The Demedicalization of Stuttering: Towards a Notion of Transfluency

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Abstract

Stuttering has always been socially constructed as a deviant and pathological behaviour. In the last century, stuttering was medicalized as a mental disorder, and specifically, a communication disorder. The biomedicine of stuttering has proposed, in the last eighty years, numberless definitions, etiological hypotheses and treatments, which have hardly contributed to the comprehension of the phenomenon, and have caused adverse secondary effects which Illich (1976) called iatrogenic. As a reesult, the medicalization stuttering yields no advantages and the very nature of stuttering remains unknown. Conversely, it could be argued that the medicalization brings about much harm, especially a stereotype that stigmatizes the stuttering community, damaging their personal identity. Therefore, I propose demedicalizing stuttering and the construction of a term–Transfluency- to design stuttering. Demedicalizing means conceiving a phenomenon as a distinctive feature or a manifestation of human diversity, but never as a pathological symptom.

Transfluency is a manifestation of diversity in speech pattern, as being black, homosexual and left-handed are expressions of diversity in race, sexual orientation and hemispheric dominance. Transfluency is a natural attribute of the speaker. Transfluency is a dramatically different speech pattern, but as human –or as natural- as the fluent one. Both are not modifiable because belong to human nature. Transfluency is a natural speech pattern. Demedicalizing and dignifying stuttering requires to carry out the process known as Coming out. Coming out dignifies stutterers because it transforms their way of life, mysterious, erratic and lonely into an authentic and transparent one, which allows him to participate in the feast of communication, and thus, to feed off human contact. Self-help groups are becoming the most adequate social spaces to start the process we have termed coming out, because members do not suffer from clinical influence or stigma.

1-. Introduction

My perspective toward stuttering does not share the axioms common to most theory and research on the subject. Current literature, both in Spanish and English, typically conceives of this problem of communication as a disease, disorder, dysfunction, or other alteration of what is considered to be normal expression. In contrast, I argue for the merits of considering stuttering as an existential condition of the subject, with no inherent pathology, and, in many instances, minimum impairment. In other words, I conceive stuttering to be an expression of human diversity: neurological, psychological, and socio-cultural.

Biomedical disciplines (speech therapy, psychoanalysis, psychology and biomedicine and so on) that study “stuttering” and carry out ”remedial work” with people considered to be “stutterers” commonly define the phenomena associated with the term stuttering as an alteration of the linguistic rhythm (or lack of prosody). Webster on line, for example, defines stuttering as: “1: to speak with

involuntary disruption or blocking of speech (as by spasmodic repetition or prolongation of vocal sounds)". More popularly, the OED (Oxford English Dictionary) defines stuttering as: "To speak with continued involuntary repetition of sounds or syllables, owing to excitement, fear, or constitutional nervous defect, to stammer"

This biomedical conception, however, ignores two essential aspects of the phenomenon of stuttering: first, that medical praxis reflects culture, professional norms, and ideology; and second that stuttering is a contextually situated social construct reflecting the historical contingencies of time, place, and circumstance. Consequently, to adhere to an essentialist biomedical conception removes virtually all responsibility for the way stuttering is manifested in society from biomedical practitioners and their practices and instead attributes it almost entirely to the biopsychological substrate of the subject.

To illustrate this, I refer to the diagnostic criteria for stuttering from the DSM-IV-TR, which is the basic manual of reference for the classification of mental disorders. To the criterion of stuttering as an alteration of fluency, this manual adds two further diagnostic criteria. I underline the second of these (B) which establishes that the alteration of the fluency interferes with academic or work performance, or social communication (APA, 2000:77-79).

However, this criterion is hardly ever met. Alterations of fluency of speech do not interfere per se with academic or work performance. Such alterations, however, are often accompanied by disapproving social reactions which, depending on the nature and degree of various contextual contingencies, result in the person experiencing such disapproval to feel humiliation that can sometimes be intense. In such instances, the stutterer may suffer terribly, get anxious and depressed, and even avoid possibilities for fulfillment in education, work, recreation, and personal relationships. In short, it is not so much (or not at all) the initial alteration of speech fluency *per se* that interferes with a person's performance, and sense of well-being, but rather it is primarily his response to his experiences of social disapproval and stereotyping (stigmatization). In any case, the biomedical definition of stuttering in general, and the B criterion in particular, removes from society in general and treatment practitioners in particular any responsibility for the origins, persistence, and consequences of stuttering.

