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# 1 Psychogenic Voice Disorders – A New Model

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Speech and language therapists face challenges both in recognising when their patient has a psychogenic voice disorder and in knowing how to manage the case effectively. To get to this point it is necessary to understand what is meant by psychogenic voice disorder, to be informed about common aetiological features of this group of patients and to know how to make a competent assessment. At this stage it is necessary to have a clear idea, from evidence-based practice, as to how this population might respond to therapy and what treatment strategies are likely to be of value.

Despite agreeing that this small group of patients exists, the literature has to date been confusing about both terminology and classification and there are a limited number of reports of evidence-based treatment protocols. There is nervousness amongst speech and language therapists around both confident diagnosis and subsequent management.

In this chapter we set out a working model of psychogenic voice disorders (PVDs) as a guide to the clinician working in this area. We provide the speech and language therapist (SLT) with a framework for recognising and classifying this patient group. In subsequent chapters we will offer guidance to the speech and language therapist in assessing and managing these voice disorders within a psychological framework that incorporates clinical supervision. We also provide an explanation for when, in some complex cases, psychological referral is indicated.

## A DEFINITION OF PSYCHOGENIC VOICE DISORDER

Drawing from previous definitions and classification systems, it is our view that a **psychogenic voice disorder** is a dysphonia (impaired or disordered voice) or aphonia (absent voice) where the causative or perpetuating factors are largely of psychological or emotional conflict. The voice problem may manifest itself with musculoskeletal tension and hyperkinetic behaviours and these may eventually give rise to laryngeal pathology, these being products or symptoms of the underlying psychological cause and the process of conversion.

What is critical here is that a confident diagnosis is reached only through careful psychological evaluation. A diagnosis of psychogenic voice disorder must not be made simply by *exclusion* of laryngeal pathology, in the way that the terms functional or non-organic might be employed. It is, of course, essential to have clarified the nature of any organic pathology through detailed laryngoscopic and preferably stroboscopic examination, however, the presence of negative results does not by default imply

psychogenic causes. Assessment must be *inclusive* of psychological factors to a critical level and have clarified the causative and perpetuating role of these factors before diagnosis can be confirmed. The psychological evaluation will be outlined in Chapter 4.

Since musculoskeletal tension is a feature common to these voice disorders, we have said before that, ‘the decision as to whether a voice disorder might be termed hyperkinetic or hyperfunctional rather than psychogenic is more a question of the degree to which underlying emotional stresses contribute to the dysphonia and of the degree of influence that those stresses have in perpetuating patterns of excessive laryngeal tension’ (Butcher et al. 1993, p. 4).

### PHYSIOLOGICAL AND PERCEPTUAL FEATURES OF PSYCHOGENIC VOICE DISORDERS

Although there is overlap in the presenting phonatory and laryngeal signs and symptoms between muscle tension dysphonias and psychogenic dysphonias, there are often some features that are specific to a psychogenic dysphonia and are therefore helpful to the diagnosis. The phonatory and laryngeal signs and symptoms of a psychogenic aponia are more diagnostically conclusive, and there are few types of voice disorder that present so dramatically.

Tables 1.1 and 1.2 illustrate the common presentations of psychogenic voice disorders and further helpful description can be found in Mathieson’s text (2001, pp. 197–201).

**Table 1.1:** Physiological and perceptual features of psychogenic dysphonia

#### **Phonatory Signs and Symptoms**

- Perceptual features *may be* similar to muscle tension dysphonia.
- It may be inconsistent with clinical examination i.e. significantly abnormal voice despite absence of laryngeal pathology or only mild pathology.
- Variable voice, which may be normal during laughing/crying yet abnormal in conversation, and may be worse according to emotional context of speech.
- Dysphonia may be episodic.
- SLT may facilitate immediate normal voice.

#### **Physiological Presentation, may be various, for example:**

- ‘normal’ larynx i.e. no laryngeal pathology or neuropathology
- normal laryngeal function on a cough, laugh, breath hold
- incomplete vocal fold adduction or a glottic chink
- bowing of vocal folds
- hyperadduction of vocal folds
- supraglottic constriction i.e. ventricular band involvement and anterior-posterior squeezing
- laryngeal pathology (e.g. nodules)

#### **Vocal Profile**

May be forced, breathy, weak, with harshness or creak. May be in falsetto and may have pitch and phonation breaks. May have variable dysphonia interspersed with normal voice.

**Table 1.2:** Physiological and perceptual features of psychogenic aphonia

<p><b>Phonatory Signs and Symptoms</b></p> <ul style="list-style-type: none"> <li>● loss of voice of sudden onset</li> <li>● may have had frequent and increasing aphonic episodes; may have had immediate aphonia</li> <li>● may have occasional squeaks of voice</li> <li>● usually normal vegetative behaviours</li> <li>● SLT may facilitate immediate normal voice</li> </ul> <p><b>Physiological Presentation, may be various, for example:</b></p> <ul style="list-style-type: none"> <li>● incomplete vocal fold adduction</li> <li>● glottic chink</li> <li>● hyperadducted ventricular band</li> <li>● bowing of vocal folds</li> <li>● normal adduction for cough</li> </ul> <p><b>Vocal Profile</b></p> <ul style="list-style-type: none"> <li>● whisper</li> <li>● sometimes only mouthing</li> <li>● usually a normal cough, grunt etc.</li> </ul>
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## COMMON AETIOLOGICAL FACTORS OF PSYCHOGENIC VOICE DISORDERS

Before presenting our model let us remind ourselves of other contributing evidence that has shaped our thinking. We can now draw on much research and literature that informs us about the aetiological features of these voice disorders. Psychogenic voice disorders are frequently multifactorial and have common factors, which we have summarised in Table 1.3. We will elaborate on these features when discussing assessment in Chapter 4. Appreciating the psychological aetiology of these voice disorders and being able to positively identify the aetiological features is critical in leading the speech and language therapist to a confident diagnosis and treatment of psychogenic voice disorder. Thus, a psychogenic voice disorder is confirmed provided that, first, a primary organic process has been carefully eliminated and second, that psychological aetiological features are identified alongside the phonatory and laryngeal presentations described above.

This assessment of the aetiological features is essential for the SLT because a diagnosis of psychogenic voice disorder implies that ‘for true resolution, predisposing, precipitating and perpetuating psycho-emotional or psychosocial issues will need to be explored and addressed’ (Baker 2002, pp. 84–5).

