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Stuttering, Subjectivity and Traumatization

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SUMMARY

ABSTRACT

This article will address:

1- What is understood by trauma;
2- Stuttering as a natural phenomenon present in speech of all speakers and how, based on communication relationships surrounding natural stuttering, a traumatization process is constituted;
3- Traumatization: the characteristics of stuttering as suffering in speech
4- The bases for a therapeutic process that understands stuttering as a traumatic response.

Keywords: Stuttering, Trauma, Therapy

INTRODUCTION

My interest in understanding stuttering began during my undergraduate course in Speech Therapy, which I completed in 1974. At the time, stuttering was presented as a problem about whose nature there were doubts. It was not clear whether it was an organic or emotional disorder, or perhaps a combination of both. The training I received to treat it was organic in nature: oral motor exercises to eliminate or minimize the tense motor manifestations that characterize stuttered speech.

After becoming a speech therapist, I began to treat people who complained of stuttering based on the training I had received. The results, however, were not satisfactory. Although they used the techniques proposed to avoid stuttering, such as softening articulation, speaking slowly, breathing before speaking, pausing speech for a few seconds when they anticipated stuttering, people continued to report suffering due to lack of freedom and insecurity when speaking, for fear that others would see them as incompetent, incapable, not knowing what they were saying.

On this path, which I followed for 10 years, two aspects intrigued me: 1- The fact that people sensed where they would stutter, whether it was a word or a phoneme, given that speech is an automatic and spontaneous action, that is, we know how

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to speak, but we don't know how we do it. 2- The fact that all the stutterers I treated reported not having any stuttering at all when, for example, they spoke to themselves, to very young children, to their boyfriend/girlfriend, to a pet, that is, in situations in which they felt completely comfortable with themselves.

The hypothesis that stuttering is a manifestation correlated to the individual's relationships with others and with society seemed quite plausible to me. With this interest, I enrolled in the Postgraduate Program in Social Psychology at PUCSPS[1] with the aim of developing a qualitative investigation into the possible nature of stuttering. Based on the works of S. Lane, A. Leontiev, A. B. Luria and P. Malrieu, I developed a research proposal that would allow me to understand it through the history of the speech development of the person who stutters. Based on the authors mentioned, I assumed that:

> by relating the manifestation of stuttering to the sequence of the larger context to which it belongs, I would have access to the movement of the individual's thoughts related to speech and stuttering. This implies understanding the development of the person consciousness in relation to them, that is, understanding the way in which the person ordered external reality in this regard (…)." (Friedman, 2004, p.28).

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I interviewed seven adults in depth, six with stuttering and one who said she had overcome it on her own. Based on their speeches, I analyzed the movement of their thought to obtain a system of categories. "A category is a logical device of theoretical scientific thought, a form of synthesis of that which presents similarity of content in discourse" (FRIEDMAN, 2004, p.28).

Of the categories that emerged, four were common to all subjects: *self-image*, *motor level*, *emotional activation* and *others*. These constituted sufficient material to access the representations that the subjects made of themselves, their speech and the world, as well as gaps, contradictions and the ideology that underlies them. They were related to stuttering and the process of language development.

The contents of the categories were understood as the contents of each subject's consciousness and the relationships between them, as the movement of their thoughts. The contents of the categories *self-image*, *motor level* and *emotional activation* of the non-stuttering subject were shown to be contrary to those of the stuttering subjects, which gave emphasis to the latter as characteristics of the development of language and stuttering. For example, the *self-image* of the subject who does not consider himself/herself a stutterer contained an image of himself/herself as a good speaker, pride in speaking, while that of the stuttering subjects contained an image of themselves as bad speakers. The *emotional activation* of the former contained pleasure in speaking and that of the latter contained fear of speaking (FRIEDMAN 24, p. 128).

