STUTTERING AS A VARIANT OF POST TRAUMATIC STRESS DISORDER: WHAT WE CAN LEARN*

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In our work on experiential therapy for stutterers, we have been impressed by many commonalities between the experience of stuttering (see ISAD 1999) and Post Traumatic Stress Disorder (PTSD). In this paper we look at these commonalities -- pattern of development, hyperarousal, organizing one's life around the disorder, and dissociation -- and also their implications for the treatment of stuttering.

Van der Kolk, McFarlane, and Weisaeth (1996) have produced the most definitive work on the subject of PTSD -- a book entitled *Traumatic Stress: The Effects of Overwhelming Experience on the Mind, Body, and Society*. We like this book for a number of reasons. As they state in the preface, (1) it blends objective science with an awareness of the contexts in which the trauma is embedded, and (2) The authors look at the impact of the trauma on various aspects of the individual -- psychological, biological, social -- and the interrelation among them. We believe this holistic approach is also imperative in working with stutterers.

They describe PTSD as follows (p. 5): After exposure to a trauma, most people become preoccupied with the event; having involuntary intrusive memories is a normal way of responding to dreadful experiences. This repeated replaying of upsetting memories serves the function of modifying the emotions associated with the trauma, and in most cases creates a tolerance for the content of the memories (Horowitz, 1978). However, with the passage of time, some people are unable to integrate the awful experience and start developing the specific patterns of avoidance and hyperarousal that are associated with PTSD. What distinguishes people who develop PTSD from people who are merely temporarily stressed is that they start organizing their lives around the trauma. [emphasis added] Thus, it is the persistence of intrusive and distressing recollections, and not the direct experience of the traumatic event itself, that actually drives the biological and psychological dimensions of PTSD (McFarlane, 1992; Creamer, Burgess, and Pattison, 1992).

What fails in people with PTSD lies in the replaying of the memories of the trauma. Instead of allowing the person to heal, the memories serve only to re-arouse the person to a level that they feel they must defend against them, and the avoidance begins. Eventually the defensive avoidance behaviors become habitual, and the person's life is fundamentally altered.

In stuttering, the pattern of development is often the same. There are repeated occurrences of stuttering, which are frustrating and embarrassing. These early reactions typically occur in children, whose reactions to frustration are likely to include the use of considerable effort to speak without stuttering or to get past the stuttering event as quickly as possible. Frustration, embarrassment and fear are particularly strong reactions in young children. When social circumstances similar to those of previous stuttering experiences occur, the stutterer is hyperaroused -- i.e., strongly provoked to struggle in an effort not to stutter. The struggle naturally tends to increase muscular tension, which makes smooth, easy talking more difficult. So, the stuttering continues

and grows, recreating itself.

As the frustration, embarrassment, and fear continue, the stuttering "worsens," that is, a number of new avoidance techniques are added to the existing struggles. These additional "layers" alter the physical pattern of stuttering in a way that partially disguises it and increases the fear that stuttering has come to create. Eventually, the pattern of avoidance and whatever is left of the original struggle behavior create barriers to effective communication, and daily experiences of embarrassment, frustration, and fear continue. At this point, stutterers begin to organize their lives around their stuttering. This is the first commonality with PTSD that we noticed.

Dissociation, an integral and well known component of PTSD, has been described in some detail, though only recently, in the psychology literature (van der Kolk, McFarlane, and Weisaeth, 1996). Of PTSD, Van der Kolk (1996) writes (pp. 191-92) that

"Many traumatized children, and adults who were traumatized as children, have noted that when they are under stress they can make themselves "disappear." That is, they can watch what is going on from a distance while having the sense that what is occurring is not really happening to them, but to someone else."

Dissociation allows the person to "experience no, or only limited, pain or distress; and to be protected from awareness of the full impact of what has happened" (van der Kolk, McFarlane, and Weisaeth, 1996). The characteristics of dissociation are: "altered time sense, -- time may be experienced as either slowed down or accelerated -- depersonalization, out-of-body experiences, bewilderment, confusion, disorientation, altered pain perception, altered body image, [and] tunnel vision. (van der Kolk, van der Hart, and Marmar, 1996, p. 313).

The dissociation that stutterers experience seems to be similar to that experienced by nonstutterers with PTSD. Van Riper (1982) described this dissociation in stutterers as "le petite mort," (the little death) but gave few concrete data about it. Heite (2001), based on a survey of 108 stutterers, found that about two thirds of stutterers experience dissociation during some portion of the stuttering sequence. In most cases the dissociation subsided with the end of the behavior, although it could also occur before or during stuttering behaviors.

We (Starkweather and Givens-Ackerman, 1997) have speculated that this dissociation may protect the stutterer (or nonstutterer for that matter) from the psychological pain of shame, embarrassment, fear, or anger. This may or may not be so, although Heite's finding that the frequency of dissociation in stutterers is correlated with the frequency of their avoidance behaviors (Heite, 2001) lends credence to this interpretation. Dissociation in stutterers may also be simply a physiological by-product of any strong feeling, and some of the symptoms, such as a distorted sense of time, tunnel vision, and a buzzing or rushing sound, suggest the possibility that the vascular changes that accompany strong emotions may create the phenomenon.

It seems evident that the development of stuttering and the development of PTSD follow parallel courses, the only difference being that in the case of stuttering the daily experiences that are so painful are a combination of current stuttering, memories of past stuttering, and anticipation of future stuttering rather than intrusive memories alone. In PTSD, memories of the awful event are triggered by specific stimuli in the person's surroundings related to the original event. Of course, as we all know, in stuttering the

defensive behaviors, e.g., word-changing, speech avoidance, struggle, and forcing, are also triggered by specific stimuli in the person's surroundings that are related to the original event.

