A case of stuttering of traumatic origin

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Abstract

This paper presents a case of stuttering which apparently originated in an early traumatic incident, along with a description of Traumatic Incident Reduction (TIR), the treatment approach employed in resolving the complaint. The evolution of therapy and its outcome are shown through an edited transcript of significant segments of the work.

Key words

Trauma- PTSD- Postraumatic Stress Disorder- TIR- Traumatic Incident Reduction- Stuttering

Introduction

According to Hales, Yudofsky and Talbot, “the etiology of learning disorders, motor abilities and communication, though unknown, is presumably related to slow maturing and to dysfunctions or injuries either in the cortex or in other cortical areas which are linked to those specific processing functions” (pg. 802). Later on, they state that “among the etiologic theories there are genetic, neurological, psychodynamic and behavioral concepts. It is possible to draw different etiologic subgroups of stuttering” (translated from the Spanish version).

Not posed as an option is the possibility that stuttering might have traumatic origins.

A search in PILOTS (Published International Literature On Traumatic Stress) showed three matches — two of them about the side effects of medication and one on a stuttering incident subsequent to a suicide attempt.

However, stuttering may be understood as a postraumatic dissociative symptom, as Robert C. Scaer (Scaer, 2000) states:

> *The clinical impairment experienced by the dissociated individual under those circumstances will almost always present as physical deficits that defy physiologic explanation by examination, laboratory tests or imaging studies. Diagnoses entertained by physicians in these states include hysteria, conversion and psychosomatic disorders. The cause for these states is uniformly assumed to be psychological, and the common factor to be stress. Almost all of the deficits have a neurological nature, and may affect any system, including visual, auditory, vestibular, speech, balance, sensation and motor function.(…) Their symptoms are remarkably common from patient to patient. Difficulties with speech elocution and mechanics are common, with word blocking, stutter and unusual dysarthric patterns of speech.*

Traumatic Incident Reduction

Traumatic Incident Reduction [TIR] was developed by Frank Gerbode MD, Gerald French MACP, CTS., and others and first described by Gerbode in1984. It is a short, simple, client-centered and highly structured treatment.

Its originators recognize the influence of the work of Carl Rogers and Sigmund Freud. The fact that this treatment is centered in the client comes from Rogers, but Rogers' concept of permissive non-directiveness is not a part of TIR. From Sigmund Freud we find the influence of his early works, in which he speculated on a traumatic origin of neurosis. Unlike Freud's work, however, the TIR protocols preclude the use of interpretation and analysis.

TIR was included by Dr. Charles R Figley in his project, “Active ingredients in the treatment of trauma”, at Florida State University’s Traumatology Institute. A systematic clinical demonstration of TIR was done, altogether with similar demonstrations of three other treatments: EMDR (Eye Movements Desensitization and Reprocessing), TFT (Thought Field Therapy) and VKD (Visio-Kinesthetic Dissociation). TIR proved to be very effective: positive results were achieved in less than four hours (average) of treatment, providing significant relief to the clients.

TIR is based on the belief that themes — unwanted feelings, emotions, sensations, attitudes, and psychosomatic pains, herein connected with stuttering — are rooted in traumatic events. TIR is aimed at reaching that root, and at resolving it and the theme related to it by "unburdening" its emotional charge.

Basic TIR

When the target is a known traumatic episode — known by the client, that is, such as a rape or combat event s/he is aware of and troubled by prior to the session — the particular form of TIR procedure employed is called Basic TIR. Basic TIR, the simplest form of the technique, consists of having the client silently review the traumatic incident repeatedly, sometimes a great many times.. At the end of each review, the therapist/facilitator asks the client to describe what happened. It is common and expected that as the client reiterates the traumatic event, his/her recall of the traumatic memory shifts and evolves. Catharsis often occurs (though not necessarily or inevitably); not uncommonly, the client may experience one or more reviews of a heavily “charged” incident with great intensity – possibly as if the incident were occurring again; over time in the session(s), however, the narration gradually undergoes a transformation. Typically, complete emotional discharge takes place, the clients suffering ceases, and significant cognitive changes, shifts, and insights spontaneously occur. This moment is known as the End Point and is, in fact, the point at which – with no further therapist-initiated discussion or analysis whatsoever – the TIR is ended.

Thematic TIR

When the presenting issue is not a known trauma but, rather, an unwanted “theme” — a feeling, emotion, sensation, attitude, or pain — the existence of a traumatic root is assumed and then searched for by starting with the client’s simply locating, “viewing”, and describing incidents containing the theme and applying the procedure to that particular

event. In brief, a (non-hypnotic) regression is provoked until the “root” traumatic incident which lies in the root of the problem is reached by the client, at which point the technique becomes essentially indistinguishable from Basic TIR, going to its resolution through repeated iterations of this last incident. This somewhat more complex form of the procedure is called Thematic TIR.