In summary, the research showed that the formation of a stigmatized image of the speaker is at the root of the production of speech with stuttering. It also showed that this image is formed from communication relationships based on an ideology of good speech, which supports rejection attitudes of the natural disfluencies of the child's speech by their primary caregivers or people who are significant to them. As a result of this image, the person develops the habit of worrying about the way they speak and begins to predict the places in their speech where they will stutter. In this way, they try to control the way they speak so as not to stutter. This, however, disorganizes the gestures of speech, given that speech is an automatic/spontaneous activity. This way of functioning, worrying about the form of speech and anticipating stuttering, traps the person in the paradox of trying to be spontaneous. The result is that the more one tries to speak well, the less one achieves this goal, and when one does not worry about the form of speech, which means that one does not worry about one's self-image, one flows. This makes sense with the fact that people who consider themselves stutterers can speak fluently in certain situations and not in others.

Based on these results, I began to describe this type of stuttering as "suffered stuttering" and redirected the therapeutic approach from a psychosocial perspective. I began to work on raising awareness of the nature of subjective content related to the prediction of stuttering, given its constitution marked by communication relationships experienced in early childhood.

I also began to work on awareness of articulatory gestures, which are few in number as can be seen from articulatory phonetics, so that the person could perceive them when speaking and could observe that a gesture feared in one place in speech reappears without being feared in several other places. With this type of work I began to see good results with the therapeutic process, as shown in the testimonials on the web page <https://www.gagueiraesubjetividade.info/depoimentos.php>

In 2015 I came across the work of Peter Levine and the notion of developmental trauma, which significantly expanded my understanding of the nature of "suffered stuttering", and the possibilities of therapeutic work. This led me to also study the work on trauma by Daniel Siegel, Bessel Van der Kolk, and Gabor Maté. This is what this current article is about.

TRAUMA

Trauma, according to Bessel Van der Kolk (2020), Gabor Maté (2023), Peter Levine (2023), is what happens inside a person when difficult or painful events are experienced, and not adequately processed, causing incapacity of spontaneous and authentic self-expression. In other words, trauma is not the event itself, but rather the mark that remains in the memory from an event that the person was unable to deal with. Even knowing that the danger has passed, the person does not feel that way, does not feel that the threat is over, the physiological and emotional responses to that event remains open, waiting for a solution.

Trauma, says Maté (p. 27), is an internal wound, a lasting rupture due to what remains inside the person as a result of difficult or painful events. Traumatic memory is something stored in automatic actions and reactions, generating repeated and reenacted sensations and attitudes as visceral reactions. Maté also says that trauma permeates our culture not only on a personal level but also in social, parental, educational relationships, in popular culture, in the economy and in politics, due to the highly utilitarian, perfectionist, competitive, comparative and demanding mentality that characterizes it.

According to Van Der Kolk, all trauma is pre-verbal, either because the psychic wounds suffered were often inflicted

before the brain was capable of formulating verbal narratives, or because they were recorded in regions of the brain or the rest of the body that words and thoughts cannot directly access.

In this regard, Levine (2023) describes that memories can be explicit or implicit.

Explicit memory, the best-known type of memory, is divided into declarative and episodic. Declarative memory is comparable to a catalog of detailed information that allows us to consciously remember and tell factual stories. It is factual and cold information. Episodic or autobiographical memory contains nuances of feelings and richly encodes personal experiences. It is "a dynamic interface between the rational (explicit/declarative) and irrational (implicit/emotional) capable of promoting coherent narratives of stories that we tell ourselves and others" to give meaning to life. (LEVINE 2023, p.40).

Implicit memory is divided into emotional and procedural and cannot be deliberately called upon or accessed as reminiscences. It emerges

> [...] as a collage of sensations, emotions and behaviors […], it appears and disappears surreptitiously, far beyond the limits of our conscious perception. It is organized mainly around emotions and/or skills, or procedures – things that the body does automatically (sometimes called action patterns). (LEVINE, 2023, p.40)

Emotional memories signal and encode important experiences to serve as reference later. They are like loaded signals that select specific procedural memories from a set of possible motor memories and induce the organization of themes for action.

