delivery patterns or use of notes. That is, if we make the diagnosis "faulty organization," "poor research," "soft voice," "poor eye contact," "sloppy gestures," and the like, specific directions for improvement are warranted as though each were equally capable of improvement separately. The assumption is made that there is a correct standard, which the student must measure up to.

Improvement, however, is judged by the teacher, not by an objective observer nor by subjective report from the student. Observed improvement is attributed to the success of the method; non-improvement is the fault of the student. The relationship between training methods and improvement has not been measured — only hypothesized from the hopes of the instructor! An equally tenable hypothesis

would be that the mere opportunity to speak has a salubrious effect and motivates improved performance by desensitizing the speaker to the audience situation in the absence of threat.

Becker notes that society imposes on man the necessity to speak clearly and fluently.[47] Offering a student a chance to speak in a classroom also provides a mechanism for catharsis. This is the one place in the college environment where the student will receive a little undivided attention, not only from peers but also from an authority figure whose approval is being sought. This opportunity makes his personality more vulnerable to threat, because the rules of the academic game as he understands it do not seem to prevail. His improvement may be analyzed in terms of Szasz's games definition.[48] The student understands what is expected of him generally in the academic game, and is ready to comply, since compliance also serves to fit the rules of his own 'game' of socially motivated self-expression. Society rewards the fluent, coherent speaker for his behavior and so reinforces his desire and ability to play the game. Reticent behavior is not rewarded. The reticent (substitute 'C') speaker is penalized by both criticism *and* a poor grade. This is a shock to a vulnerable personality that may have exposed itself. Negative reinforcement results, particularly when peers are permitted to join in the criticism. Their insensitivity to threat-cues often leads them to overcriticize, particularly projections of intrinsic personality mechanisms, heightening the threat to the phenomenal self of the speaker that was exposed, ostensibly to meet the new rules of the speech class game. The unthreatened students can learn something of the nature of social response by listening to their peers criticize. For the reticent speaker, peer criticism only reinforces negative self image and a further penalty is exacted for a failure he has already admitted and expected would not figure in the game. Up until the time the speech teacher asked him to express himself he had devised a method of working around the threat he felt from speaking, but now the classroom situation demands reversal of his internalized behavior in order to succeed. He may try, or he may withdraw, but his internal tension is heightened, whatever he elects to do.

When the threatened speaker exposes his personality and his values, he expects to be reacted to as 'person' rather than 'performer.' But standard criticisms are performance oriented. One response is to withdraw into dullness, to play the game as best he can and preserve a little self-esteem. The threat of the criticism, however, will affect his personality and his communication ability for a long time to come. Muir has traced back several adult speech problems to criticisms offered by teachers (sometimes not speech teachers), parents, significant others in the subject's ontogenesis.[49] In the light of this, an even more satisfactory framework for evaluations would be to examine the student's manifest and covert apprehension levels to determine whether transferable training has come about. Emphasis should be on problems in communication felt external to the speech class. The speech class is only a clinic in which real problems can be worked out with a minimum of threat.

Becker contends that a child develops his verbal patterns in the framework of a total social setting. The child must learn the arbitrary nature of symbolization and its effect on his world.[50] He learns that he can manipulate the world to greater or lesser degrees through the use of his symbolic capacity. He may learn that he is capable of mature control, or he may learn futility, or something in between. In any case, the response of his world of peers and superiors will alter his total personality and this will be reflected in his verbal behavior. The speech teacher can do little short of using clinical methods to alter verbal patterns so inculcated. The speech teacher is not a psychoanalyst, but he cannot be permitted to be an authoritarian director of performances. For the student who 'succeeds' the class as traditionally operated may represent a successful directive therapy. For those who do not succeed, another therapeutic pattern is indicated. There is too little evidence that traditional directive methods succeed in altering human communication behavior to warrant continuation with present methods without solid testing.