## LOW MOOD/DEPRESSION AS AN AETIOLOGICAL FEATURE

In addition to the features described in Table 1.3 we have found that patients with psychogenic voice disorders frequently present with lowered mood or mild–moderate

**Table 1.3:** Common aetiological features of psychogenic voice disorders

<b>Stressful life events and anxiety</b>	Usually either follow an event of acute stress or are associated with stressful events over a long period of time. Anxiety and physical tension is an extremely common symptom. (Butcher et al. 1987; House and Andrews 1988; Kinzl et al. 1988; Freidl et al. 1990; Aronson 1990a; Gerritsma 1991; Roy et al. 1997; Deary et al. 1997; Andersson and Schalen 1998; Baker 1998; Mathieson 2001)
<b>Common to females</b>	More predominantly a female condition; approximately 8:1 females to male. (Aronson et al. 1966; Brodnitz 1969; House and Andrews 1987; Greene and Mathieson 1989; Gerritsma 1991; White et al. 1997; Millar et al. 1999)
<b>Family and interpersonal difficulties</b>	Frequently embroiled in family and interpersonal conflicts and experience difficulties with communication in these relationships. (Butcher et al. 1987; Andersson and Schalen 1998)
<b>Difficulty expressing views and emotions</b>	Person has considerable difficulties with assertiveness and the expression of inner feelings in specific situations. 'Conflict over speaking out' is a common feature. (Butcher et al. 1987; House and Andrews 1988; Kinzl et al. 1988; Freidl et al. 1990; Gerritsma 1991; Austin 1997; Andersson and Schalen 1998)
<b>Suppressing anger and frustration</b>	Being unable to express anger and frustration is the main inner conflict. Person is usually aware of a conflict but is coping by suppressing emotions and therefore not verbalising the anger. (Aronson et al. 1966; Butcher et al. 1987; House and Andrews 1988; Aronson 1990a)
<b>Burden of responsibility</b>	Taking on or trying to cope with above-average personal responsibilities. (Butcher et al. 1987)
<b>Over-commitment and helplessness</b>	Along with a tendency to be over-committed with responsibilities and in their family and social networks, they feel powerless about making personal change or changing the current situation. (Butcher et al. 1987; House and Andrews 1988; Andersson and Schalen 1998)
<b>Near normal psychological adjustment</b>	Not usually individuals who have a serious psychological disturbance. Not more than about 5% with a 'hysterical conversion' disorder. However, may be vulnerable to anxiety symptoms and have a tendency to somatise. (Aronson et al. 1966; House and Andrews 1987; Butcher et al. 1987; Aronson 1990; Gerritsma 1991; White et al. 1997; Millar et al. 1999)

depression. Common signs and symptoms are tearfulness, reported low mood, pre-occupation with negative thoughts and feelings of helplessness and hopelessness.

Many authors note depression accompanying psychogenic voice disorders, for example pioneering studies by Guze and Brown (1962) and Aronson et al. (1966) showed their population to have a high degree of neurotic anxiety or depression. House and Andrews (1987) found only a small percentage, 16%, of their dysphonic population to be depressed, whereas a smaller study by Kinzlet al. (1988) found almost 50% to have a depressive neurasthenic syndrome. More recently Deary et al. (1997) found dysphonic women to have more anxiety and depression than either healthy or general practice controls. In 1999 Millar et al. found dysphonic women scored higher than controls on the depression subscales of the HADS (Hospital Anxiety and Depression Scale). Mathieson (2001) also describes depression associated with psychogenic disorder.

We have not included low mood or depression as a direct aetiological feature of psychogenic voice disorders because it can not be clearly determined whether the depression contributed to the voice disorder or whether it followed. In many cases we would suggest that the low mood or depression is secondary to the voice disorder. The person feels low because inner conflicts have not been resolved, and because the voice disorder frequently has a handicapping effect by preventing the person from performing normally, often having a negative impact on work and reducing social integration. In many circumstances they are grieving over the loss of normal voice function and are experiencing feelings of helplessness – features commonly associated with depression. However, given that many have been experiencing interpersonal difficulties and have difficulty expressing feelings, it would not be surprising if their lowered mood emerged in this context and became evident prior to voice loss. If this is the case, voice loss then becomes yet another thing to be depressed about.

Severe clinical depression is rarely seen in this population and we discuss this separately in Chapter 9.

#### UPPER RESPIRATORY TRACT INFECTION AS AN AETIOLOGICAL FEATURE

Despite the fact that psychogenic voice disorders are typically characterised by normal laryngoscopic findings, clinicians will be familiar with case histories that relate colds and upper respiratory tract infections to the time of onset of the voice disorder.

There is a view expressed by some authors, for example Kinzlet al. (1988), that where a psychodynamic conflict already exists it is likely to be somatised at the site of least physical resistance. If a patient becomes overtaxed by a chronic stress situation, physical symptoms may develop at a site already weakened by infection. Furthermore, these authors also note that infections often occur or become worse during stress situations and that psychological factors have an influence on immunocompetence.

Other authors, for example Andersson and Schalen (1998), believe that the upper respiratory tract infection (URTI) only acts as a precipitating factor to the voice

disorder, by provoking defensive laryngeal mechanisms. However, it seems that all authors are agreed that there is no direct causal link between the upper respiratory tract infection and the psychogenic voice disorder.

## A NEW CLASSIFICATION SYSTEM FOR PSYCHOGENIC VOICE DISORDERS

We now present our model of classification for psychogenic voice disorders, summarised in Table 1.4. What now follows is the theoretical framework that underpins this model.

While our classification for psychogenic voice disorders has drawn on Freud's concept of conversion (the view that a psychological conflict is converted into a physical symptom), it has been reformulated to take into account the common aetiological features found in this population. The research supporting these findings and our own clinical impressions is the result of our work as clinical psychologist and speech and language therapists for over 20 years. Our classification has some common ground with previous classification systems, and, for example, it is sympathetic to Aronson's view (1990a) that these patients manifest psychologic disequilibrium, that the laryngeal muscles hypercontract in response to emotional stress and that the personality or emotional factors are the driving force of the problem. Our view that diagnosis depends upon an assessment that is inclusive of positive psychological factors to a critical level is also the position taken by Morrison and Rammage (1993) in their classification. Aronson expresses a similar position: 'A psychogenic voice disorder is broadly synonymous with a functional one but has the advantage of stating positively, based on an exploration of its causes, that the voice disorder is a manifestation of one or more types of psychologic disequilibrium, such as anxiety, depression, conversion reaction or personality disorder, that interfere with normal volitional control over phonation' (1990a, p. 121).