Procedural memories are the impulses, movements and internal bodily sensations that guide our actions, skills, attractions and repulsions and can be divided into three categories:

1) Those involving learned motor activities such as walking, talking, dancing, having sex, which continue to develop and refine throughout life;
2) Those involving immediate programmed responses that activate survival instincts in the face of a threat in the form of fixed action patterns such as enduring, contracting, withdrawing, fighting, fleeing, freezing and also establishing and maintaining territorial boundaries. It plays a crucial role in the formation and resolution of traumatic memories;
3) The fundamental tendencies of the organism's response:
    a) at the physical level: approach, motor acts of expansion, extension and reach in the face of sources of nutrition and growth and avoidance, motor acts of stiffening, retraction and contraction, in the face of sources of harm and toxicity;

> b) at the social level, attraction: getting closer to people or seeking what one wants in life and repulsion: moving away from that which has an unpleasant taste or odor, as well as from individuals who seem emotionally toxic. (LEVINE, 2023, p.51)

Levine exemplifies procedural memory as a motor skill acquired through learning to ride a bicycle, considering it a challenging activity because it requires mastering the forces of gravity, speed and momentum. He explains that with the help of parents, for example, these forces end up being mastered procedurally, without involving any explicit knowledge of physics or mathematics, but rather, through trial and error. However,

> [...] if, in our first efforts, by misfortune, we skid on the loose gravel and crash to the ground, this affects the acquisition of balanced movements and necessary and appropriate body postures. So, when we finally manage to handle the bicycle, we may do so with a hesitation that leads to instability [...]. What should evolve naturally into an acquired motor skill full of nuances overlaps and becomes a habitual reactive pattern of survival, which consists of resisting and contracting, or else overcompensating, taking counterphobic risks: both results are far from ideal and are examples [...] of the persistence of a procedural memory. In

> fact, persistent and maladaptive procedural and emotional memories form the central mechanism underlying all traumas and various social issues and problematic relationships. (LEVINE, 2023, p.63-64)

Levine (2023), Van Der Kolk (2020), Maté (2023) agree that there are two types of trauma. The debilitating ones, designated with a capital "T", which involve automatic reactions and adaptations of the mind and body to specific painful and overwhelming events, identifiable in childhood or later. They are related to violent events such as war, death threats, murder, assault, rape, serious accidents, etc. And the "apparently inconsequential" ones (LEVINE, 2023, p.63) designated with a lowercase "t", related to common everyday experiences that seem perfectly normal.

Maté (2023, p.30) comments that he has often observed the lasting marks that seemingly banal or unmemorable events, but painful and very prevalent in childhood, can leave on the psyche of children. Events such as bullying, casual but frequent harsh comments from a well-meaning parent, or simply a lack of sufficient emotional connection with caring adults.

Children, especially highly sensitive ones, can be hurt in many ways both when bad things happen and when good things don't happen, such as when their emotional needs for connection are not met, or when they are no longer seen and

accepted, says Maté (2023, p. 30). Trauma of this type does not require a major disruption or misfortune like "T" traumas and can also lead to the pain of disconnection from the self.

This change, says Maté, happens subtly, slowly and therefore is difficult to perceive. And, as it is internalized, this lost connection begins to shape the view of reality, so that the person begins to believe in the world they see through this lens, and who the person thinks they are is, in part, the product of a traumatic loss.

NATURAL STUTTERING – A PATH TO TRAUMATIZATION

Natural stuttering, also called disfluency, is something that can happen to anyone. It has to do with the lack of words or the difficulty in organizing words into sentences at a given moment of speech. This condition can be related to emotional states such as fear, anxiety, euphoria and also to ignorance of the subject, poor command of the language, among other possibilities. It is common for vowel repetitions to occur, such as "a, a, a" or o, o, o, repetition of what has already been said, elongation of sounds such as in "I think, I think thaaaaat…", thus creating time for words to be evoked and speech to continue.

This occurrence does not affect the understanding of speech for the listener, nor for the speaker. As for the listener, it is not the sound of the words that is learned, but rather the meaning of speech. As for the speaker, he is guided by the meaning of what he says, while the form remains forgotten, that is, we know how to speak without knowing how we know it; we are guided by the meaning of what we want to express.

When the child begins to form longer sentences, around 2.5 to 3.0 years of age, natural stuttering, as described above, is quite common, because, from a linguistic point of view, the

lexicon and syntax are still in the process of acquisition and development. According to Scarpa (1995, p.176), the child's fluent passages are those already established, known and come in blocks. The disfluent or stuttered ones are those that are under construction and, therefore, more unstable, as they involve more complex steps both in selection and organization of words to elaborate the statement.