The 'normal' approach to the problem of reticence is through the designation "stagefright." The approach to the compulsive over-talker is often "get off my back" or "go out for debate." In either case, the assumption is that conditioning through training under criticism will improve whatever criteria are diagnosed as deficient. The literature on "stagefright" is insightful, but it has not as yet been generally translated into an approach to pedagogy in the typical classroom.

Douglas noted that feelings of personal security are related to effectiveness in public speaking.[51] Those individuals who were rated as 'better speakers' tended to possess the characteristics of mature personal security, self assurance, group identification, and optimism. Poorer speakers gave evidence more typical of chronic insecurity. Penalizing the poorer speaker with a low grade heightens the feeling of insecurity, while the 'A' speaker has his feelings of acceptance heightened. The rift between the two widens and the potentiality for authoritarian domination of the 'better speaker' over the 'poorer' becomes apparent. The poor speaker tends to withdraw even further from participation and plays the game with a little less elan than before. He may rationalize his discouragement by verbalizing a need to study for other courses, or complain about the unfairness of the speech requirement. His limited preparation time is spent mostly in generating anxieties and thus his performance potential is even further reduced.

Ainsworth tended to confirm the connection between stagefright and personality problems by noting tendencies toward shyness, seclusiveness, withdrawal, depression, guilt feelings, and inhibited disposition in stagefright subjects.[52] Several other authorities agree with the findings: Jones,[53] Gilkinson,[54] Wilkinson,[55] and Greenleaf[56] offer similar conclusions that frightened speakers are threatened people. The logical inference is that maximization of threat will heighten anxiety and reduce the potential for effective speaking.

Apprehension or nervousness does not necessarily mean failure on the platform. In the greater number of cases, anxiety is general-

ized toward the unfamiliar context. Once the teacher and the class become 'knowns' automatic desensitization has had its effect and performance improves in a familiar situation. This leads to success in the class and *possible* carryover. In the minority, perhaps a large minority, of cases, however, anxiety deepends. We assume that mastery of tension in the classroom will carry over, but this assumption is not fully tenable. Those students who master the situation because of the greater fear of failure in the total college context will not necessarily have their anxieties quelled in relation to an unrelated speech performance. Management of anxieties, not necessarily elimination of anxieties is the apparent key to platform success. Mastery imposed by authoritarian threat is temporary, and it has already been noted how, in such circumstances, they may return in a specific situation and interfere even more with performance potential. Thorough measurement of both the long and short term effects of speech training must be made to determine what proportion and what type of student does succeed in making a carryover of performance skill from classroom to more typical public situations. There is enough new evidence about the association of speech problem and personality problem to invalidate the blanket assumption that success in class equals success out of class.

If we accept the idea that there is some connection between reticence, verbal withdrawal, and dysrhythmia with personality disturbances, the need for special treatment is sharply delineated. Gold[57] reports his view that current thinking in psychiatry classifies any verbal withdrawal as a form of schizophrenia. Goldfarb shows that schizophrenics are general disjointed in conceptual responses, particularly space-time orientations.[58] Guertin offers evidence that schizophrenic verbal patterns range over a wide field of difficulty, varying by social conditioning.[59] Seth and Beloff generalize the verbal problem of schizophrenics by showing their inability to handle abstract ideas spontaneously.[60] Fenichel, Freedman, and Klapper construct a theory of therapy which has as its base the removal of the schizophrenic from the offending environment.[61] Recent studies by the Chapmans underscore this point by showing the differentiation in verbal responses by schizophrenics and normals.[62] Connect all these things together and the weight of the evidence supports the contention that the only rational approach to the treatment of personality associated verbal disorders is through special treatment in a constructed environment preliminary to release into a normal environment. The speech pathologists have recognized this for a long time. Severe cases usually require institutionalization. These cases, however, would probably not appear in a typical speech classroom. The mild personality associated speech disorders commonly seen by the speech teacher demand little more than an alteration of pedagogical approach designed to minimize threat and allow personality to come more in harmony with the social context.