### HYSTERICAL CONVERSION

Applying Freud's hysterical conversion label to psychogenic voice disorders is not straightforward. First of all, while his concept of conversion is valuable and should be retained, we take the view that Freud placed too much emphasis on the way the conversion resulted from unconscious sexual or aggressive conflicts, the way these conflicts are controlled by repression, and the way the conversion or behavioural response is reinforced socially by secondary gains. Second, taken as a whole, studies in the field of voice tell us that at maximum less than half the psychogenic population have

**Table 1.4:** The model

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| <ul style="list-style-type: none"> <li>• Type 1: Classical Hysterical Conversion</li> <li>• Type 2: Cognitive-Behavioural Conversion</li> <li>• Type 3: Psychogenic-Habituated</li> </ul> |
|---|

features that fit Freud's diagnostic criteria for hysterical conversion and it may be as few as 4–5% (Aronson et al. 1966; Butcher et al. 1987; House and Andrews 1987; Gerritsma 1991). This evidence makes the term hysterical conversion an inappropriate classification for all psychogenic voice disorders. Thus, although the use of the rather outdated term **hysterical conversion** – or as we prefer **classical conversion** – does seem to have a place in the context of voice, the term is not interchangeable with psychogenic as a classification and appears useful for only a minority of patients. If used specifically the term hysterical conversion should be reserved for use when the psychological processes or diagnostic criteria of a traditional Freudian conversion disorder are present. This diagnostic difficulty has led us to propose a new application of the term conversion in the context of psychogenic voice disorders.

## INTRODUCING TWO TYPES OF CONVERSION VOICE DISORDERS

The classification that we put forward is for clinicians to look more closely at the psychological processes that have contributed to the patient's voice disorder and to consider two distinct types of conversion (Butcher 1995).

Our opinion is that conversion disorders need not imply the full-blown Freudian hysterical conversion psychological processes. This model is supported by the current psychiatric criteria for conversion disorder in the Diagnostic and Statistics Manual (DSM-IV-TR), (American Psychiatric Association 2000). The DSM-IV criteria requires the initiation or exacerbation of the symptom to be preceded by psychological conflicts or other stressors. However, the DSM criteria no longer require the symptoms to represent a symbolic resolution of an unconscious psychological conflict, reducing anxiety and serving to keep the conflict out of awareness ('primary gain'). Neither do the criteria require the individual to derive benefit or secondary gain, and the feature of *la belle indifférence* is not an essential requirement. Thus, modern thinking is that the term **conversion disorder** is used to represent a wide category and that a hysterical conversion is considered as one manifestation or sub-category of conversion disorder. Furthermore, in terms of Freud's initial model of conversion disorder having its origin in the repression of unacceptable sexual or aggressive impulses, it should be mentioned that these days most contemporary psychoanalysts would also acknowledge that the repression of *any* unacceptable anxiety feeling or thought can lead to a conversion disorder. This is reflected in the current DSM's wider interpretation of conversion.

### Conversion Disorder – DSM-IV-TR Definition

The current diagnostic criteria for conversion disorder (DSM-IV) includes the following factors:

- The essential feature is the presence of symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition.
- Conflicts or other stressors precede the symptom or deficit.

- The symptom or deficit is not intentionally produced or feigned and, after appropriate investigation, it cannot be fully explained by a general medical condition.
- Furthermore, the symptom or deficit causes clinically significant distress or impairment in social, occupational or other important areas of functioning.

Thus, we can draw on the studies of psychogenic voice disorders and the current psychiatric diagnostic criteria, both outlined above, to distinguish between two types of conversion. The distinction of the two types of conversion is introduced below.

#### TYPE 1: CLASSICAL HYSTERICAL CONVERSION

- It fulfils the DSM criteria for a conversion of psychological stress into a physical symptom.
- Symptoms like *la belle indifférence* or difficulty in consciously accessing unacceptable feelings suggest the *repression* of emotional conflicts.
- The primary gain is that repression removes the unpleasant conflict or feelings from consciousness.
- Some secondary gain from others, such as increased attention and concern, is likely to exist and acts as another powerful reinforcer of the conversion reaction.

#### TYPE 2: COGNITIVE BEHAVIOURAL CONVERSION

- It fulfils the DSM criteria for a conversion of psychological stress into a physical symptom.
- Conversion of psychological stress into a physical symptom is the apparent result of trying to *suppress* anxiety associated with emotional conflicts.
- The primary gain is avoidance of the feared consequences of acting on feelings.
- There are likely to be few compensatory secondary gains.

The two types of patients in this model experience a conversion of a psychological conflict into a physical symptom, but the nature of the inner conflict is different in each type and furthermore the person's coping mechanism will be different for each type, as we shall see in Table 1.5.

The model can be applied equally well to aphonics and to dysphonics. The determining factor as to which type a patient falls within, depends on a careful assessment that fully appreciates the psychological history and the presenting signs and symptoms. As described above, we have labelled these two groups of conversion voice disorders as Type 1 and Type 2. Type 1 represents what appears to be the minority of patients who fit a traditional Freudian hysterical conversion classification. The remainder and larger group of patients, 95%, fall into Type 2, who also experience a conversion of anxiety into physical symptoms, i.e. the voice disorder, but this conversion process is of a different order than that described by Freud. The distinction of the psychological processes at work in each group is described more fully in Table 1.5.



**Table 1.5:** Psychogenic conversion voice disorders – distinguishing features of the two main types

<b>Type 1 Classical hysterical conversion</b> (Traditional Freudian model. Rare, approx 5%)	<b>Type 2 Cognitive behavioural conversion</b> (Psychosocial/cognitive-behavioural model. Common, approx 95%)
1. Individual predisposed to problems by personality type, life experiences, traumas, social taboos around <i>expressing aggression/sexuality</i> and does not cope well with the presence of unacceptable or threatening emotions.	1. Individual predisposed to problems by personality type, life experiences, traumas, social taboos around <i>assertiveness</i> and the <i>expression of feelings</i> , which lead to lowered self-expression, self-esteem and feelings of powerlessness.
2. Exposure to negative life events or conflicts surrounding verbal expression of sexuality or aggression.	2. Exposure to negative life events or conflicts surrounding verbal expression of feelings.
3. Personality: uses <i>repression</i> and denial as coping mechanisms.	3. Personality: uses <i>suppression</i> or more conscious inhibition as a coping mechanism.
4. Repression eliminates awareness of the conflict and awareness of anxiety. This makes treatment more difficult because the cause is not accessible to the patient and therapist.	4. Suppression does not resolve conflicts, so the person continues to experience conflicts and the anxiety they cause. However, because they are near the surface the conflicts are easily accessible to patient and therapist.
5. The unconscious conflict is converted into physical symptoms, which outwardly symbolise the nature of the conflict.	5. The anxiety and inhibition becomes channelled or converted into musculoskeletal tension, much of which is focused on the site or battleground of the conflict, i.e. verbal expression.
6. The condition provides primary gains (avoidance of inner conflict, the experience of anxiety and the consequences of acting on the sexual or aggressive impulse) as well as secondary gains or reinforcements, which help maintain the condition.	6. Some primary gains (the person avoids the feared consequences of expressing feelings, but they cannot fully avoid the anxiety except to gain some relief through actively or consciously suppressing the conflict). The conversion of the conflict into a physical disorder causes additional anxieties and any secondary gains rarely provide significant compensation.
7. Low motivation to change because the primary and secondary gains provide sufficient reinforcement to maintain the status quo.	7. High motivation to change because suppression, inhibition and conversion have not resolved either the conflict or the anxiety or provide significant secondary gains.