Scarpa (1995) also says that the fluent subject is an abstraction since, by its very nature, language is marked by lack and incompleteness. Speeches move through other speeches and the one who makes the fluency is the other who recomposes the disfluencies and imperfections of speech.

From the point of view of brain development, as explained by Daniel Siegel (2012, p.104), the right hemisphere, which corresponds to the domain of imagination, holistic thinking, non-verbal language, and autobiographical memory, develops first. The left hemisphere, responsible for logical, spoken and written language, linearity, lists, and literal thinking, only begins to mature from 3 or 3.5 years of age. In this condition, there will be a large number of times when the child will not quickly evoke words or the organization between words, to say what he or she wants to express, which can lead him or her to repeat vowels, syllables, or words, until the desired word is evoked.

However, it may happen that adults responsible for a child - parents, guardians, relatives, teachers -, react negatively to these repetitions because they consider them wrong,

inappropriate, undesirable, given an idealized pattern of speech expected by them. This reaction, as I have observed in 50 years of clinical practice, manifests itself in the adult's facial expressions, as well as in requests such as: *speak slowly, speak properly, take a deep breath, think before you speak, stop stuttering, stop repeating syllables*.

From such a reaction we have that: 1 - the child does not receive a response to the content of his/her speech indicating that he/she has been understood and 2 – he/she receives the information that he/she should speak differently. Since he/she is in the process of acquiring language, the child is not able to identify the supposed error and to attend the adult's demand. What prevails is "an authoritarian discourse, dominated by the absence of reversibility, which places the child in a top-down relationship" (AZEVEDO; FREIRE, 2001, 150-151), in which its emotional needs for connection are not being met or seen.

This is, therefore, a communication relationship with the potential to disrupt the child's ability to communicate, because he/she does not have the elements to integrate the adult's reaction and know how to speak in a way that pleases. The communication relationship thus becomes an adverse experience for the child, as it becomes inconsistent and unpredictable. This, in turn, is likely to generate insecurity in the child's speech, given that children do not have sufficient psychomotor or relational resources to deal reflexively with their speech or the adult's reaction.

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For children, as Daniel Siegel (2010, p.247-248) explains, the lack of harmony between them and the person responsible for meeting their needs, represented by negative reactions to their way of speaking, awakens feelings of shame and guilt. Siegel also explains that human beings have two basic needs to ensure their survival: belonging and authenticity. Displeasing, in any way, those who are responsible for their survival, threatens the sense of belonging and is felt as a danger to their existence. Children, then, seeks to adapt their behavior or to please their caregivers, compromising the development of their authenticity.

The practice of not responding and making observations about the content of the disfluent parts of the child's speech, denying them meaning, is, however, quite common and socially accepted, considered normal in family, school and health environments. This can be considered an example of what Maté called the "myth of normal"[2] and is considered one of the forms of trauma with a lowercase "t", or developmental trauma, given its potential to lead to the pain of disconnection between the speaker and his or her speech, as the child begins to fear the occurrence of disfluent or stuttered passages that displease adults.

2 Maté (2023, pp.15-17) discusses several examples of myths of the normal, such as the climate catastrophe that already affects us and that we have simply assimilated into everyday life, or medicine that ignores or fails to metabolize the evidence that living people cannot be separated into distinct organs or systems, nor even into minds and bodies, in order to adapt and adjust its practices to this perspective.

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The disconnection, this fear of being authentic in one's way of speaking, crystallizes in an imbalance in the relationship between the form and meaning of speech. In this regard, Azevedo and Freire (2001, p.153) state that "in the discursive order there is a natural tension between language (form) and speech (meaning)". In the fluent position, the authors say, there is a privilege of meaning (speech) to the detriment of form (language). This means that the speaker knows how to speak, but is unable to know, to control, how the meanings are transformed into sounds, given that the form of speech remains forgotten.

However, when the child begins to fear disfluencies, the form of speech becomes an object of concern and can be anticipated by the child, in an attempt to avoid it in order to feeling seen and accepted by adults. The anticipation of the occurrence of disfluent words or sounds, or the generic conviction that one will stutter when speaking, contains the illusion that one knows what in discursive functioning is unknown.