Morse, among others, attacks the overuse of the schizophrenic diagnosis by psychiatrists but does so without minimizing the importance of a verbal disturbance for the person who suffers from it.[63]

Certainly specialists in the field of speech are not sufficiently sophisticated in psychiatric nosology to diagnose or treat 'schizophrenia.' However, the field has already assumed the burden of special clinical treatment for one type of verbal disorder, stuttering. It has been demonstrated that stagefright, verbal withdrawal, and excessive compulsiveness in speech, regardless of psychiatric diagnosis, exist on a continuum with stuttering and fit the same dimension of aiding the subject to avoid the normal communicative context. These, therefore, should be considered worthy of special treatment as well.

Research findings for stuttering show a pattern similar to those for verbal problems in general. Goodstein[64] and Johnson[65] both demonstrate an association between stuttering and desire for social withdrawal. In this sense, the typical speech problems encountered by the public speaking teacher may be regarded as related to stuttering. Those individuals most intimidated by the classroom situation deserve an essentially similar approach. It cannot be inferred that conditioning a speaker by forcing him to speak will work any better than forcing an acrophobic to go up in an airplane, or locking a claustrophobic in a broom closet, particularly in the light of Heilbrun's findings that authoritarian environments heighten personality disintegration and communication disturbance.[66] The broadness of the agreement about stuttering is significant, despite surface disagreements among experts. Barbara notes that regardless of the approach to *therapy*, there appears to be general agreement that stuttering has an emotional base; Blanton, Fletcher, Gifford, Robbins, and Solomon are offered in evidence.[67]

It is clear that not all fearful people stutter or show manifest stagefright symptoms, nor even display patterns of reticence. Some attempt must be made to connect situation with speech disturbance. Perhaps disturbed oral communication is a function of a specific anxiety in a pre-determined social setting. Berry and Eisenson note that the variation in stuttering pattern depends on social context:

> Students of stuttering have long known that stutterers have varying difficulty according to the nature and size of their audience. Almost all stutterers are completely fluent when talking aloud to themselves in the privacy of their own rooms. They can talk with normal or almost normal fluency when addressing animal pets. Adult stutterers usually have little difficulty talking to small children. When we analyze the relatively easy situations for most stutterers, we find that a 'common denominator' of the speaking situations is a relative absence of communicative responsibility.[68]

Johnson says almost the same thing about stagefright:

> Relative particularly to fluency problems are anxiety-tension manifestations commonly termed 'stagefright.' That is, of course, not confined to the stage, and involves a more or less serious disturbance of speech. This is very common and in severe cases, the effects on speech are both disintegrative and restrictive.[69]

Social context appears critical, and this is the peg on which therapy can be hung, for by altering social context as in a clinical environment, it is possible to bring about some adjustment to the difficulty, though not necessarily elimination of it. West refers to context when he says:

> Some persons classify themselves as stutterers and consider their problem serious who have few or no obvious breaks in the fluency pattern. Judged by over symptoms alone, the latter would frequently not be classified as stutterers at all . . .[70]

In short, the internal feelings of the individual, conditioned by social cues, result in the self-evaluation of difficulty. Many times the depth of feeling-involvement cannot be inferred from overt symptoms. Once an individual has given a name to his feelings, they can become tokens in the game that the individual has elected to play. Blanton notes:

> Stuttering is a blocking of the person's ability to adjust to other people. It is a personality defect due to anxiety in meeting various social situations, rather than a speech defect.[71]

The words "stagefright," "reticence," or "disturbed verbal behavior" could be neatly substituted for "stuttering." Further, it is clear that therapies offered for stuttering could not be carried on in the normal speech classroom.[72]