In contrast, my constructivist anthropology approach, which takes a non- essentialist position toward reality, grants society the main role in the process of creation of knowledge. The fundamental axiom of my position is hence that stuttering is a sociocultural construct. This justifies the epistemological inversion that guides my work. If biomedicine conceives of man as a biopsychosocial unit, in which the segments bio or psycho are predominant, my approach grants priority to the socio segment. Thus I conceive of man as a socio-bio-psycho unit. This epistemological turn is vital to support my cardinal proposition which is that there significant advantages to demedicalizing stuttering.[1]

In the last two decades, postmodern thought has been turning classical epistemology inside out, overcoming the ideas from the illustration on reason, science and subject. For example, Feyerabend, in *Against Method* (1976), questions the widespread belief that knowledge arises from the systematic application of research procedures. Among others, Latour and Woolgar (1979) show that scientific knowledge is a social construct, and that putative scientific facts reflect the interests and the relationships of the people involved, because pure objectivity does not exist.[2]

[1] Medicalization consists in considering a phenomenon as a clinical entity (alteration, disorder or disease) consisting in a set of symptoms or syndrom. Demedicalization proposes to conceive a phenomenon as a distinctive feature or a manifestation of human diversity, but never as a pathological symptom.

[2] Di Trocchio's book of 1995, whose title is illustrative –"Le bugie della scienza : perché e come gli scienziati imbrogliano"- explains the fallacy of the traditional concept of science.

To sum up, empiricism can be considered to be not above the moral or the ideological, as commonly stated, but rather below them, and hence subject to the power of ideology. As Foucault argues, knowledge is inextricably linked to power. One can cite many examples to illustrate this. In the 19th century, for example, there were drapetomania (the phenomenon of slaves fleeing their masters) and the pathological conception of masturbation. In the 20th century, there are homosexuality, drunkenness and being left handed among others (Conrad and Schneider, 1992).

My work and that of others (Mainetti, 2006) is part of the demedicalization movement of the 21st century, which began in the last quarter of the last century with Illich (1976). This work has a had a powerful effect on traditionally medicalized and stigmatized communities such as gays, lesbians, bisexuals and transsexuals, deaf, blind and other disabled people, people defined with mental disorders, and others. The consequence has been that some members of traditionally stigmatized communities have begun to challenge and resist the damaging consequences of medicalization, and to take pride in and even enjoy singular aspects of their existential condition. The inputs from anthropology and sociology have been decisive to open the road to these collectives. After all, as Ortega y Gasset pointed out more than ninety years ago: Truth is a matter of perspective.

Now I will expound on this anthropological constructivist perspective.

2-. Deviant and medicalized behaviour.

Stuttering is a medicalized deviant behaviour. In the present paper, I develop the meanings of deviance and medicalization, and the main side effects of medicalizing stuttering.

2.1-. Definition of deviance.

Conrad and Schneider state that: <<There are two general orientations to deviance in sociology that lead in distinct directions and produce different and sometimes conflicting conclusions about deviance is and how sociologists and others should address it>> (1992:1).

The positivist approach <<assumes that deviance is real and, that it exists in the objective experience of the people who commit deviant acts and those who respond to them>> (1992:1-2).

The interactionist orientation to deviance <<views the morality of society as socially constructed and relative to actors, context, and historical time. Fundamental to this view is the proposition that morality does not just happen; since it is socially constructed, there must be constructors.>> (1992:2).

I take the interactionist perspective toward deviance. According to it, deviance consists of those categories of negative judgment which are constructed and applied successfully to some members of a social community by others. Two characteristics of deviance can be stated:

a-. Deviance is universal, but there are no universal forms of deviance. There are very few acts that are defined as deviance in all societies under all conditions. All acts are defined according to society rules and politics.

b-. Deviance is a social definition. That is, deviance is not *given* in any behaviour, act or status. It must be defined intentionally by significant actors in the society or social group. (…). Deviance does not inhere in the individual or the behaviour; it is a social judgment of that behaviour. In short, it is not the act but the definition that makes something deviant (Conrad and Schneider, 1992).

To sum up, "deviance is universal yet widely variable. It is in essence a social judgment and definition and therefore culturally relative. Deviance is socially created by rule making and enforcement, usually by powerful groups over people in less powerful positions" (Conrad and Schneider, 1992:7).

Thus, deviant behaviours are human constructions.

2.2-. Definition of medicalization.

Medicalization is a process that seeks logical connections between events or phenomena in the human body. A connection is a *mechanical* relationship between conditions and effects; conditions must be both necessary and sufficient for the effect to occur. A conception of illness is needed to identify pathological conditions and effects (symptoms). In short, there are two conceptions of illness: the positivist and the cultural relativist.

The positivist (biomedical) conception of illness, which has become entrenched in popular culture, is that it is the presence of disease in an organism which inhibits functioning. The positivist or biomedical conception of illness conceives of man as a unit with three components: the biological, the psychological and the sociological (a *biopsychosocio* unit). This perspective grants the biological and the psychological substratum (the *bio* and the *psycho* components) a superior rank.[3]

The cultural relativist position states that a condition is a disease or illness only if it is recognized and defined as one by the culture. This point of view grants priority to the *socio* element of the unit.

I assume the second model of illness –and the social construction of deviance- because it makes possible the main proposal of this paper: demedicalizing stuttering. Below, I examine different kinds of behaviour constructed as deviant and pathological in the last two centuries. Some of them were demedicalized later and socially reconstructed as common behaviours or singularities.

2.3-. Medicalized deviant behaviours in the 19th century.