Thus, a new discursive functioning begins, in which the child initiates to anticipate the place where he or she will stutter, as a form of defense to try not to do so, and stuttering ceases to be a natural, occasional, irrelevant manifestation, and becomes a pain, a suffering, a failure, a wound, something that cannot/should not be seen. The privilege of form over meaning, therefore, as Azevedo and Freire (2001) say, leads the speaker to the loss of the fluent position.

This loss gives rise to a traumatization process in which the way of perceiving and relating to people changes due to a load of stress, which falls on speech, given the danger that stuttering represents. This generates a pattern of behavior, an adaptive response, fixed in procedural memory in automatisms to try to speak in a way that pleases caregivers and maintains the feeling of belonging, connection, and security of the bond.

It is not a lack of love or affection, but an instability in the bond, which leads to a perception of non-acceptance of oneself as a speaker, compatible with the characteristics of developmental trauma. This, as Van der Kolk (2020, p. 201) explains, is not marked by a specific event, but by a pattern of interaction, a type of relationship with caregivers that generates conflicts, generalized biological and emotional dysregulation, failed or disturbed attachment, and a deficient sense of personal identity and competence.

SUFFERED STUTTERING

Daniel Siegel explains that the need to be seen by others activates the attachment circuits. When this need is met, the feeling is one of joy. However, when it is not met, the feeling is of being invisible or not understood and the nervous system responds "with a sudden action of the brake pedal of the regulatory circuits", which generates unique physiological responses such as heaviness in the chest, nausea, a dejected or distant look, so much so that there is a withdrawal into oneself, "because of the pain that, often, does not reach consciousness."

> This feeling [...] occurs whenever one is ignored or receives confusing signals from others and is experienced as a state of shame. States of shame are common in children whose parents [...] habitually stop tuning in to them." (SIEGEL, 2010, p.247)

Not having the content of the message recognized and receiving observations about the way of speaking does not meet the child's need to be seen and is consistent with the feeling of not being understood, of not receiving clear signals from the adult. This leads to a lack of harmony and, consequently, shame for having stuttered. In this way, as Siegel explains, the child is vulnerable to the

> reactivation of shame and humiliation in contexts similar to the original situation. […] As the child gets older and the cortex develops more fully, the state of shame becomes associated with a belief built at the level of the cortex that 'I am defective', because this perspective is safer for the child than "my parents are not trustworthy" [...]. At the very least, the mental mechanism of shame preserves the illusion of safety and protection that is at the heart of sanity. (SIEGEL, 2010, p. 248)

In this sense, Van Der Kolk (2020, p.138) supported by Winnicott explains that the young child learns to become the idea that the mother or significant others have of him/she. To do this, he/she reduces his/hers inner sensations and tries to adapt to the needs of those who care for him/her, which carries the realization that something is wrong with him/her.

In cases where the stuttered content of messages is not recognized, the child may begin to see him/herself as a stutterer and stuttering as something bad, something that disconnects him/her from the ability to speak well. Stuttering may then become shameful and generate guilt, leading, subtly and slowly, to the formation of a defective speaking self.

Therefore, it is understood as a "stigmatized image of oneself as a speaker" or "image of a bad speaker" (Friedman 2004), which fears not being accepted, fears being seen as weak, incapable, not knowing what one is saying, that can

begin to compose emotional memories that will signal, encode and serve as a reference for later speaking experiences.

Hence, the formation of a stigmatized image of a speaker corresponds to a process of traumatization in the ability to speak that materializes in the production of "suffered stuttering".

As in Levine's (2023) bicycle example, the child, feeling that he or she is a defective speaker, develops the defensive strategy of anticipating the possible location of the stuttering in order to overcome the fear and shame of stuttering and try to control the situation. As Levine (2023, p. 63) said regarding procedural memories, a "habitual reactive survival pattern emerges, which consists of resisting and contracting".

In stuttering that constitutes itself as form of suffering, what appears are retractions of the phono articulatory muscles, which, by blocking the release of air and, therefore, of voice, are the defense responses of the Autonomic Nervous System to avoid/escape from the danger of stuttering.