There seems to be sufficient indication that stuttering and stagefright are, in some way related, and further, that they are related to a general category of personality disturbances characterized by inability to function well in situations where oral interaction is necessary. Recent preliminary investigations of subjects classified into the categories of "stutterer," "stagefright victim," and "reticent" serve to confirm this connection. Interview with some forty subjects, including written projectives, tend to indicate a uniform fear of social context, a uniform expression of capability when confronted with inferiors, and most important, a generalized deviation from the value structures of the norm. If these findings are confirmed in a more rigid experimental context, then the significance for the teacher of speech cannot be overestimated. He would cease to be a teacher in the classical sense, imparting knowledge and directing behavior, but would become a nondirective clinician. Each student would have to be approached as an individual clinical subject. Backus has already stated vigorously that there is no real separation between 'normal' and 'abnormal' behaviors, let alone a separation between the various categories of abnormality. She states:

> Speech is viewed in psychological terms for all persons, not just for those judged to have 'maladjustments,' or not just for those who have 'speech disorders.' The concept of a dichotomy between normal and disordered speech may have a convenience administratively in speech departments, but it is not considered relevant in discovering causal relations in a client's behavior. For instance, available evidence appears

to indicate that the same laws . . . govern phenomena classed 'stagefright' in the classroom and . . . 'anxiety' in the clinic.[73]

A similar view is expressed by Nelson:

> It may be possible now to discern that these people (reticents) have actual communication disorders or 'speech defects,' and certainly they experience a concern similar to that of a person with a clinically diagnosed speech or language disorder. These individuals may reasonably require diagnosis and clinical type treatment before they can expect to function successfully before an audience.[74]

The precise nature of the clinical approach necessary in the typical public speaking class has not yet been worked out. There is no question but what it is necessary. Imposition of arbitrary threats like grades on speeches, peer criticisms, and the variety of personality-attacks that result from instructor criticism honestly and sincerely given may have some success in improving overt verbal quantity and quality for the majority of students. The incidence of physiological symptoms, emotional fantasies, verbalized threats, etc. in a typical population of speech students, however, is large enough to warrant a broad re-evaluation of pedagogical assumptions and methods, leading to the development of a new set of goals and methods for the teaching of speech. One thing is sure. The traditional motif of teaching speech on a recitation-criticism basis now has the burden of proof, and must show it is not harmful or be revised!

FOOTNOTES

1 Leonard Goodstein, "Functional Speech Disorders and Personality; A Survey of the Literature," JOURNAL OF SPEECH AND HEARING RESEARCH (December, 1958). Cf. also
Franklin Knower, TABLE OF CONTENTS OF THE QUARTERLY JOURNAL OF SPEECH, 1915-1960, SPEECH MONOGRAPHS, 1934-1960, AND THE SPEECH TEACHER, 1952-1960 WITH A REVISED INDEX COMPLETE THROUGH 1960. Bloomington, Indiana: The Speech Association of America, 1961.

2 Lee Edward Travis (ed.), HANDBOOK OF SPEECH PATHOLOGY, New York: Appleton-Century-Crofts, 1957.

3 *Ibid.*

4 Charles Van Riper, SPEECH CORRECTION: PRINCIPLES AND METHODS, 4th Ed., Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1963.

5 Ernest Becker, THE BIRTH AND DEATH OF MEANING, New York: The Free Press, 1962.

6 Jordan Scher, "Ontoanalysis, the New Psychiatry," Unpublished paper written for delivery at the Speech Association of America Convention, Denver, 1962.

7 Mildred F. Berry and Jon Eisenson, SPEECH DISORDERS: PRINCIPLES AND PRACTICES OF THERAPY. New York: Appleton-Century-Crofts, Inc., 1956.

8 Wendell Johnson, PEOPLE IN QUANDARIES. New York: Harper and Brothers, 1946.

9 Jules Masserman, "Ethology, Comparative Biodynamics, and Psychoanalytic Research," in Jordan Scher (Ed.) THEORIES OF THE MIND. New York: The Free Press, 1962.

10 John Paul Brady, "Language in Schizophrenia," AMERICAN JOURNAL OF PSYCHIATRY, XII, 1958.

11 Alfred M. Freedman, Eva V. Ebing and Ethel W. Wilson, "Autistic Schizophrenic Children," ARCHIVES OF GENERAL PSYCHIATRY, VI, 3 (1962).