I expose briefly two examples of medicalized deviant behaviour in the 19th century, which were demedicalized in the 20th century.

a-. Drapetomania. Drapetomania was a supposed mental illness described by American physician Samuel A. Cartwright in 1851, that caused black slaves to flee captivity. He published "an article in a prestigious medical journal describing the disease *drapetomania*, which only affected slaves and whose major symptom was running away from the plantations of their white masters" (Conrad and Schneider, 1992:35). According to Cartwright, the behaviour of the very few slaves who wanted to escape was deviant and pathologic.

Cartwright (1851) indicated the disorder was "unknown to our medical authorities, although its diagnostic symptom, the absconding from service, is well known to our planters and overseers". He stated that the malady was a consequence of masters who "made themselves too familiar with (slaves), treating them as equals (Cartwright, 1851)." The treatment prescribed was beating the slaves with large sticks.

Drapetomania is an example of scientific racism.

b-. Onanism. In the Victorian era, onanism was socially constructed as a deviant and medicalized behaviour. Physicians conceived it as a disease or addiction, prescribing mechanical and surgical treatment for its cure.

Today it is considered a common and even healthy behaviour.

[3] Kleinmann (1988:143-144) states that biomedicine is based on a stratigraphic view of sickness "in which biology is the foundation, and psychological and social dimensions of sickness are seen as epiphenomenal, suprastructural layers to be stripped away to get at the infrastructural, i. e. biological base".

2.4-. Medicalized deviant behaviours in the 20th century.

A broad range of deviant behaviour has been considered as mental disorders in the 20th century (Conrad and Schneider, 1992). In fact, the list of mental disorders has dramatically increased in the second middle of the century: in 1942, there were 112 disorders (DSM I); in 1968, 163 (DSM II); in 1980, 224 (DSM III); in 1994, 374 (DSM IV).

The increase of mental disorders is due to the medicalizing deviant behaviour, such as chronic drunkenness, learning difficulties, homosexuality, hyperkinesis and so on, biomedicine usually conceives deviant behaviour as pathological.

Being left-handed and homosexuality were demedicalized in the 20th century.[4] Some phenomena firstly constructed as pathological behaviour are later reconstructed as healthy attributes of humankind, such as sexual orientation (homosexuality), the need for freedom (drapetomania) or hemispheric dominance (left-handed), because they resist clinical modification.

What is the real nature of stuttering? Is it a behaviour or a consubstantial attribute of the subject – and thus irremediable?

2.5-. Stuttering as a medicalized deviant behaviour.

Stuttering has been always constructed as a deviant and medicalized behaviour.

A-. Stuttering as a deviant behaviour. Stuttering has almost always been defined as highly undesirable (Bobrick, 1996). In the last century, Lemert (1951) conceived stuttering as a deviant behaviour. At the turn of the century, Petrunik noted that stuttering has been included in the speech impairments category as a form of deviance: "Sociologically, speech impairments are forms of deviance from norms that define appropiate ways of producing speech" (Petrunik, 2000:477).

Stuttering is socially constructed as a deviant pattern of speech when it is perceived to be *sufficiently* different from the common one (the fluent pattern) that it satisfies the two main characteristics of deviant behaviour: universal and socially defined.

B-. Stuttering as a medicalized behaviour. Stuttering is a speech pattern which has been always medicalized (Bobrick, 1996).

Until the end of the 19th century, stuttering was conceived to have many causes, including physical abnormalities of organs such as the tongue. At the beginning of the 20th century, some physicians began to attribute stuttering to some sort of psychological disorder because no damage was found in tongue or breathing organs (Bobrick, 1996).

In the last century, biomedicine classified stuttering as a mental disorder because of its deviance from the common pattern of speech and the absence of abnormalities in the rest of the organs. The DSM-IV-TR classifies stuttering as a mental disorder, and specifically, a communication disorder (APA, 2000:77-79).

2.6-. Side effects of the biomedical construction of stuttering.

The biomedical model considers the *bio* and the *psycho* substratum as pathological, and this approach produces some undesirable side effects on the patient´s social identity, because biomedical praxis is not innocent (Illich, 1976). As illnesses are social judgement, they are negative judgments (stigma).

[4] Lombroso (1895) described left-handed as a "degenerative stigma".

Classifying stuttering as a communication and mental disorder harms the social identity of this community to the extent that the identity is a stigmatized one. Goffman refers to spoiled social identity as "stigma". It is in this sense, that stuttering is considered a social stigma by Goffman (1963), Freidson (1970) and others.

In others studies (Loriente 2006; Loriente 2007) I described how a biomedical praxis of stuttering produces a stereotype that stigmatizes the stuttering community -and I suspect the same would be happening in other stigmatized communities, such as the homosexual one, in which science and medicine have decisively contributed to the construction of homophobia (Nieto, 2003).