There are also repetitions of what has already been said, repetitions of vocal sounds, exchange of the feared word for another one that is not feared, which are used to gain time and escape from the word or sound anticipated as dangerous. These, as we saw above, become the immediate responses programmed in procedural memory, making the fight and flight responses chronic, as if danger could appear at any moment.

Since these forms of speech are outside the idealized pattern of fluent speech, they can continue to displease

caregivers and significant others, thus maintaining interactions that reject the stuttered passages in a process of retraumatization.

Learned motor activities continue to develop and refine throughout life. In "suffered stuttering", what appears is a refinement of behaviors to avoid stuttering, such as supporting words or sounds that precede words considered dangerous in order to release them; replacing feared words with others with the same meaning when possible; when not, avoiding what one was going to say, saying something else instead; completely avoiding speaking by remaining silent and, also, avoiding communication situations considered too dangerous.

We thus have that the fundamental tendencies of the fixed traumatic responses of the organism in "suffered stuttering" are avoidance of sounds, words, situations and people, involving motor acts of stiffening, retraction and contraction of the phono articulatory organs and/or behaviors of avoidance and escape from communication situations.

The fundamental subjective mark of "suffered stuttering", which distinguishes it from natural stuttering, is to foresee the place where the stuttering will occur in order to fight or flee from it and thus avoid shame and guilt. Over the course of 50 years of therapeutic practice, I have heard people report that they *feel* like they are going to stutter and/or they *see* in their minds the words or sounds in which this will occur. These are repeated sensations that lead to repeated behaviors, reenactments experienced over the years, the product of

traumatic memory, of the lasting rupture with the spontaneity of speech. The speech, however, remains intact, given that all people who suffer from stuttering can present zero stuttering in situations in which they feel comfortable, without being judged. Who the person thinks they are – a second-class speaker, a speaker who feels diminished for identifying as a stutterer – is the product of this traumatic loss that leaves a deep mark on their life.

THERAPY

> *Without understanding how trauma is inscribed in the form of impressions and memories in the body, brain and mind, as well as in the psyche and soul, the therapist will get lost in the labyrinth of cause and effect.* (Levine, 2023, p.23)

Since speech is a constant in a person's life, the fear of stuttering is continually recycled into a persistent avoidance of people, situations, sounds and words, and the person continues to defend themselves from a threat they experienced in the past. Recovering means putting an end to this continuous mobilization to not stutter and restoring the safety of the entire organism, returning, as Maté (2023) says, to being whole within oneself.

Van Der Kolk (2020, p. 97) says that one of the most important aspects of overcoming trauma is reciprocity, feeling safe with other people, feeling truly heard and seen by the other, feeling that one is in someone's mind and heart, so that the physiology can calm down, heal and develop.

In this sense, in the therapeutic space, it is about creating a safe environment for working with traumatic procedural memories, which, as Levine points out, are fundamental in treatment, due to their persistence, power and longevity.

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> Of all the memory subsystems, the one of instinctive survival reactions is the deepest and most powerful and, in moments of threat and stress, it generally overrides the other subtypes of implicit and explicit memories. (LEVINE 2023, p.63)

Since procedural memories form the foundation of sensations and also of many feelings, thoughts and beliefs (LEVINE, 2023, p.63), as is also the case of feeling and/or seeing dangerous words and sounds; feeling that you will not be able to speak; feeling fear and shame of stuttering; believing that you will fail; the therapeutic work is to access these memories to renegotiate the trauma.

In this regard, Levine (2012, p. 248) writes about "embodiment" which means "acquiring through consciousness the ability to feel physical sensations as they pulse through the body". He states that trauma victims are disembodied, with their sensations limited and disorganized. People can be either overwhelmed by bodily sensations or disconnected from them and unable to differentiate them from one another. When overwhelmed, they cannot discern nuances and generally overreact. When disconnected, they become numb and become stuck in inertia.

In "suffered stuttering," although the person feels concretely that speech is not coming out – since there are retractions of the phono articulatory muscles that block the exit of air and voice – and that as a result their action is to

push in order to continue speaking, there is no recognition of what in the body is obstructed in order to allow this pushing.