## DEFINING THE MODEL

### TYPE 1 CONVERSION (CLASSICAL HYSTERICAL CONVERSION)

With regard to psychogenic voice disorder, our view is that the traditional interpretation of conversion disorder may be valid in cases where there is evidence of more severe psychopathology in a combination of persistent or protracted aphonia, the patient's passive acceptance of the condition, poor compliance with treatment, bland denial of distress or *la belle indifférence*, and indications that the condition provides important primary and secondary gains. This we classify above as Type 1. Although this rarer type presents usually as aphonia, we have seen this occasionally in patients with psychogenic dysphonia, typically with a tense, strained, falsetto voice. Other voice clinicians describe this Type 1 category. Mathieson (2001, pp. 199 and 205) acknowledges that only a small number of aphonics develop a true conversion symptom aphonia and fewer still will present with a true conversion symptom dysphonia. When Aronson describes conversion voice disorders (Aronson, 1990a, pp. 129–134), resulting in both aphonia and dysphonia, he too refers to the classical Freudian conversion disorder. In their classification system Morrison and Rammage (1993) describe briefly conversion aphonia and dysphonia that would probably fit the true Type 1 category.

Importantly, a Type 1 (classical Freudian hysterical conversion disorder) is extremely resistant to therapy because, unfortunately, the combination of repression and denial with primary and secondary gains makes the condition difficult to treat. Psychoanalysis was developed specifically as a treatment which would – through free association, the therapeutic transference and deepening insight – help the patient resolve the unconscious conflict at the heart of their problem, yet even analysts acknowledge that this population has a poor prognosis. It is fortunate that this is a rare complaint.

Joan a 53-year-old married mother of three grown up children presented with a 4-year history of dysphonia and episodic aphonia. ENT investigations had revealed a normal larynx with no pathology. The onset of this voice disorder followed shortly after an urgently arranged operation to remove a lump on her tongue. Despite the real possibility of the lump being cancer, she could not recall being afraid or concerned for her wellbeing at this time.

Similarly, despite having moderately high scores for anxiety and depression as determined on the Hospital Anxiety and Depression Scale, Joan also denied any current awareness of anxiety or emotional stress. Furthermore, despite some evidence to the contrary, she denied experiencing any conflicts over speaking out or difficulties in expressing her feelings or experiencing any burden of responsibility. Thus, the psychological assessment confirmed Joan's use of **repression** or **denial** as a mechanism of defence for coping with emotional conflicts and anxiety typical of a Type 1 (classical hysterical) conversion. This tendency to use repression

and therefore her lack of insight into her thoughts and feelings made it difficult to offer Joan treatment.

*For full case details see Chapter 10, pages 178–80.*

A case study by Baker (1998) illustrates the complexities of treating a true Type 1 conversion dysphonia.

## TYPE 2 COGNITIVE BEHAVIOURAL CONVERSION

By contrast, the majority of patients with psychogenic voice loss appear to be suffering from symptoms of musculoskeletal tension and anxiety caused by life stress and interpersonal conflicts that frequently involve difficulty expressing feelings. Although their distress is converted into a physical loss or impairment of voice, and while inhibited or suppressed anger may play an important role, these patients fit more comfortably within the modern classification of conversion disorder rather than the classical Freudian interpretation. Aronson (1990a) describes these psychogenic voice disorders within a broad category of musculoskeletal tension voice disorders and Mathieson (2001) classifies them as stress-related dysphonia or aphonia. We propose calling this group a Type 2 cognitive behavioural conversion voice disorder; they form the great majority of the psychogenic voice disorders found in speech and language therapists' caseloads. We have chosen to label this type as 'cognitive behavioural' since popular use of the term 'psychosomatic' has negative associations and other more descriptive terms such as 'psycho-social-biological' are too unwieldy. The label cognitive behavioural does imply the interplay between psychological process and the physical/behavioural responses, although it may not adequately highlight the social and biological features. The Type 2 patient may include both the psychogenic dysphonic and aphonic and probably explains why the majority of aphonics do return to normal voice relatively quickly with an experienced voice therapist. Mathieson describes this type of psychogenic aphonic (2001, pp. 199–200) as being tense, anxious and distressed by their aphonia, near to tears, overburdened, and with a history of stressful life events. Both Aronson (1990a) and Mathieson (2001) report a good prognosis for patients who can develop insight into the psychosomatic basis of the aphonia. These views closely reflect our own experience with this population.

Although some authors take the view (Aronson et al. 1966) that the secondary gain of the voice disorder provides attention from others in the majority of patients and while Freud's model emphasises that secondary gain is a feature of Type 1, we have found the secondary gain is usually quite negligible or non-existent for Type 2.

In contrast to the poor prognosis afforded to the Type 1 classical Freudian conversion patient, there are grounds to be optimistic about treating the more common forms of conversion disorder causing aphonia or dysphonia. Psychodynamic treatment might benefit this group (Type 2) by helping the individual understand the suppressed emotional impact of early traumas that have predisposed them to inner conflicts,

causing such things as low self-esteem, feelings of powerlessness and difficulties with assertiveness. Alternatively, therapists treating this group might employ cognitive behaviour therapy (CBT). This approach would commonly emphasise the role of unconscious schemas (core constructs about the self, world and other people), the way dysfunctional cognitions (rules for living, underlying assumptions, automatic thoughts) shape emotions and behaviour, and would focus on practical strategies like stress management and role-playing techniques to help the person control anxiety, improve communication skills and be more assertive.