[12] Francis Schachter, Lucie Mayer and Earl Loomis, "Childhood Schizophrenia and Mental Retardation: Differential Diagnosis Before and After One Year of Psychotherapy," AMERICAN JOURNAL OF ORTHOPSYCHIATRY, XXXII, 4 (1962).

[13] Victor Rowley and Dwayne Keller, "Changes in Children's Verbal Behavior as a Function of Social Approval and Manifest Anxiety," JOURNAL OF ABNORMAL AND SOCIAL PSYCHOLOGY, Vol. 65 (July, 1962).

[14] Lloyd Rogler and ugust Hollingshead, "Class and Disordered Speech in the Mentally Ill," JOURNAL OF HEALTH AND HUMAN BEHAVIOR. II (Fall, 1961).

[15] Arthur W. Combs and Donald Syngg, INDIVIDUAL BEHAVIOR. New York: Harper and Bros., 1959.

[16] Masserman, *Op. Cit.*

[17] Thomas Szasz, THE MYTH OF MENTAL ILLNESS. New York: Harper-Hoeber, 1962.

[18] Thomas A. Sebeok, Alfred S. Hayes and Mary Catherine Bates, APPROACHES TO SEMIOTICS. The Hague: Mouton & Co., 1964.

[19] Clarence L. Barnhart (Ed.) AMERICAN COLLEGE ENCYCLOPEDIC DICTIONARY. Chicago: The Spencer Press, 1950.

[20] Van Riper, *Op. Cit.*

[21] Jurgen Ruesch and Gregory Bateson, DISTURBED COMMUNICATION. New York: Norton & Co., 1957.

[22] Paul Goodman, GROWING UP ABSURD. New York: Random House, 1960.

[23] Laura Muir, CASE STUDIES OF SELECTED EXAMPLES OF RETICENCE AND FLUENCY. Unpublished M.A. Thesis. Washington State University, Pullman, Washington, 1964.

[24] Jurgen Ruesch, THERAPEUTIC COMMUNICATION. New York: Norton & Co., 1961.

[25] Paul D. Holtzman, AN EXPERIMENTAL STUDY OF SOME RELATIONSHIPS AMONG SEVERAL INDICES OF STAGE FRIGHT AND PERSONALITY. Unpublished Ph.D. dissertation. University of Southern California, 1950.

[26] Johnson, *Op. Cit.*

[27] Masserman, *Op. Cit.*

[28] W. Stein, CONTEMPORARY PSYCHOTHERAPIES. New York: The Free Press, 1960.

[29] Carl Rogers, CLIENT CENTERED THERAPY. New York: Harper & Bros.,

[30] Masserman, *Op. Cit.*

[31] Harold Lillywhite, "Symposium on 'A Broader Concept of Communication Disorders,' An Introduction," THE JOURNAL OF COMMUNICATION. XIV.I (1964).

[32] *Ibid.*

[33] Johnson, *Op. Cit.*

[34] Dominick Barbara (Ed.) PSYCHOLOGICAL AND PSYCHIATRIC ASPECTS OF SPEECH AND HEARING, Springfield, Illinois: Charles Thomas, 1960.

[35] Johnson, *Op. Cit.*

[36] *Ibid.*

[37] *Ibid.*

[38] Szasz, *Op. Cit.*

[39] Barbara, *Op. Cit.*

[40] *Ibid.*

[41] Muir, *Op. Cit.*

[42] Charles Morris, VARIETIES OF HUMAN VALUE. Chicago: University of Chicago Press.

[43] David Riesman, THE LONELY CROWD. Garden City: Doubleday, Anchor Books, 1953.

[44] Walter Williams, "Inner-Directedness and Other-Directedness in New Perspective," THE SOCIOLOGICAL QUARTERLY, V, 3 (Summer, 1964).