The point of union between body and mind, as Levine (2010) explains, is sensation. In sensation, he says, body and mind speak the same language. Becoming aware of sensations is an example of so-called *bottom-up* processing, in contrast to *top-down* processing, expressed by Descartes in the phrase *I think therefore I am*. "*Bottom-up* processing is more capable [...] of altering basic perceptions of the world" because "we are, first and foremost, motor creatures and secondarily have activated the observing/perceptive/thinking mind (LEVINE, 2010, p.250)." It allows us to learn to focus on physical/physiological sensations as they continually transform into perceptions, cognitions and decisions. In this way, transformation occurs in the mutual relationship between *top-down* and *bottom-up* processing.

In this way, the awareness of disconcerting or frightening physical sensations, such as the blockages in stuttered speech, becomes associated with a strengthened tolerance, an emotionally regulated state, throughout experiences of body awareness during the therapeutic process. This, according to Levine (2010, p.258), can avoid or dissolve deep-rooted emotional and physical symptoms, although it may be difficult to experience this awareness, especially at the beginning. "One only begins to experience the body directly gradually" (LEVINE, 2010, p.262).

According to Van Der Kolk (2020, p.30), "for real change to occur, the body needs to learn that the danger has

passed and to live in the reality of the present moment" in an emotionally regulated state.

In the treatment of "suffered stuttering," this can be achieved by working, for example, first on the conscious perception of the body as a whole and of each of its parts, in the sensations of tension and release.

Next, the conscious perception of the sensations of speech gestures and of the entire phono articulatory mechanism, in order to feel and understand them fully and safely.

Finally, the conscious perception of the sensations in these same gestures when they are stiffened in a way that prevents the passage of air and voice, and the perception of other parts of the body that may also be tense at these moments. It is important to remain conscious of these sensations until their conclusion: the release, in order to reconcile with them.

As Van Der Kolk (2020, p.41) comments, to overcome trauma, physical experiences are necessary to restore the feeling of visceral control. In "suffered stuttering", in addition to what is explained above, these experiences can develop, for example:

1 - when speaking and waiting attentively and with curiosity for the sensation that speech will not come out and the subsequent blockage to appear;
2 - by giving time to this blockage until one clearly perceives the effort of pushing against a closed

air passage, that is, perceiving oneself in the old response of fighting against muscular rigidity, and simply letting the tension dissipate;

3 - by perceiving the paradox contained in the action of avoiding words considered dangerous, saying others in the place that, frequently, contains the same articulatory gestures that were avoided.

This is because, depending on the anatomical and physiological nature of phonation, the closures or blocks can only occur in seven places of the oral cavity:

1 - throat muscles and vocal cords;
2 - back of the tongue with the soft palate;
3 - tip of the tongue with the alveolar region;
4 - the tip of the tongue between the teeth;
5- upper teeth with the lower teeth;
6 - upper teeth with the lower lip and
7 - contact of the upper lip with the lower lip. In this way, the same closures occur in different sounds such as, for example, “p, b, m”, which occur through lip closures.

The proposal is to experience the moments of stuttering with curiosity and kindness, instead of continuing to fight against it.

Alongside the body work is the mental work, the *top-down* processing, which can be developed through breathing and meditation techniques[3]. This type of work with the higher cortical functions, in particular those located in the prefrontal cortex, is fundamental to favor the ability to regulate emotional responses, as Davidson and Begley (2013) found.

These emotional responses, in "suffered stuttering", usually involve, as we have seen, shame, fear, guilt, insecurity, diminishment or devaluation of oneself, and acceleration of speech to avoid stuttering. The block, which exists as procedural memory devoid of content, acts as if the person were being poorly evaluated for the way they speak.

Levine (2012, p.255) says that the only way to know ourselves is to learn to always be very aware of what is happening in our body and mind moment by moment, as the various situations that follow arise.

Conscious breathing techniques such as *coherent breathing*, which consists of always inhaling and exhaling for the same amount of time, or *square breathing*, which consists of, always for the same amount of time, inhaling, holding the air in the lungs, exhaling, holding the lungs empty, are examples of procedures that calm the mind and body and can favor the ability to be aware of both.

3 Meditation is understood here as the ability to see, to be aware of thoughts and feelings, so as not to get involved in an internal dialogue and be carried away or subjected to it.