The case of Sue, a 42-year-old, who presented with a falsetto dysphonia of sudden onset, illustrates a Type 2 (psychogenic cognitive behavioural) dysphonia that resolved quickly through a combination of CBT assessment/treatment techniques and symptomatic voice therapy.

Initially Sue attributed her voice loss to laryngitis, although she did not identify any URTI. However, through a careful psychosocial interview she identified significant emotional stresses and conflicts throughout the preceding year and immediately preceding the dysphonia. Sue had experienced a traumatic year during which her husband had an affair and left her. She had experienced high anxiety levels and had attempted suicide. She explained that her husband continued to dominate her and regularly let himself into the house. She wanted to move on but she was financially bound to him and she felt powerless with him. Sue felt angry towards her husband, because of his betrayal, his dominance and because of the prospect of losing her home. In the weeks preceding her dysphonia she had become increasingly unhappy at work and in particular with her boss. She knew that he too was having an affair and that she had transferred a lot of the anger she felt towards her husband onto her boss, causing difficulties in the work place.

Understanding the link between emotional stress and voice loss enabled Sue to quickly understand the causal features of her dysphonia and to develop self-insight. This insight allowed Sue to move forward, to set herself targets to behave more assertively with her husband and to make positive plans for her future. Symptomatic voice therapy helped to re-establish modal voice; however, the quick resolution was attributed primarily to Sue's insight and understanding and her ability to think and behave differently as a consequence.

*For full case details see Chapter 10, pages 191–4.*

Considering psychogenic aphonia within this model of Type 1 and Type 2 may help throw more light on observations recorded in earlier voice studies. For example, in 1969 Brodnitz described a large study of 74 aphonics. Of the 53 patients who entered therapy, all but 2 recovered normal voices, 44 doing so during the first therapy session; the remainder requiring an average of 4–6 sessions to restore normal voice. Seventeen of the patients went on to receive psychotherapy to help with severe

emotional conflicts. One case was resolved finally through hypnosis and only one case was intractable despite voice therapy and psychotherapy. We would postulate that a closer examination of the psychological profile of these 53 patients might reveal a majority who would fulfil our Type 2 criteria with a minority, perhaps only the two, fulfilling the classical Freudian Type 1.

The distinction between Type 1 and Type 2 certainly helps to explain why in the majority of cases a confident speech and language therapist will be able to guide an aphonic to a quick return to normal voice, frequently within the initial session, while there is a minority of cases where this is not possible and despite exhausting the clinician's repertoire of behavioural tricks and counselling skills the aphonia remains intractable. Although some of these more complex aphonics will fall within a Type 2 conversion and will probably resolve with the help of skilled psychological support, it is within this hard-to-treat group that there will be a rarer Type 1 conversion disorder. We will offer an approach to managing the return of voice for Type 2 aphonic in Chapter 5 (pages 90–7).

With our knowledge of the aetiological features of psychogenic voice disorders described earlier, we can now individually attribute these to the Type 1 or the Type 2 conversion group. The distinguishing aetiological features of each group are detailed in Table 1.6.

## DISTINGUISHING FEATURES OF TYPE 1 AND TYPE 2

To summarise from our classification system there are key distinguishing features between Type 1 and Type 2.

### PREDISPOSITION TO PSYCHOLOGICAL PROBLEMS/PERSONALITY TYPE

Both types of patient may have life experiences and traumas that make them vulnerable to problems. In particular Type 1 is likely to have experienced family or social taboos around the expression of aggression, sexuality or other unacceptable or taboo emotions while Type 2 will probably have encountered taboos around the expression of assertiveness, feelings or views. However, what really distinguishes the two groups is their personality and coping strategies. The Type 1 personality uses *repression* as a mechanism of defence and, eventually, turns a blind eye to stress. Type 2 on the other hand reacts emotionally to stress, tries unsuccessfully to *suppress* emotions and, as a result, tends to establish anxiety driven patterns of behaviour.

### **The Trigger/conflict**

In a typical case, according to Freud, the trigger for the Type 1 conversion will be around an exposure to a life event or conflict surrounding the verbal expression of sexuality or aggression. The conflict becomes the fear of acting on a sexual or aggressive urge. Because this is unconscious, we have no proof that this is going on

**Table 1.6:** Distinguishing aetiological features of conversion Type 1 and Type 2 psychogenic voice disorders

<b>Conversion Type 1 or 2</b>	<b>Aetiological Features</b>	
<b>1 and 2</b>	<b>Stress and anxiety</b>	Usually either follows an event of acute stress or is associated with stress over a long period of time. Anxiety and physical tension is an extremely common symptom.
<b>1 and 2</b>	<b>Common to females</b>	It is predominantly a female condition.
<b>1 and 2</b>	<b>Family and interpersonal difficulties</b>	Frequently embroiled in family and interpersonal difficulties.
<b>1 and 2</b>	<b>Difficulty expressing views and emotions</b>	The person has considerable difficulties with assertiveness and the expression of inner feelings in specific situations.
<b>1 = repressing 2 = suppressing</b>	<b>Repressing or suppressing uncomfortable emotions</b>	Expressing anger and frustration or finding it difficult to handle unacceptable emotions is the main inner conflict. Type 1: Unaware of conflict because repression has made it unconscious. Type 2: Aware of conflict but coping by suppressing emotions.
<b>2</b>	<b>Burden of responsibility</b>	Taking on, or trying to cope with above average personal responsibilities.
<b>2</b>	<b>Over-commitment and helplessness</b>	A tendency to be over-committed with responsibilities and in their social networks and feeling powerless about making personal change or changing the current situation.
<b>2</b>	<b>Near normal psychological adjustment</b>	Not usually individuals who have a serious psychological disturbance.

but can only assume something very conflicting is occurring for the person to be caught up in the act of repression. It must be stressed here – as an extension of Freud’s initial formulation – that modern day psychoanalysts believe that the conflict may involve unacceptable feelings other than sex and aggression. The case of Joan (see earlier case study, page 10 and Chapter 10, pages 178–80) is a good example. The evidence indicated that what she was repressing when the dysphonia began was not sexual or aggressive feelings. It was the unacceptable thought of very likely having cancer and possibly dying. Yalom (1980), for example, has made a strong case for viewing fear of death and meaninglessness as a cause of psychopathology (see also Butcher, 1984, for

a further discussion with case examples of the way fear of death or preoccupation with mortality can be a cause of clinically significant anxiety and symptoms of depression).

Typically, the trigger for the Type 2 conversion seems to be exposure to a life event or events that increase feelings of powerlessness or conflicts around the verbal expression of feelings which may include anger. The conflict is the difficulty in expressing feelings or the conflict over speaking out experienced by the person.