[45] Barbara, *Op. Cit.*

[46] *Ibid.*

[47] Becker, *Op. Cit.*

[48] Szasz, *Op. Cit.*

[49] Muir, *Op. Cit*

[50] Becker, *Op. Cit.*

[51] Robert L. Douglass, "The Relation of Feelings of Personal Security to Effective Public Speaking," SPEECH MONOGRAPHS, 1948.

[52] Stanley H. Ainswroth, "A Study of Fear, Nervousness, and Anxiety in the Public Speaking Situation," SPEECH MONOGRAPHS, XVIII, 3 (1949).

[53] Marnetta Jones, "The Relationship of Certain Personality Traits to Stage Fright," SPEECH MONOGRAPHS, IX (1943).

[54] Howard Gilkinson, "Social Fears as Reported by Students in College," SPEECH MONOGRAPHS, IX (1943).

[55] Esther Jensen Wilkinson, "A Study of Disintegrating Background Factors in the Development of Effective Speech Personality," SPEECH MONOGRAPHS, XI (1944).

[56] Floyd I. Greenleaf, "An Exploratory Study of Social Speech Fright," SPEECH MONOGRAPHS, XII (1948).

[57] Frank Gold, M.D., Interview conducted in Cleveland, Ohio, August, 1964.

[58] William Goldfarb, "Self-Awareness in Schizophrenic Children," ARCHIVES OF GENERAL PSYCHIATRY. VIII, 1 (1963).

[59] Wilson B. Guertin, "Are Differences in Schizophrenic Symptoms Related to the Mother's Avowed Attitude Toward Child-Rearing?" JOURNAL OF ABNORMAL AND SOCIAL PSYCHOLOGY. Vol. 63, (1961).

[60] George Seth and Halla Beloff, "Language Impairments in a Group of Schizophrenics," BRITISH JOURNAL OF MEDICAL PSYCHOLOGY. Vol. 32, (1959).

[61] Carl Fenichel, Alfred Freedman, and Zelda Klapper, "A Day School for Schizophrenic Children," AMERICAN JOURNAL OF ORTHOPSYCHIATRY. Vol. 30, (Jan., 1960).

[62] Loren J. Chapman and Jean P. Chapman, "Interpretations of Words in Schizophrenia," JOURNAL OF ABNORMAL AND SOCIAL PSYCHOLOGY. 1, 2 (Feb., 1965).

[63] Hilde L. Morse, "The Misuse of the Diagnosis 'Childhood Schizophrenia,'" AMERICAN JOURNAL OF PSYCHIATRY. Vol. 114 (1958).

[64] Leonard Goodstein, "Functional Speech Disorders and Personality: A Survey of the Research," JOURNAL OF SPEECH AND HEARING RESEARCH. (December, 1958).

[65] Wendell Johnson, "Problems of Impaired Speech," JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, CLXX, 17 (1959).

[66] Alfred B. Heilbrun, Jr., "Perception of Maternal Child-Rearing Attitudes in Schizophrenics," JOURNAL OF CONSULTING PSYCHOLOGY. 24 (April, 1960).

[67] Dominick Barbara, STUTTERING. New York: The Julian Press, 1954.

[68] Berry and Eisenson, *Op. Cit.*

[69] Johnson, *Op. Cit.*, 1946.

[70] Robert West, Marle Ansberry and Anna Carr, THE REHABILITATION OF SPEECH. 3rd Ed., New York: Harper and Bros., 1957.

[71] Smiley Blanton, "Stuttering," JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. CLX, 17 (1956).

[72] Robert W. Rieber, "Stuttering and Self-Concept," JOURNAL OF PSYCHOLOGY. 55, (1963).

[73] Ollie Backus, "Group Structures in Speech Therapy," in Lee Travis, *Op. Cit.*

[74] C. Donald Nelson, "Student Speaking Disorders — Beyond the Symptoms," THE JOURNAL OF COMMUNICATION, XIV, 1 (1964).