With PTSD, "Because of [the] timeless and unintegrated nature of traumatic memories, victims remain embedded in the trauma as a contemporary experience, instead of being able to accept it as something belonging to the past" (van der Kolk and McFarlane, 1996, p. 9). In stuttering, the trauma actually is a "contemporary experience." It is, in other words, not surprising that stutterers begin to see their disorder as the most important aspect of their identity, and to organize their lives around it by, for example, choosing careers in which they believe they will not need to talk as much, giving their children names that begin with sounds that are easy for them to say, holding back from various forms of socializing, not using the telephone, and so on.

What does this parallel development of stuttering and PTSD imply? First, since there is a well-developed and highly effective method for dealing with PTSD (van der Kolk, McFarlane, and Weisaeth, 1996), it behooves us to look at this method and see how it compares with our treatment of stuttering. Furthermore, since dissociation is a common part of PTSD as well as stuttering and we have no specific treatment for dissociation in stutterers, it should be useful to look closely at those aspects of treatment for PTSD that deal with dissociation.

Making a summary statement about the treatment of PTSD, van der Kolk, McFarlane, and Weisaeth (1996) write:

"The overall aim of therapy with traumatized patients is to help them move from being haunted by the past and interpreting subsequent emotionally arousing stimuli as a return of the trauma, to being present in the here and now, capable of responding to current exigencies to their fullest potential" [emphasis added] (pp. xv-xvi).

In stuttering therapy too, at least as we see it, the overall aim is to move stutterers from being haunted by their stuttering past and their accumulated interpretations of what that past may mean, to a place where they no longer interpret emotionally arousing stimuli as a necessary precursor to stuttering. As with the therapy for PTSD, we seek to help stutterers stay present, in the here and now, capable of talking to their fullest potential.

How is this done? In PTSD "...[traumatized] people need to place the trauma in the larger perspective of their lives (van der Kolk, McFarlane, and Weisaeth 1996, p. xv)." So too can stutterers learn to place their stuttering in the larger perspective of their lives. Furthermore, with PTSD clients, "The therapeutic relationship... is often the cornerstone of effective treatment. It tends to be extraordinarily complex, particularly since the interpersonal aspect of the trauma, such as mistrust, betrayal, dependency... tend to be replayed within the therapeutic dyad" (van der Kolk, McFarlane, and Weisaeth, p. xvi). Many speech therapists would feel comfortable making that statement about stutterers.

We do not think that the evidence warrants a conclusion that dissociation is integral to the experience of stuttering. Only two-thirds of Heite's respondents claimed it. Furthermore, the verbal descriptions of Heite's respondents did not always coincide with van der Kolk and his colleague's description of dissociation in PTSD. Nevertheless, dissociation, exactly as described by van der Kolk and his colleagues, does occur in

many stutterers during stuttering events. At the least, the phenomenon deserves attention.

The specific methods recommended by van der Kolk, van der Hart, and Marmar (1996) are "discussing these patients' experiences in a safe setting, and encouraging them to share personal reminders of the trauma with the therapist." Since, in stuttering, the events that can provoke dissociation are both actual stuttering and the accumulation of many memories of stuttering moments, a parallel treatment would be to allow the stutterer to stutter openly and freely in a setting that is safe. This is a familiar technique for stuttering therapists of the nonavoidance persuasion.

van der Kolk, McFarlane, and Weisaeth (1996) describe a gradual building up of the PTSD victim's ability to remember the trauma without hyperarousal, from a very small confrontation with one aspect of the memory to a more complete narrative description of the event as something that happened to them in the past. SLP's will recognize this as a hierarchical approach, starting with some small change in stuttering in the therapist's office, then gradually building up to more complete changes of speech, feelings, and thoughts outside the office in the stutterer's real world. The stutterer, meeting alone with the therapist, is encouraged to let the stuttering show, to examine it closely, to talk about it with the therapist (and even "talk to it" as our new book describes), and to feel the emotions and sensations that are a part of the experience.

Once the person can do this without hyperarousal and reaction, the stutterer might try stuttering in this new and open way with one very close friend or relative, and when this has been accomplished without hyperarousal with others, until, gradually, the stutterer begins to be free of the burden of fear, avoidance becomes less likely, struggle diminishes, and the stuttering itself diminishes, first in duration and then in frequency. We use this technique -- called "The Designated Listener" -- in experiential therapy for stutterers. This technique, or one like it, can help the stutterer remain "in this world" while stuttering.

It is worth noting here that the actual traumas of stuttering are more in the social realm and in many ways less devastating than the events that typically result in PTSD. But they are repetitive and frequent, like the memories of trauma that haunt PTSD patients, occurring for most stutterers on a daily basis. Repetition can be damaging. Muscles and tendons become injured not only by sprains and wrenching but also by repetitive use, as in carpal tunnel syndrome. So it is with stuttering. The traumas may be "small," but they occur over and over again.

It seems to us not unreasonable to conclude that stuttering is a very specific form of PTSD, in which small repeated social traumas, resulting from disfluent speech, cause social embarrassment, frustration, and fear. Over time, the stutterer comes to anticipate these events and defends against them with struggle, avoidance, denial, and perhaps dissociation. For these stutterers, stuttering has become the most important thing in their lives. To treat it, therapists can help stutterers learn that the experience of stuttering need not include severe emotional reactions, struggle, and avoidance. Stutterers can come to see their experience of stuttering from a broader perspective, and therapists can help them do that.

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* This article is adapted from our book Experiential Therapy for Stutterers, due in 2004.