### **Coping Mechanism**

The coping mechanism for a person in Type 1 is an unconscious repression and denial of the conflict. The process of repression effectively eliminates the conflict and any awareness of anxiety, thus the person is satisfactorily free from distress and will often show little concern for their symptoms, or *la belle indifférence*. Conversely, the coping mechanism for a person in Type 2 is a more conscious suppression of the conflict. Suppression does not resolve or fully remove the conflict from consciousness so the person continues to experience the conflicts and the anxiety that they cause:

### **The Conversion**

In both Type 1 and Type 2 the conflict is converted into physical symptoms, the malfunctioning voice; in both groups the conversion itself does symbolise the type of conflict. In Type 1 the significance of the voice loss is that it prevents the person from either expressing sexually unacceptable feelings or speaking about other taboo subjects like death or meaninglessness or, more commonly, verbally expressing feelings of anger or outrage; it is therefore symbolic of these unconscious conflicts and governed by the operation of repression. In Type 1 and 2 the anxiety and inhibition resulting from the conflict is converted into musculoskeletal tension, mostly around the larynx. Thus the conversion is focused on the site or battleground of the conflict; however, in Type 2 it is usually symbolic of the difficulty in showing assertiveness or feelings of self-expression and is created by the action of suppression and the physical inhibition of voice.

### **Primary and Secondary Gains**

The conversion for Type 1 provides both primary and secondary gains that are reinforcing. The primary gains include the avoidance of the inner conflict, anxiety and the consequences of acting on the sexual or aggressive impulse. Secondary gains exist as a consequence of the voice disorder, for example, avoiding responsibilities or gaining the solicitous and caring behaviour of others.

There are some partial primary gains for Type 2, namely the person avoids the feared consequences of expressing true feelings. However, because the conflict is only inhibited or suppressed, the person continues to experience the anxiety. Furthermore, the voice disorder itself tends to cause additional anxiety and any secondary gains rarely provide significant compensation.

AND TYPE 3

To complete the picture we need to discuss patients with a non-organic dysphonia who do not entirely fit the Type 1 or 2 groups and we believe are in fact a subgroup of Type 2. We have outlined the distinguishing features of all three types in Table 1.7.

**Table 1.7:** Comparing the distinguishing features of the three PVD types

<b>Type 1 Classical (hysterical) Conversion</b>	<b>Type 2 Cognitive-behavioural Conversion</b>	<b>Type 3 Habituated Conversion</b>
(Traditional Freudian model. Rare, approx 5%)	(Psychosocial/cognitive-behavioural model. Common, approx 95%)	(Originating in Type 2 processes, which have largely resolved)
1. Individual predisposed to problems by personality type, life experiences, traumas, and social taboos around expressing aggression/sexuality.	1. Individual predisposed to problems by personality type, life experiences, traumas, social taboos around <i>assertiveness</i> and the <i>expression of feelings</i> , which lead to lowered self-expression, self-esteem and feelings of powerlessness.	1. Individual predisposed to problems by personality type, life experiences, traumas, social taboos around <i>assertiveness</i> and the <i>expression of feelings</i> , which lead to lowered self-expression, self-esteem and feelings of powerlessness.
2. Exposure to negative life events or conflicts surrounding verbal expression of sexuality or aggression.	2. Exposure to negative life events or conflicts surrounding verbal expression of feelings.	2. Exposure to negative life events or conflicts surrounding verbal expression of feelings.
3. Personality: uses <i>repression</i> and denial as coping mechanisms.	3. Personality: uses <i>suppression</i> or more conscious inhibition as a coping mechanism.	3. Personality: uses <i>suppression</i> or more conscious inhibition as a coping mechanism.
4. Repression eliminates awareness of the conflict and awareness of anxiety. This makes treatment more difficult because the cause is not accessible to the patient and therapist.	4. Suppression does not resolve conflicts, so the person continues to experience conflicts and the anxiety they cause. However, because they are 'near the surface' the conflicts are easily accessible to patient and therapist.	4. Suppression had not resolved conflicts but circumstances have changed. The conflicts have resolved or greatly diminished so that there is no longer any need for suppression. The original conflict has been minimised and may be forgotten.



<p>5. The unconscious conflict is converted into physical symptoms, which outwardly symbolise the nature of the conflict.</p>	<p>5. The anxiety and inhibition becomes channelled or converted into musculoskeletal tension, much of which is focused on the site or battleground of the conflict i.e. verbal expression.</p>	<p>5. The anxiety and inhibition was originally channelled or converted into musculoskeletal tension (MST) much of which was focused on the site or battleground of the conflict. Despite resolution of the conflict and anxiety the musculoskeletal tension (MST) becomes conditioned. Thus, the voice disorder is maintained out of habit.</p>
<p>6. The condition provides primary gains (avoidance of inner conflict, the experience of anxiety and the consequences of acting on the sexual or aggressive impulse) as well as secondary gains or reinforcements, which help maintain the condition.</p>	<p>6. Some primary gains (the person avoids the feared consequences of expressing feelings, but they cannot fully avoid the anxiety except to gain some relief through actively or consciously suppressing the conflict). The conversion of the conflicts into a physical disorder causes additional anxieties. Any secondary gains rarely provide significant compensation.</p>	<p>6. There is no longer any primary gain because the conflict has resolved. Any secondary gain is negligible in maintaining the problem.</p>
<p>7. Low motivation to change because the primary and secondary gains provide sufficient reinforcement to maintain the status quo.</p>	<p>7. High motivation to change because suppression, inhibition and conversion have not resolved either the conflict or the anxiety or provide significant secondary gains.</p>	<p>7. Psychological distress no longer driving high levels of motivation to get better. Motivation levels likely to be similar to larger population of muscle tension dysphonia (MTD) patients, including varying levels of distress over their voice loss.</p>

## TYPE 3: PSYCHOGENIC-HABITUATED VOICE DISORDER

These are the patients who started out with a psychogenic voice disorder but along the way the precipitating stressors or conflicts diminish or resolve yet the dysphonia or aphonia continues because of habituated behavioural patterns of voice use. These patients were not described in our earlier work but we believe they make up a small proportion of the 95% of patients with identified Type 2, cognitive behavioural conversion. Several authors describe these patients. Mathieson (2001) explains:

Depending on the duration of the problem when the patient attends for treatment, the voice reflects not only the current psychological status of the individual but also vocal habit. In some instances the precipitating stressful event or circumstances have passed and the patient is no longer unduly stressed or distressed, but the kinaesthetic model for normal phonation cannot be retrieved and so the problem persists.

