SPEECH AND VOICE CORRECTION

THIS is a book edited by Emil Froeschels, M.D., President of the International Society for Logopedics and Phoniatrics and President of the New York Society for Speech and Voice Therapy. There are 19 contributors, most of them attached to institutions for treatment of the voice, speech and hearing. There are 22 chapters in all. The first, on anatomy and physiology, is excellent and should be a great help to those who propose to practise Speech Therapy, as well as to those already doing so. References are made to various types of breathing, costal, epigastric and abdominal. On breathing for voice, there is on page 7 this statement: "In testing eight prominent singers we could establish the fact that each of them breathed differently. From this we concluded that singing teachers should not recommend any general type of breathing." The eight prominent singers probably never learned not needed to learn about breathing. These were well equipped with excellent lung capacity and would have perfect elasticity of the throat and chest muscles. These are the born singers and in England these are not many in number. There are many potentially really good singers and they need careful training in the development of their lungs. The chest should be developed definitely in the lower costal region. This development will ensure the perfect descent and extension of the diaphragm and bring about whole lung breathing. The abdominal muscles must be trained to contract powerfully and drive up the great viscera and so press up the diaphragm. The abdominal muscles in contraction become the motive power of the voice. During inspiration the abdominal wall must remain perfectly still. This will stop the pernicious belly-breathing which causes much ill-health from visceroptosis. A good deal is set out in this same chapter on the consonants and vowels and on the zones of articulation which deserve careful study by the student.

In Chapter 2, aphasia is ably dealt with by another contributor. It is a wide subject and the writer rightly says that speech therapy for aphasic children and adults must be planned to satisfy the special biological, social and economic needs of each patient. He is rather unhopeful of rapid progress in the aphasic adult, and says he must expect to expend years, not months, to regain a part of his reading, speaking and writing ability. In severe cases this is true but milder cases may improve in a few weeks. Chapters on dysarthria and alalia are worthy of careful study. The types of case described are not common in the hospital speech clinic in England. Dyslalia includes all functional defects of articulation and its various types are set out and named, and such names are recognized by the Committee of the American Speech Correction Association. They are new, in some instances, to Speech Therapists in England. The treatment for many types of dyslalia is carefully described and should be very helpful.

Rhinolalia is dealt with in another chapter. The writer sets out various exercises for overcoming this distressing affection. A very effective method of overcoming the impaired movement of the soft palate which is often causing the rhinolalia is the use of a tongue depressor night and morning, depressing the back of the tongue on the sound of "Ah". This is not set out in this chapter but it is worth trying when there is a paresis of the palate. As the back

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of the tongue is pressed down on the sound of " Ah " the soft palate is drawn up, and if the voice is kept low in pitch complete recovery should occur.

The chapter on hearing rehabilitation is naturally very technical and is possibly outside the field of the ordinary Speech Therapist.

The chapter on cleft palate operations leaves out one famous English surgeon's name. Sir James Berry followed Langenbeck's method and his results were very good indeed. Sir Arbuthnot Lane spared many mothers the shock of seeing their children badly disfigured by hare-lip by doing a very early operation to remedy matters. Lane employed a flap operation to close this palatal cleft which did give some very good speech results. Brophy's operation was very severe, the hard palate being closed by traction wires through the superior maxilla and lead plates. The discomfort to the patient must have been rather great. We understand that now most successful plastic operations are performed which give wonderful results in the functioning of the reformed palate and in the speech.