Biomedical praxis has created a stereotype that conceives stutterers as <<nervous people, introverted, insecure, tense and shy>> (Castejón *et al.* 2005:496). The content of the stereotype comes from the praxis of the main biomedical disciplines that have dealt with stuttering: speech therapy, psychoanalysis, and clinical psychology, and neuropsychology. As I wrote elsewhere (Loriente 2007:76):

<<I consider that the four main disciplines that have studied stuttering (logopedics, psychoanalysis, psychology and scientific biomedicine) create the common beliefs that both fluent speakers and stutterers maintain with regard to stuttering, and the stuttering community, and that constitute the medicalized stereotype which stigmatizes the stutterer. Conceiving the stutterer as a nervous person, insecure, or somebody who fears speaking, is a consequence of theories which consider stuttering to be a disorder of nervous origin. To suppose or suspect that a stutterer is a traumatized person (or with some sort of trauma originated in childhood) is the result of a psychoanalytic or psychodynamic bent. To associate the speech pattern of stutterers with their personality is the result of research on psychology and personality. Finally, those who consider that the stutterer suffers from neurological irregularities which affect system coordination such as movements and similar, are based on scientific research originating at the University of Iowa in 1929>>.

To sum up, I state that biomedical praxis creates the beliefs that fluent speakers and stutterers alike maintain with regard to stuttering, and the stuttering community; and that constitute the medicalized stereotype that stigmatizes the stuttering community.

Below I indicate some secondary side effects of the medicalizing experiment.

2.7-. Secondary side effects.

While medicalization offers neither accurate understanding nor effective clinical solutions in the medium term for many stutterers, it can have harmful consequences which increase, and postpone *sine die*, any hope of healing. It does this to the extent that it creates a personal identity based on suffering (because the stutterer internalizes clinical stigma), damages dignity, pride and self-steem, conveys a lonely and marginalized way of living (symbolized by the metaphor of the closet), fosters intergroup conflict which shows up as discrimination and stereotyping, and makes the social acceptance of stuttering, self- acceptance, and "coming out" more difficult.

Much of the suffering of members of the stuttering community comes from the internalization of the main side effects of the medicalizing experiment, as I explain below.

2.8-. The personal identities of members of the stuttering community.

Stigmatized populations internalize the stigma, producing a personal identity filled with pain and suffering. In fact, the personal identity of stutterers is filled with suffering because, as social psychologists explain, personal identity feeds on the social one (Ovejero, 1998:273; Turner *et al.*, 1990).

The subjective reality of members of this community consists of feelings and thoughts which articulate a personal identity filled with suffering. In my fieldwork (Loriente, 2006), I note three main feelings -shame, guilt and fear- in addition to a fragile self-concept. Other researchers have drawn similar conclusions.

For example, Corcoran and Stewart (1998:247) point out the four main manifestations of suffering for the stuttering community: <<helplessness, shame, fear and avoidance>> expressions that cause "nightmares, humiliation, dread, isolation, and thoughts of suicide" (1998:260. Significantly, the feelings and thoughts that characterize persons who stutter are similar to those of members of other stigmatized communities.

Below I cite an eloquent message which describes the extreme suffering of a stutterer:

Hi to everyone, I have written before …. My name is Robert[5]. I am twenty years old and have always stuttered. I am really fed up with all this… Many times I have suicidal ideas, I have never tried it; but I do believe that some of the times when I was not all right, if I had had a weapon, I am sure I would blow my brains out. I know I need psychological help, but well, I have never looked for it. I am very dissatisfied with my way of life. I have cried my eyes out with all this, I suppose like the rest of you, but I have almost thrown the towel in. There is nothing I can do. I BELIEVE THAT BEING A STUTTERER HAS RUINED OUR LIVES. At least I will never be happy. I am sick of the way people look at me…. I am sick of the way people look at me, of the stupid kid who mocks you while you try with all your heart to say something, and that laughs at me for something against which I have fought fifteen years of my life without the slightest success, of those who think you are stupid because you can´t speak. I can't stop crying before the computer screen while I write this. I do not know what to do. Thank you very much for listening to me to those who have read this message. Goodbye.

The manifestations of suffering of the writer of this message coincide with those of other populations of stutterers (Corcoran and Stewart, 1998). From this I conclude that the personal identities of members of the stuttering community typically hinge on similar concerns. This is certainly the case in those societies which construct stuttering as form of deviance.

The main fear of Robert is not the difficulty of speaking *per se*, but the social consequences it provokes: "I am sick of the way people look at me. I am sick of the way people look at me, of the stupid kid who mocks".

Avoidance of suffering leads Robert to lead a marginalized way of life, because his experience of social disapproval, draws him to retreat from mainstream society, or in other words to confinement in the closet.[6] The stuttering community is aware that stuttering does not harm anybody, yet, those who listen are humiliated by disapproving gestures, looks, mockery, and so on. The response "of those who think you are stupid because you can´t speak" constitutes a stereotype that hurts like few others. The suffering of the writer is mainly due to the response of social disapproval.

It is the internalization of stigma which produces a personal identity associated with pain and suffering.