The therapist intervention is highly structured. The protocol consist of a series of questions and instructions that guide the client to and through the traumatic situation and the feelings, sensations, cognitions, etc. that such contact generates: in essence, the client is asked to go to the beginning of the incident, to go over it mentally and in silence, and finally to describe what has happened. The therapist (or “facilitator”, to employ the term that Gerbode prefers) offers no evaluation or interpretation whatsoever, since it has been found that these can be and are best provided quite spontaneously by the client. The therapist/facilitator works very hard and consciously *not* to be interesting to the client so that the client’s entire attention can be focused on the contents of his/her own mind—on recovering the traumatic memory, on getting into contact with it, and on putting it into words.

A case of stuttering of traumatic origin

The client, “Jorge” a 30-years-oldmale, had stuttered all his life. Prior to these sessions, Jorge had often sought medical opinions and had psychological and phonoaudiologic treatments without positive results. The severity of his stuttering grossly affected his social interactions, causing serious communication impairment that led him to isolation. Jorge had a hypothesis about the origin of his disorder: a traumatic incident he had suffered at he age of 3, which is referred to below. None of his previous therapies had focused on that incident which remained unaddressed. Furthermore, the fact of his merely presuming a link between the traumatic incident and the stuttering did not bring him any relief.

The therapist began by applying the Thematic TIR protocol to the theme of “stuttering” assuming — with the protocol — that if a causal connection between the theme and the traumatic incident in fact existed, the protocol would lead automatically to addressing the causal or “root” traumatic event.

The following transcription contains fragments of the main TIR sessions. It should be noted that while two sessions were devoted to the resolution of this client’s issue, it is

quite possible that it could have been done in one. Single sessions devoted to the resolution of single specific traumata are actually the rule than the exception when employing TIR.

Except as otherwise noted, the transcript below shows only Jorge's sequential answers to the therapist's iteration of the question, "Tell me what happened", after having silently reviewed the incident. Repetitions, stuttering, and colloquial style have been omitted in order to render the text easily readable. Only the most significant fragments — those showing the evolution of the work done during the session — are presented. The author's notes are in brackets.

The first incident Jorge reviewed was a relatively recent one containing the stuttering. Following the Thematic TIR protocol, the therapist then directed him to look for and find – which he was able to do -- earlier and earlier incidents, until eventually he arrived, in fact, at the traumatic event he suffered when he was 3 years old.

> "What left the symptom behind was not always a 'single' experience. On the contrary, the result was usually brought about by the convergence of several traumas, and often by the repetition of a great number of similar ones. Thus it was necessary to reproduce the whole chain of pathogenic memories in chronological order, or rather, in reversed order, the latest ones first and the earliest ones last; and it was quite impossible to jump over the later traumas in order to get back more quickly to the first, which was often the most potent one."
>
> Freud, p37.

Thematic TIR beginnings:

Therapist :find an incident containing stuttering

Jorge: Well, one happened when I was in my sophomore year of high school (aged fifteen) and I was made to read a short text and I felt uncomfortable. I sweated a lot… I felt people laughed at me. Although they didn't actually laugh, I felt they made gestures, they found it funny. I sweated a lot. It was just five or six lines, and it took me fifteen minutes to read them (...) I feel that everybody's eyes are looking at me, they are thinking that I'm going to stutter, they want me to do

so, I don't know why I think so but do I think so and I sweat, I get nervous and stutter even more. [Note the change to present tense, very commonly observed in TIR]

5th iteration (1st. Incident)

Jorge *Well a teacher comes and made us all read a book, a few paragraphs each one. She started from the first row; I was in one of the last ones. I always sat at the back of the classroom so that if it took too long, I didn't read or didn't do what I had to do. She made us all read. I tried to go to the bathroom in order not to have to read, but she wouldn't let me go. I read, I read awfully… it was something about some mountains. Someone else had to read because nobody could understand what I had read. I sweated a lot and people seemed to find it funny. Nothing else.*

Therapist: O.K., is there an earlier similar incident?

Client: Once in the primary school: they made me read, I felt bad because I was a child and everybody was laughing.

9th iteration (2nd Incident)

Client: We were late for a class. The classroom was at the end of a corridor, on the first floor; there was a balcony and when we walked past we saw the door was locked. We unlocked the door and saw everybody was already in their seats. They stare at us, the teacher was angry because we were late, so she made us five, those who had been late, take out a story book and read it and people laughed when it was my turn because I read very bad. I sweated, I was very nervous and she was angry, she looked upset.

Therapist: O.K. Is there an earlier similar incident?