Techniques like these can be used to initiate a meditative state, from which one can recognize thoughts and feelings, especially if they are part of the traumatic memory. Staying present in the breath and labeling each thought that arises with a single word (e.g.: work, child, paying bills, etc.), instead of letting oneself be carried away by them, can be an interesting technique.

Becoming familiar with the meditative state helps, initially during the therapeutic interaction, to notice oneself trying not to stutter and to explore what states of tension and release in the body and in articulatory gestures and what thoughts and feelings are present. Becoming aware of the mental and bodily aspects that are part of the sensation of imminent stuttering, places the person who has "suffering stutter" in a new condition regarding themselves and their speech, by opening the possibility of a comprehensive and regulated look at what is actually happening to them.

As Maté says (pp. 330-331), "when we heal, we are busy rescuing the lost parts of our self, not trying to change or improve them […] healing means becoming whole" and reestablishing the feeling of security in oneself, in relationships with others and with life by freeing oneself from automatic programming, in order to be able to reconnect with what is essential within oneself. Maté also says that

> [...] when we are able to look back at a traumatic memory from a place of empowerment, the

> memory is updated as if this action had been available and functional at the time of the original trauma. This newly consolidated experience then becomes the new updated memory where the somatic experience of the present (empowered) profoundly alters the past memory. They are like emerging resources that become the bridge between the past and the future – the remembered/reunified present. (MATÉ, 2023, p.160-161)

In short, when one recovers the spontaneity of being who one is and speaking freely, fluency is a consequence of the process; it is never the target.

Fifty years have passed since my initial therapeutic work which was based on traditional oral motor techniques in Speech Therapy to control stuttering**,** up until the deep understanding of stuttering as a suffering, a fixed, adaptive and dysfunctional traumatic response that leads to a disconnection with the spontaneity of speech and the impossibility of a secure bond in communication situations with others.

To this extent, the therapeutic work with oral motor techniques to avoid stuttering, widely used in the health field, which is based on a disconnected vision between the mind and the body, between the speaker and speech, can be a representative approach to the 'myth of normal'.

Some considerations about therapeutic work with children

The therapeutic proposal outlined so far presupposes a meeting with a person who himself or herself brings a complaint of stuttering to the therapist. However, the complaint is often brought by concerned parents who report that their child, often at 2.5 or 3 years of age, was fluent in speech and suddenly became stuttering.

The approach in this case, after accepting the parents' request for help, can continue with clarifications regarding the process of language acquisition, in order to understand how stuttering is constituted as a suffering, based on what has been outlined so far.

In addition to these clarifications, it is important to accompany the parents in situations of interaction with the child, to help them understand, in the concreteness of the speech, how the child is moving in the use of language, searching, playing and discovering its rules, in such a way that the relationship between the parents and the child becomes one of reciprocity and security.

In this way, therapeutic work can shift from disfluencies to the parents' beliefs and values that support these reactions of denying meaning to disfluent speech, in order to help them

↻ summary

overcome this reaction and begin to respond to the content of the child's speech. As in the bicycle example above, the child will need a secure connection, attentive listening, and a smile from the caregiver to feel confident in his or her speech again.

This work is also essential when "suffered stuttering" is already active in a child's subjectivity. A change in the way parents view their stuttering is essential for the child to be able to overcome the suffering in his or her speech.

In this case, work with the parents continues alongside work with the child who, in a playful way, is led to

- learn all the gestures of speech;
- recognize his or her competence in producing them;
- realize that speech production is automatic;
- explore all the possibilities of stuttering when speaking;
- observe that stuttering occurs naturally in the speech of parents, siblings, friends, teachers, and people in general;
- that there are people who naturally stutter more than others;
- that stuttering depends on the situation;
- speaking with random sounds, but with intonation as if it were an unknown language;
- speaking with different voices;
- speaking with different accents;

↻ summary

- dubbing and being dubbed;
- s peaking without a voice;
- playing at stuttering on purpose with the therapist and with other people.

In addition, it is beneficial for the child to have the freedom to follow the conversation between the therapist and their parents, when the latter hear that stuttering is natural and there is no reason to worry when it happens.

In short, anything that can help the child feel safe and free to be and speak in its own way.

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