Given that the medicalization of stuttering offers few if any benefits, but can often cause a great deal of harm, I advocate demedicalizing stuttering. Demedicalizing means conceiving a phenomenon as a manifestation of human diversity, not as a symptom of pathology. Understanding stuttering as a manifestation of human diversity requires constructing a new term for stuttering: transfluency.

[5] Not the real name.

[6] The way of life of those living in the closet is directed by lies, secrecy and silence.

3-. Transfluency

If the biomedical model of illness (or the positivist conception) conceives of man as a biopsychosocial unit, in which the segments *bio* or *psycho* are predominant, the relativist cultural model of illness grants priority to the *socio* element: illness is a human construction.

A relativist cultural orientation makes possible a non pathological model of stuttering or, in other words: demedicalizing stuttering.

3.1-. Two requirements for demedicalizing stuttering.

Conrad and Schneider -who assume the relativist cultural model of illness-, state two requirements to demedicalize a phenomenon: "Demedicalization does not occur until a problem is no longer defined in medical terms and medical treatments are no longer seen as directly relevant to its solution" (1992:255).

3.1.1-. Different terms to define stuttering.

With regard to the first requirement, the interested reader may consult my research (Loriente, 2006; Loriente, 2007), in which medical or clinical terms are not used to describe the members of the stuttering community. Instead, other terms that come from anthropology, sociology and social psychology are useful. These terms include stigma, deviance, personal and social identity, intergroup conflict, social construct, stereotype, stigma, coming out, and transfluency.

3.1.2-. Therapies and their (in)effectiveness.

Commercial treatments for stuttering have abounded over the past few centuries. At the beginning of this century, Le Huche (2003) noted more than two hundred treatments. A variety which led the stutterer and speech therapist Wendell Johnson in 1939 to be surprised and respectful "The longer I work with stutterers, the more tolerant I become of anyone who has any therapeutic ideas at all concerning it... There is no such thing as the method for treating stuttering, and the fact that so many differing methods are more or less successful is of more than incidental interest".

Given the broad range of therapies available and the only sporadic effectiveness of most of them, practically all patients and clinicians have experienced the failure of treatment. This has led some speech therapists to reject attempts to rehabilitate adult stutterers for ethical reasons. Many members of the stuttering community have spent significant amounts of money aimed at achieving fluency or other equally utopian therapeutic objectives, without obtaining significant results. According to the survey we carried out in our field work, taking part in self-help groups is more helpful for many stutterers than taking part in speech therapy.[7]

Techniques, very effective for other behaviours such as desensitization, paradoxical intention, progressive relaxation, in vivo exposition, cognitive restructuring or the likes; or psychopharmacon as powerful as antipsychotics (Haloperidol, Olanzapine or Ziprasidone) have proved ineffective in the

[7] In the survey we asked participants to evaluate numerically (from 0 strongly disagree to 10, strongly agree) the benefits obtained from treatment by a clinician (doctor, phoniatrician, psychoanalyst, psychologist and logopedian), obtaining an average of 4.5. In the next question we asked them to evaluate numerically (from 0 strongly disagree to 10, strongly agree) the benefit obtained from being a participant in self-help groups. Here the average was 6.6, a difference of more than two points.

medium or long term treatment of stuttering. Málaga (1987:17) reports that stuttering "must be, with cancer, one of the pathological pictures on which more medicines have been tried".

The Spanish Agencia de Evaluación de Tecnologías Sanitarias de la Junta de Andalucía (Agency for Evaluation of Health Technologies of the Andaloucian Autonomous Region in Spain) carried out in 2007 a complete report on the clinical therapies on stuttering, and it concludes. "No clearly effective interventions on stuttering have been discovered, at least in terms of results related with speech, either objectively or subjectively.[8]

The results of interventions for adults with specific therapeutic objectives show a minimal clinical result. It can be confused with the placebo and/or spontaneous remissions. For example, the evaluations of the Camperdown program (O´Brian, 2003), involving the consumption of olanzapine (Maguire *et al.*, 2004), or of the program on understanding stuttering (Langevin *et al*., 2006), show few promising results.

Thomas and Howell (2001:26-27) and (Zebrowski & Conture, 1998) have found methodological problems in most research on the clinical effectiveness of speech therapies that invalidate the results obtained. For example, the research of Bothe *et al*. (2006) has sampling problems which compromise the validity and reliability of their results.

With regard to child-juvenile stuttering, researchers have also evaluated specific therapeutic interventions, such as the use of clonidine (Althaus *et al*., 1995), or the famous Lidcombe program (Harris *et al.*, 2002), among others. The results are very similar to those obtained with adults. At best there is a slight reduction of stuttered words in children who participated in the Lidcombe program.

The ineffectiveness of speech therapies for many of those who stutter suggests the need to reconstruct conceptions of stuttering. Stuttering seems to be a consubstantial and irremediable attribute of humankind, as are many others attributes which have been demedicalized: sexual orientation (homosexuality), the need for freedom (drapetomania) or hemispheric dominance (left-handedness).

I contend that conceptions of stuttering should be demedicalized and replaced with the term transfluency.