Client: ... In the kindergarten, but I didn't talk very much there. I always sat quietly in a corner, I remained silent and avoided being sociable. This way I was

the leader to a certain extent, but not later on: I used to plan something and everybody followed me, but when I needed to talk about something, I couldn't

Therapist: O.K. Find an earlier incident containing stuttering

Client: When I got hurt. We were in the playground and I got hurt in my eye, and I didn't say anything.

11th iteration (3rd Incident)

Client: I come into a large playground in the kindergarten. There were a lot of children jumping and there were two tall benches with a board in between. I went under that board but a nail sticked out of it and it stuck into my eye. A lot of blood flowed out and one of the children came and asked me what had happened and I didn't say anything. I cried till the teacher came and they took me to the hospital and got me sew.

14th iteration

Client: We were in the kindergarten playground and we were in the swings. There were some logs and I was sitting on them. The teacher brought some cookies for us to eat and she held a game so that everybody would play. I didn't want to play, I stayed there isolated, tried not to participate in the game. I felt ashamed of participating because of what the other children could say. The teacher insisted on my participating but as we were so many I always tried to leave and nobody realized I didn't participate.

This iteration of earlier and earlier incidents continued until he arrived at the traumatic event he had suffered when he was 3 years old and his grandmother had poisoned his grandfather.

The client recalled a certain moment when the family realized the fact that this grandmother had committed the crime, and all of them were, of course, very shocked. When the police came and told the family, my client was not given any explanation by anyone. He knew, intuitively, that something was very wrong, but was given no data and

felt alone, apart, and scared. Nobody gave him any support at that moment and they did not consider it necessary to address the subject with him. They just told him "go to the backyard to play."

Therapist: Alright. Is there an earlier, similar incident?

Client: I remember that, a long time ago, everybody would shut up or hide something when I was nearby. I was little, around 3 or 4 … I see that everybody used to hide, that when I was around and they were talking about something, they would leave.

1st iteration (4th incident)

Client: I'm in the house and I asked something and they answered me in a bad mood. When I went there or heard something... I went there and they fell silent or made gestures as to not say anything.

2nd iteration

Client:. Everybody was being bad, as if they were angry, worried. My father talked a lot over the phone. I asked what happened and nobody'd answer me or they'd answer in a bad mood. They talked and when I approached to hear something it was obvious they changed the subject or they told me to "go and play in the yard…."

8th iteration

Client: I was in the house, in that big old house. I was little. My parents were in their room with my uncle; my mum was crying, my dad was on the phone. Everybody looked angry and I tried to find out what happened but they told me nothing and sent me to the yard. My grandmother [the other one] took me to the yard. The door bell rang and it was the police, they went into the room and stayed there

Therapist: OK. Is the incident getting lighter …heavier…?

["It was not completely clear to the therapist/author which 'direction' this incident was "going in". The protocol offers that "lighter?/heavier" question as a way of resolving that problem. The client's answer dictates the therapist's next instruction: if "lighter" — the direction we ***want*** *to go in — the same incident is addressed again; if "heavier" (duller or more painful or confusing), the therapist asks after an earlier, similar incident].*

Client: Lighter.

13th iteration

Client: I was in the house, in the yard, I heard somebody screaming in the room. I got to see my mother crying and my dad talking on the phone. I tried to get in but they didn't let me, all of them were very nervous. I kept asking what was happening but they told me nothing. My grandmother took me to the yard and then the door bell rang and it was the police. They went into my parent's room, I kept on trying to go there but my grandmother would take me out to the yard

Therapist: OK. How does the incident seem to you now?

[The therapist asked this as the client seemed to have attained at least partial relief and was manifesting boredom, and no more emotion was coming out of the incident, which they had been running for 1:09 to this point]. In fact, as noted above, it might well have been possible, even desirable, to have simply continued to a full resolution. In the event, however, the therapist ended the session for the day and it was resumed the next week

Client: Yes, yes, it's enough for today.

Duration : 1.09 hs.

[I ended the session because the client was getting bored, and no emotion was coming from the incident anymore]

Second TIR session

Therapist: Find an incident on which we are going to work.

The therapist began the next session by asking the client to find an incident to work on. Had he been observing the TIR protocol more closely, he would simply have reoriented the client to the not yet fully resolved incident and continued.

In fact, however, the client responded by hewing precisely to what the protocol called for:

Client: Let's start WITH the last one I WAS LOOKING AT, when I was 3. I was in that house, at home, and my mother was crying and my father was on the phone and they told me to go outdoors.