(p.198)

The description by Brodnitz (1969), illustrates why aphonics in this group can be so successfully remediated. 'In many instances, particularly if the aphonia has persisted for a long time, the psychologic conflict that produced the aphonia may have lost its validity. The patient is quite ready to resume normal communication but he needs expert help to accomplish this' (p. 1249). This is why a firm authoritative approach by the speech therapist, guiding the patient through a sequence of graded behavioural tasks works well, with no need to become involved in an in-depth psychological interview.

This group of patients were certainly psychogenic in origin and would share the hyperkinetic muscle misuse patterns shared by all patients with psychogenic voice disorder. Despite the fact that the stressors have resolved or significantly diminished, the patient continues to have a voice disorder because it has become habituated into a pattern of muscle misuse.

A patient with dysphonia in this category would be Wendy, a 22-year-old who had a long-standing conflict expressing views to her mother. The voice disorder had its origin in an emotional conflict and the attempt to cope with the distress through suppression of the conflict (a Type 2 aetiology), the resulting anxiety causing increased musculoskeletal tension particularly of the laryngeal mechanism. This hyperkinetic voice pattern became strongly patterned over time. In Wendy's case her relationship with her mother considerably improved and the conflict resolved, yet the dysphonia persisted because it had become habituated. This was a voice disorder with a psychogenic cause, the psychogenic factors resolved but the behavioural features persisted as a result of habituation.

Recognising the presence of a psychogenic-habituated voice disorder also highlights the way in which both Types 1 and 2 are vulnerable to developing a faulty laryngeal muscle set through the practice of regularly misusing the voice.

## TAKING ACCOUNT OF MAJOR TRAUMA

Within the common aetiological features of PVD we have cited wide-ranging references linking the onset of the voice disorder to stressful life events. This precipitating feature may be due to events and stress of the recent past or be linked to stressful events that have endured for some time. We have shown in our definition of Type 1 and Type 2 conversion voice disorders that there is a psychological coping mechanism of either repression or suppression of the stressful conflict. We now need to consider a conversion reaction that has in its origins a variation both in the type of the original stressor and in the psychological coping mechanism.

There is a body of evidence amongst psychologists working with victims of major trauma, that some individuals use **dissociation** as a means of repressing the traumatic event and removing it from consciousness. In these cases the traumatic event caused psychological stress of such a profound nature that the individual becomes dissociated from the experience, in other words the patient cannot bring to mind details of what happened or may even have no conscious memory of the event. It is now widely accepted for example, that dissociation in children who have suffered sexual abuse is common and may play a role in helping them cope with major traumatic events. Because the trauma is dissociated from consciousness there is also a dissociation from voluntary control that may result in a conversion reaction affecting motor or sensory systems.

It was Pierre Janet (1920) who first developed the concept of dissociation in connection with trauma. Initially Freud fully supported the view that terrifying traumatic events causing profound psychological distress – for which the person was unprepared – resulted in dissociation and led to a conversion reaction. Freud used this theoretical framework to explain the conversion disorders experienced by soldiers in the First World War when they experienced conversion aphonia or blindness. Freud later moved from this stand to develop his model of conversion related to unacceptable sexual and aggressive impulses, which we have reviewed in our description of Type 1 PVDs.

However, Janet's model continues to be of value currently in cognitive behavioural models of post-traumatic stress disorder (PTSD). He recognised that when some people were placed in an unbearable and frightening traumatic situation which evoked 'vehement emotions' that could not be integrated into personal understanding or awareness, the experience can become 'dissociated' or split off from consciousness. It was Janet's view that where the memory traces of the trauma have remained unexpressed they would become fixed and it is only through the traumatic experience being brought back fully into consciousness and told as a personal narrative that the traumatic experience can become integrated into the self, thus allowing the patient to process and come to terms with the experience. This explanatory model and treatment concept closely parallels contemporary views in cognitive behaviour therapy on the nature and treatment of PTSD; specifically, the emphasis on processing memories of the trauma through exposure, reliving and a focus on emotional 'hot spots' (see, for example, Ehlers & Clarke 2000; Grey et al. 2002).

In a recent publication Baker (2003) has presented thought-provoking evidence that in rare instances a psychogenic voice disorder can be linked to a forgotten traumatic event that may have occurred months or years prior to the onset of the voice disorder. In these cases Baker illustrates that a trigger reawakens the trauma and that this coincides with the onset of the voice disorder. Significantly the qualitative nature of the traumatic experience is represented in the somatisation of the voice disorder. The conversion or physical symptoms coalesce at the site of the trauma – in these cases, the throat, voice and airways. Baker uses Pierre Janet's model of dissociation and conversion to make sense of the psychological processes at work in these cases.

Using case studies, Baker describes the scenario of two patients with psychogenic voice disorder whose voice or full psychological recovery did not resolve through either symptomatic voice therapy or from attempts to recall recent stressful events or from a conflict over speaking out (as might be expected with a Type 2 patient). One of the patients presented with a psychogenic aphonia superimposed on a left vocal fold paresis. This required careful differential diagnosis and close liaison and consultation with the otolaryngologist. Through skilful therapeutic guidance both patients were able eventually to recall traumatic memories that had previously remained unconscious and unexpressed. These traumatic events varied in the time elapsed, from four months to 38 years. As part of the traumatic experience there was a direct threat to the throat, be it a fear of choking to death or an inability to cry out for help.

In each case a more recent stressful experience, which had some similarity or association with the earlier traumatic experience, reawakened memories and emotions of the original trauma and precipitated the voice loss. The validity of this is discussed by current experts in the treatment of PTSD (van der Kolk, McFarlane and Weisarth 1996) who explain that traumatised patients seem 'to react to reminders of the trauma with responses that had been relevant to the original threat' (p. 52). However, the dissociated state continues to prevent memory of the trauma from surfacing from the subconscious to consciousness.

These cases described by Baker do not fit comfortably with either a Type 1 classical Freudian conversion or Type 2 cognitive behavioural classification. For example, although apparently repressing the trauma they did not demonstrate features of *la belle indifférence*; the repression was not related to fear of acting on a sexual or aggressive impulse, the conversion does not occur at the time of the initial trauma, and they were clearly motivated to resolve their voice problem.

What they do have in common with a Type 1 formulation, however, is that through the action of the unconscious process of repression and dissociation they have found a way of avoiding being conscious of an unacceptable experience and as a result, have been unable to either assimilate or accommodate the experience into their view of themselves, their world and the behaviour of others.