3.2-. Definition of transfluency

The construct of transfluency proposes that the spoken communications of stutterers are not pathological symptoms or deviant behaviours, and that as such do not imply clinical and or social consequences. A transfluent speech pattern is understood differently from that of a stuttering pattern because it is not considered to be a pathogenic set of symptoms or syndrome. Therefore transfluent subjects are not considered to be patients or sick people who require clinical treatment. This construct proposes the untying of subject (existence) and body (essence), which involves a significant advance of personal identity and freedom.

"Trans" is a latin noun or prefix, meaning "across", "beyond" or "on the opposite side". Transfluency means speaking without worrying, classifying or seeking to remedy one´s speech pattern. The speaker´s speech pattern (whether fluent, cluttered or stuttering) just exists, and there are as many speech patterns as individuals. Just as different sexual orientations and expressions of diversity such as left-handedness are not considered to be inherently pathological, no particular speech pattern is considered to be pathological.

[8] The document can be consulted in:

http://www.juntadeandalucia.es/salud/contenidos/aetsa/pdf/Tartamudez_def2.pdf

The construct of transfluency shares the basic aspirations of the New Social Movement (NSM), formed by a group of individuals and communities which want to "recover their existential freedom, and the power to self-ordain their lives. In a sense, movements which espouse such objectives are emancipator movements that pursue individual and collective freedom. To a large extent, they are inspired by the philosophical tradition of the Frankfurt School" (Liñares, 2003:54). This focus on emancipation is present in other social movements such as "the feminist and antipatriarchal movement, the gay-lesbian movement (and glam-rock), pacifism and antimilitarism, the antiauthoritarian libertarian movement, insubmission and civil disobedience, squatters, ecologism, animal rights movement, deaf movement. All of them have had the same driving force: collective emancipation and existential freedom". (Liñares, 2003:54). I include the transgeneric and intersexual movement (Nieto, 1998; 2003), and the neurodiversity movement which calls for collective emancipation and existential freedom for those defined with neurological conditions and psychiatric disorders such as autism, Tourette's syndrome and schizophrenia.[9]

To sum up, transfluency is a new conception of stuttering, an attempt to dignify members of the stuttering community. In this conception, stutterers express themselves through a transfluent pattern of speech and come out of the closet everywhere and with everybody, living freely and accepting themselves.

4. Coming out of the closet of stuttering

Coming out is a personal and political process. In the initial stage, it is a primarily a personal process: "Coming out means you no longer feel like a freak who must hide a terrible secret; instead, you feel like a normal person who is proud of who he or she is, the way normal people tend to be" (Signorile 1996: xxiii-xxiv).

In later stages, it is a political process as well as a personal one. As the feminist adage states-: "The personal is the political" (Signorile 1996:xxiv). Coming out is a political process because of its final purpose: attaining the same rights and responsibilities as members of the fluent community.

Those coming out from the closet of stuttering describe the process in terms very close to the ones used by other stigmatized subjects who came out from other closets. The coming out process is similar because the origin of suffering is the same: social stigma implying one is less fully human than others.

In fact, North American stutterers who belong to minority sex groups (gay, lesbian, transgender), and who came out twice, say there are many similarities between both processes.[10] Coming out is similar in all these communities. It is similar because the darkness of the closet does not allow easy exits and external light blinds all those coming out for the first time to a similar degree.

Those who pass twice describe the similarities of the process in each instance: "Twice, we come out of the closet. Twice, we choose between community and isolation. Twice, we contend with well-meaning professionals who want to make us "normal." Twice, we deal with families who don't fully accept us. Twice, we create our own circles of understanding friends".

From all the accounts recorded in this research I highlight the following one because it very clearly describes the process of coming out:

[9] The reader can go to: http://www.neurodiversity.com/

[10] This community was founded in 1993, in the convention of the National Stuttering Association (NSA), and currently: <<is an informal network of gay, lesbian, bisexual, and transgender stutterers and their friends. Passing Twice meets every year at the NSA convention, and also holds workshops at other stuttering conferences around the world. In between, we keep in touch through a quarterly newsletter, an e-mail list, and an annual mailing list>>. The reader can go to: http://passingtwice.com

WE HAVE TO COME OUT OF THE CLOSET AND DIGNIFY STUTTERING. (This is easier said than done). FLUENCY IS NOT THE MOST IMPORTANT THING (This is revolutionary statement) (…) As I truly understand these new ideas I appreciate how my life is turning to the better, WITHOUT IMPROVING MY FLUENCY, it should be noted.

This account illustrates coming out perfectly clear. It is the process some stutterers begin in self-help groups, and, to a lesser extent, in virtual groups.

Self-help groups are becoming the best social spaces to start the process I have termed coming out, because they do not suffer from clinical influence or stigma.

Members of these groups reject the strategies of covering up, and break the taboo of stuttering, turning the darkness of the closet into transparency and authenticity. In self-help groups, stuttering is not cause for disapproval or clinical remedial action. Rather, it is a phenomenon which becomes a distinctive feature of a dignified subject –exempted from pathology or stigma. In other words, stuttering becomes transfluency.