4th iteration [it's actually the 17th iteration of this incident the 4th in the second (4th Incident)

Client: I was in the yard playing with a toy truck. It was a nice day and I heard a scream coming from one room, from my mum's room. My mother was crying, my uncle was very nervous, and my father was on the phone, which rang over and over again. I asked what happened and I was told nothing and I was taken out into the garden. My grandmother took me out. Then the door bell rang and it was the police. A tall, big policeman went into the room. He was a guy wearing a blue uniform. I looked in and they took me out. I feel angry because they didn't tell me anything, they all mistreated me. It was as if I didn't belong to those people, to my family.

T: OK. Is the incident getting lighter …heavier…?

C: Lighter, but I'm sweating a lot.

14th iteration

C: Sometimes an unpleasant feeling arises inside of me, sometimes it seems to be just a story.

17th iteration

C: I was in the yard, I was playing with a red toy truck, I was happy... I hear some screams coming from a room. I went to find out what was going on and they told me nothing. My uncle was nervous, my dad was on the phone and my mum was crying pretty much. Frightened, I asked my father what had happened, because I could feel something was happening, and they just told me: "It's nothing, go away" and I felt rejected, as if they were pushing me away. Then my grandmother came and took me to the yard. I asked her what had happened and she replied "nothing at all". Then the doorbell rang and it was the police. They went into the room, stayed there for a long while and then left with my father.

T: OK. Is the incident getting lighter …heavier…??

C: Heavier.

T. Alright. Is there an earlier, similar incident?

C: I don't know, but …

He recalled a moment prior to his Grandfather's death, while both were eating soup together —NB: the poison was in the food— and he remembered his Grandfather's sad eyes, and felt guilty for not having done anything to save him. (Recall: he was 3!)

C: I don't know if it is only my imagination but ... it came to my mind that my grandfather knew he was being poisoned and did nothing… and it is as if I have always felt guilty because I couldn't do anything. And, in some way, he didn't do anything, I was just 3 years old and I couldn't do anything.

1st iteration (5th Incident)

C: My grandfather knew he was being murdered and he didn't do anything. He didn't want to do anything. He died because he wanted to, not because he was murdered … besides the fact that he was murdered.

7th iteration

C: My grandfather looked sad while he was eating his poisoned food. His eyes were sad and he looked at me while he was eating. He knew it was poisoned and didn't do anything. He ate it all and I always feel guilty because I couldn't do anything.

The topic of the murder was taboo in his family, and only eleven years after the incident, at age 14, did he find out why she was jailed.

After he remembered this event, and reviewed it enough times to remove the emotional charge from the memory, he ceased stuttering.

At this point, he was speaking much more fluently, a significant cognitive shift occurred -- he realized that he was not guilty -- and he felt released from a burden. He became physically oriented to me in the present, his attention no longer introverted and in the past.

TIR can elicit intense catharsis and quite often does. This was not the case with this client. He reviewed and recounted the incident many times, but always calmly. The only sign of the emotional (dis)charge was that he ended the session completely soaked with sweat.

Jorge finally decided to talk to his family about the subject. After 27 years of silence, all of them were taken by surprise! Now, he and his older brother have decided to investigate the event and to write a book about it.

Prior to our work with TIR, he used to avoid contact with others as much as possible because he feared stuttering. Now he finds that he can speak calmly and doesn't feel intimidated. If he starts to feel anxious, he calms down with just a deep breath and

continues to speak fluently. He still has a slight trembling in his voice, which I think could be resolved with phonoaudiologist training.

Conclusions

Even though addressing the child traumatic incident led to a positive outcome this fact does not provide solid enough support to attribute the etiology of stuttering to that incident. A link between them is certainly suggested, however.

In this case, one can find the illustration of some of the main characteristics of TIR. On one hand, its characteristic of being person centered, following the interest of the client and giving no intervention, no suggestion about the etiology or function of the symptom. The therapist/facilitator acted simply as a guide in taking the client through his review of the incidents. The link between the symptom and the traumatic incident was established by the client himself

At the same time, it is possible to see the procedural structure, as well as the therapist interventions, the latter limited to giving the questions, instructions, and acknowledgments required by the protocol In order to direct and accompany the client on his journey.

The therapist's influence on the final issue of the therapy has been reduced virtually to the point of non-existence. He really has become "merely" a facilitator of his client's work. Any therapist, adequately trained in TIR and carefully observing the straightforward protocols, could have achieved same results, given the fact that most of the therapy work in a TIR session is done by the client.

There could be drawn, also, some conclusions about the properties of traumatic memories, and their storage in the form of body sensation memories, and the effect of translating them into verbal code, transforming them into a narrative, that brings relief from the suffering, allowing the focus of the memory to stay where it properly belongs: in the past.

There is much work and hard research to be done in testing the clinically observable efficacy of TIR. Meanwhile, this kind of case study can be useful in encouraging researchers to put TIR under scrutiny in a scientific way.

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