The chapter on stuttering sets out the various ideas of several individuals. No difference between stammering and stuttering is made. The names of seven authorities are set out as believing that stuttering is induced by making a left-handed person use the right hand. In reality, stuttering or stammering being of emotional origin, the annoyance caused to the patient by being made to use his right hand instead of the left may aggravate a stammer. It is difficult to see how it could cause it. Stammering or stuttering generally comes on in the third or fourth year of a child's life. It comes on gradually and affects those who are born with a highly developed and sensitive speech centre which, on strong emotions of the mind, gets over stimulated, and the speech centre like any other centre is disordered or is upset by hyperæmia. This is the opinion of the reviewer, but Henry Munro in a tract, in the Library of the Royal College of Surgeons, written in 1850 makes this perfectly clear. His own words are as follows :

" There exists in some individuals an idiosyncrasy amounting probably only to a great irritability or sensibility of fibre in that part of the brain or ganglia as well as their efferent nerves which control the motions requisite for speech and this peculiarity exposes it to be most easily deranged and driven into spasmodic action by the mental desire to speak. If there exists a tendency to local congestion about any of the motor fibres of the brain or spinal ganglia it would itself cause irritable spasmodic action or paralysis (in proportion to the amount of pressure) of the muscles supplied by them."

Young children treated by lower costal development and using a contraction of the abdominal muscles as they speak may be cured of a stammer in a few weeks' time. There are 87 references set out at the end of this chapter on the subject of stammering and stuttering, so there is a wide field of selection for the student anxious to learn a variety of opinions. Munro seems to have found out the true cause of stammering and stuttering. It is convenient to differentiate between stammering and stuttering in this way. Stammering relates to difficulty of production of the voiced consonants and words introduced by vowels and stuttering to the rapid repetition of the breathed consonants.

The chapter on cluttering is excellent and the treatment set out most helpful. This form of speech trouble is rare and when first seen may puzzle

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the Speech Therapist. There is a very interesting chapter on disorders of speech due to gunshot wounds. The chapter is thorough in detail and helpful in assisting the return of normal speech to patients suffering from serious head injuries.

The description of the methods of educating the speaking voice and education and re-education of the singing voice is interesting. Re-education will interest the Speech Therapist more than the education of the person who wishes to have his or her voice trained. The normal voice does not appeal to the Speech Therapist as do voices which have become affected and are in serious trouble. Of course, all such conditions are diagnosed by the Throat Specialist or by some Medical Practitioner before the Speech Therapist is asked to deal with them. The reference to singers not knowing whether their voices should be high or low in pitch needs amplification. The test is quite simple. If on the sound of " Ah " a deep note can be produced the voice in a man is bass or bass baritone, and in a woman contralto or mezzo soprano. The true tenor and soprano cannot produce deep notes. A great waste of time and money would be avoided if the young singer were told by an expert what kind of voice he or she should be trained for.

The last chapter is on the esophageal voice. The writer of this chapter advises that the patient who is to undergo laryngectomy should be fully instructed as to the operation and should learn from charts or sketches what the throat will be like when the larynx has been removed. All this might fill the patient with apprehension, but the advice that the patient should see and hear another person who has had the operation and can speak well is very wise and will give the patient hope and confidence. Some laryngectomy patients with excellent voices are always ready to demonstrate their success in talking and in showing how well in health they are. If this practice were universal much good would result, but unfortunately it is not and many patients have no idea that they may speak again. The high percentage of them do so. The earlier instruction on how to get a voice is given the better. Colledge likes his patients to attempt to get a voice very soon after the extirpation of the larynx, in fact as soon as any leakage from the pharynx has ceased, even if healing is not complete. The line of treatment set out in this last chapter is fully explained and should be helpful. The time for getting a voice varies a lot with patients. In England voice has often been acquired at the first treatment. A man seen once only for vocal education returned after four years with a voice practically normal. Another patient, a clergyman, operated upon in 1930 is still well and can take a whole service through, including the sermon. Two others have been Masters of their Masonic Lodges, and made long speeches which were easily heard by all present at meetings. Another, a solicitor, speaks so well that his clients do not know he has lost his larynx.* The patients speak on a belch which is very evident at first. Later on this is refined and the voice becomes very good. A help to acquiring voice is to drink some effervescing liquid. In conclusion, every effort should be made to teach the patient to get an esophageal voice before he starts trying to talk in a whisper. An artificial larynx should only be used when it is clear that the patient will never be able to produce a voice. Such cases are few.

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*All these cases were operated upon by Colledge and were trained by the reviewer.

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