Members of the stuttering community are encouraged to come out of the closet everywhere and everytime to carry out the personal and the political purposes. Acting this way, stutterers will dignify stuttering and suffering- and stigma- will *finally* disappear. Coming out dignifies stuttering and the stuttering community.

5-. Conclusions.

I highlight the following conclusions:

1-. Stuttering has always been socially constructed as a deviant and pathological behaviour. In the last century, stuttering was medicalized as a mental disorder, and specifically, a communication disorder (APA, 2000:77-79).

2-. Biomedicine of stuttering has proposed, in eighty years, numberless definitions, etiological hypotheses and treatments, which have hardly contributed to the comprehension of the phenomenon, and have caused adverse secondary effects which Illich (1976) called iatrogenic.

3-. So, medicalizing stuttering yields not advantages and the very nature of stuttering remains unknown. The medicalization brings about much harm, especially a stereotype that stigmatizes the stuttering community, damaging their personal identity.

4-. Therefore, I propose demedicalizing stuttering and the construction of a term–*Transfluency*- to design stuttering. Demedicalizing means conceiving a phenomenon as a distinctive feature or a manifestation of human diversity, but never as a pathological symptom.

Transfluency is a manifestation of diversity in speech pattern, as being black, homosexual and left-handed are expressions of diversity in race, sexual orientation and hemispheric dominance. *Transfluency* is a *natural* attribute of the speaker.

Transfluency is a *dramatically* different speech pattern, but as *human* –or as *natural*- as the fluent one. Both are not modifiable because belong to human nature. *Transfluency* is a *natural* speech pattern.

5-. Demedicalizing and dignifying stuttering requires to carry out the process known as *Coming out*. *Coming out* dignifies stutterers because it transforms their way of life, mysterious, erratic and lonely

into an authentic and transparent one, which allows him to participate in the feast of communication, and thus, to feed off human contact.

6-. Self-help groups are becoming the most adequate social spaces to start the process we have termed coming out, because members do not suffer from clinical influence or stigma.

6-. Addendum: etiology.

We include an addendum about the etiology of stuttering. Salgado (2005) admits that "The last cause of stuttering remains unknown after so many decades of research centered on the origin of the disorder", as Bullen had suspected more than sixty years before: "The problem as to the causes of stuttering is at present a controversial one" (Bullen, 1945:1).

We consider that the uncertainties of the researchers may be partly due to the multifactor nature of the phenomenon, and the chaotic interaction between the intervening variables, some of which are unknown, which disturb the application of the biomedical model based on the bacteriological theory that establishes a linear and unique relationship between cause and effect. Almendro (2002) says that it is impossible to account for psychological phenomena by means of linear causality, because the interaction of the intervening factors obeys the fluctuating, capricious, and practically unpredictable laws of chaos. The now rising paradigm of the theory of chaos is opening not only to the natural sciences, but also to other sciences such as medicine (Gleick, 1993).[11] Concurrence and chaotic interaction of a great variety of causing factors, renders phenomenological knowledge of the matter impossible.

And if turned out to be the case that biomedicine discovered the causes of stuttering and these turned out to be irremediable (as has happened in the case of phenomena such as being left-handed or intersexuality) what would have been the good of medicalization? And what about the harm that has been caused and the hopes that have been dashed?

7-. Bibliography.

Althaus M., Vink H. J., Minderaa R. B., Goorhuis-Brouwer S. M. y M. D. Oosterhoff, 1995, "Lack of Effect of Clonidine on Stuttering in Children". *American Psychiatric Association*, 152, 1087-1089.

Almendro M., 2002, *Psicología del caos*. Vitoria: La Llave.

American Psychiatric Association (APA), 2000, *Diagnostic and statistic manual of mental disorders DSM-IV-TR (Text Revision)*. Washington: APA.

Bobrick B., 1996, *Knotted Tongues. Stuttering in History and the Quest for a Cure*. New York: Kodansha America Inc.

Bothe A. K., Davidow J. H., Bramlett R. E. y R. J. Ingham, 2006, "Stuttering treatment research 1970-2005: I. Systematic review incorporating trial quality assessment of behavioral, cognitive, and related approaches". *American Journal of Speech-Language Pathology*, 15, 321-341.

Bullen A. K., 1945, "A cross cultural approach to the problem of stuttering". *Child development*, 16, 1-87.

Cartwright F., 1851, "Report on the disease and physical peculiarities of the negro "race". *N. O. Med. Surg. Journal*, 7, 691-146

Castejón *et al*., 2005, "Contenido del estereotipo de los maestros sobre los alumnos tartamudos". *Psicothema*, 17, 3, 496-501.

[11] The interested reader may consult the excellent paper of Masterpasqua and Perna (1997)

Conrad P. y J. W. Schneider, 1992, *Deviance and Medicalization: From Badness to Sickness*. Philadelphia: Temple University.

Corcoran J. A. y M. Stewart, 1998, "Stories of stuttering: A qualitative analysis of interview narratives". *Journal of Fluency Disorders*, 23, 247-264.

Feyerabend, P.K., 1976, *Against method*. New York: Hamanities Press.

Freidson E., 1970, *Profession of medicine*. New York: Harper & Row.

Gleick, J., 1993, *Chaos: Making a New Science*. London: Abacus.

Goffman, E., 1963, *Stigma; notes on the management of spoiled identity*. Englewood Cliffs, N.J.: Prentice-Hall.

Harris V, Onslow M, Packman A, Harrison E, Menzies R., 2002, "An experimental investigation of the impact of the Lidcombe Program on early stuttering". *Journal of Fluency Disorders*, 27, 203–214.

Illich, I., 1976, *Medical Nemesis: The Expropriation of Health*. London: Calder & Boyars.

Johnson W., 1939, "The treatment of stuttering". *The Journal of Speech Disorders*, 4, 170-172.

Kleinman A., 1988, *Rethinking psychiatry: from cultural category to personal experience*. New York: The Free Press.

Langevin M., Huinck W. J., Kully D., Peters H. F., Lomheim H. y M. Tellers, 2006, "A cross-cultural, long-term outcome evaluation of the ISTAR Comprehensive Stuttering Program across Dutch and Canadian adults who stutter." *Journal of Fluency Disorders*, 31, 4, 229-256.

Latour B. y Woolgar S., 1979, *Laboratory Life*. London: Sage.

Le Huche, F. 2003, *Le Bégaiement option guérison*. Paris: Albin Michel.

Liñares X. L., 2003, "Apuntes para una sociología de la comunidad sorda", pp. 50-60, en Pernas Lázaro E. y C. Ameijeiras Sáiz, (Coord.), "Dossier: Bibliotecas Públicas y comunidad sorda." *Revista: Educación y biblioteca*, 138, 49-125.

Lombroso C., 1895, *L´homme criminel. Etude Anthropologique et psychiatrique*. París: Félix Alcan.

Loriente C., 2006, *La tartamudez como fenómeno sociocultural: una alternativa al modelo biomédico.* Tesis doctoral. Inédita. Madrid: UNED.

http://e-spacio.uned.es/fez/eserv.php?pid=bibliuned:20291&dsID=loriente_zamora.pdf

Loriente C., 2007, *Antropología de la tartamudez*. Barcelona: Bellaterra.

Maguire G., Riley G., Franklin D., Maguire M., Nguyen Ch. y P. Brojeni, 2004, "Olanzapine in the treatment of Developmental stuttering: a double blind, placebo-controlled trial". *Annals of Clinical Psychiatry*, 16, 2, 63-67.

Mainetti J. A., 2006, "La medicalización de la vida". *Electroneurobiología*, 14, 3, 71-89.

Málaga J., 1987, "Introducción a la disfemia", pp. 13-18, en AA. VV. (Eds.), *La tartamudez. Actas y comunicaciones. IV Simposio*. Salamanca: Amaru.

Masterpasqua F. y P. Perna, 1997, *The Psychology of Chaos*. Washington, DC.: American Psychological Association Press.

Nieto J. A. (Comp.), 1998, *Transexualidad, transgenerismo y cultura. Antropología, identidad y género.* Madrid: Talasa.

Nieto J. A. (Ed.), 2003, *Antropología de la sexualidad y diversidad cultural*. Madrid: Talasa.

O´Brian S., Onslow M., Cream A. y A. Packman, 2003, "The Camperdown Program: Outcomes of a New Prolonged-speech Treatment Model." *Journal of Speech, Language and Hearing Research*, 46, 933-946.

Ovejero A., 1998, Las relaciones humanas. Psicología social teórica y aplicada. Madrid: Biblioteca Nueva.

Petrunik M. 2000, "Speech Impairments", *in* Clifton Bryant, editor-in-chief, Encyclopedia of Criminology and Deviant Behavior, Volume IV, Self-Destructive Behavior and Disvalued Identity, pp. 477-481, Philadelphia, PA: Brunner-Routledge.

Salgado A., 2005, *Manual práctico de tartamudez*. Madrid: Síntesis.

Signorile M., 1996, *Outing yourself: how to Come out as Lesbian or Gay to your family, friends and coworkers.* New York: Random House.

Thomas C. y P. Howell, 2001, "Assessing Efficacy of Stuttering Treatments". *Journal of Fluency Disorders*, 26, 311-333.

Turner, J. C., Hogg, M.A., Oakes, P. J., Reicher, S. D. y Wetherell, M.S. (Eds.), 1990, *Redescubrir el grupo social. Una teoría de la Categorización del Yo.* Madrid: Morata.

Zebrowski P. M. y E. G. Conture, 1998, "Influence of nontreatment variables on treatment effectiveness for school-age children who stutter", pp. 293-310, en Cordes A. K. y R. J. Ingham (Eds.), *Treatment efficacy for stuttering: A search for empirical bases.* San Diego: Singular Publishing Press.