We have spent some time exploring this fascinating area because it may hold significant clues when patients with a psychogenic voice disorder do not make a full resolution, and where the patient does not fit with either the Type 1 Freudian conversion or with the Type 2 conversion and perhaps where the therapist suspects that 'the full

story has not been told' (Baker 2003, p. 311). Assuming that the therapist has been vigilant in confirming, through liaison and review with ENT, that a primary organic diagnosis is not the cause, it may be important to consider in these minority of cases whether the origins of the voice disorder might lie in traumatic events experienced some time in the past and about which the patient has no conscious memory. Since the voice disorder in these cases seems to be triggered by an experience associated with the original trauma, the therapist should consider returning to detailed questioning about events around onset, encouraging patients to return in their mind's eye to the day their voice became problematic, and asking for as much detail as possible in the hope of touching on the trigger event or happening.

## MUSCLE MISUSE VOICE DISORDER

This leaves the group of patients who clearly have developed a vocal abuse or misuse in the absence of significant psychological conflict or stress. This group will have its origin in the behavioural or functional use of the voice, such as in the case of professional voice users who are pushing their voice beyond healthy limits and without attention to good voice care.

We apply the term **muscle misuse voice disorder** within our classification system to refer solely to voice disorders that are associated with laryngeal muscle misuse and where there are no significant psychological factors in the origins of the voice disorder. Historically these might have been labelled 'functional' but we accept that this is an ambiguous label.

We would not deny that patients in this muscle misuse group may present with some degree of stress – perhaps having an inner pressure to perform well and be successful, perhaps having perfectionistic tendencies or the need to be in control coupled with performance anxiety or tension – but major psychological conflict and stress will not have been the primary aetiology or maintaining factor for this group. Of course, these patients will also experience their fair share of stressful life events; however, they will typically manage these stresses appropriately and not become overburdened by them, and they are likely to have good support networks from family or friends. In our experience it is true that these patients may demonstrate areas of over-commitment either in their work or in their social engagements, but this does not make a major contribution to negative emotional states. Our Type 2 conversion voice disorders, on the other hand, may present with very similar voices to this group and with similar hyperfunctional laryngeal patterns but they will have a positive psychological aetiology of more significant inner and interpersonal conflict. We acknowledge, however, that this is not always an easy distinction to make. It is often one of degree and it requires a sensitive psychosocial interview to arrive at a positive diagnosis.

The treatment for this group of patients will focus on behavioural voice therapy to unpick the faulty patterns of behaviour and re-establish good voice habits. There will be minimal attention to cognitive strategies required for this group.

## **Case studies demonstrating differences between a muscle misuse dysphonia and a Type 2 psychogenic cognitive behavioural dysphonia.**

### **MUSCLE MISUSE DYSPHONIA**

Jim was a 21-year-old presenting with swollen and oedematous vocal folds. He was determined to make a life as a singer and had begun to experience vocal strain when singing four months earlier when he had felt under the weather. Subsequently, he had noticed difficulties singing freely, a loss of his higher register and some hoarseness in his speaking voice. Jim presented with moderate harshness and increased laryngeal tension in his speaking voice, mildly raised loudness, a rapid rate of speech and a tendency to drive his voice on shallow breath support. He was extremely talkative and he was a heavy voice user. He sang in a rock/pop band as the only vocalist and also sang as a solo act. He was performing in up to four gigs a week in pub venues and was rehearsing twice a week. He described himself as a social animal and admitted to shouting with his mates. Jim had a slightly chaotic life style; he tended to stay up into the early hours of the morning, finding it hard to unwind after a gig. He was an occasional smoker of cigarettes and cannabis but drank little alcohol. Although Jim had quite recently parted from his long-term girlfriend, he was not distressed by this and viewed it as an opportunity to socialise more. He said that he found relaxation difficult and in the clinic he was a fidget. He threw himself enthusiastically into his voice therapy although his view was that a couple of sessions should fix his voice and he did not seem motivated for a full course of voice therapy.

The SLT classified Jim as having a muscle misuse dysphonia aggravated by some vocal abuse. Voice therapy was directed to two areas. First, to behavioural modifications around his voice use; namely reducing the number of gigs and rehearsals, pacing the gigs and changing the selection of some of the music, reducing his talking, eliminating shouting and slowing the rate of his speech. Second, to direct symptomatic voice therapy techniques, to establish centred breath, to free the body, to vocal deconstriction exercises and a free projected voice.

Jim attended three sessions of voice therapy. He made quick and successful modifications to his voice use and vocal behaviour in some areas but not in others, such as reducing his rate of speech. He reported improvements in his singing immediately; he no longer felt vocal strain or discomfort and was able to negotiate pitch changes in his music more easily. There continued to be features of harshness and slightly increased loudness in Jim's speaking voice but he felt further improvement was down to him practising. The therapist felt that a true resolution of the dysphonia was unlikely since Jim was not keen to commit to more voice therapy sessions. A laryngostroboscopic review in the voice clinic, three months after Jim's initial voice therapy assessment revealed a marked improvement with almost normal vocal folds.

## TYPE 2 PSYCHOGENIC COGNITIVE BEHAVIOURAL

Cathy was a 42-year-old singer who was referred to speech and language therapy with increasing vocal strain during her singing performances, hoarseness after singing and oedematous vocal folds. She sang professionally in clubs, mostly rock and pop styles, typically one or two gigs each weekend as a solo vocalist. When assessed, Cathy was not dysphonic in her speaking voice but in voice exercises she demonstrated vocal strain with a marked increase in laryngeal tension, moderate breathiness and raised pitch. She had neck and shoulder tension and her larynx was tight to palpate.

Cathy smoked 25 cigarettes a day and had an alcohol dependency problem. She had a history of depression and had occasional suicidal thoughts. She had been in psychotherapy for a number of years (although recently she had not found this useful as it was not giving her solutions, and she said she was only going along so as not to let the trainee psychotherapist down). She had recognised that her singing was a mixed blessing; on the one hand it was an emotional release and she used the lyrics to express herself, on the other, if she felt the audience was not listening to her it would reinforce her feelings of poor self-worth and would trigger a depressive reaction. She said that for every good gig she would have one bad one. Cathy tended to jump to errors of thinking if her audience did not give warm appreciation. She would conclude that they did not like her or her voice and as well as feeling depressed she would then develop some performance anxiety and fear during the week before the next gig. Cathy also felt unhappy in her marriage but said that she didn't know how to resolve this. She tended to share few of her thoughts and emotions with her husband but would fall in with his view of things despite having her own opinions. She preferred not to 'rock the boat' but, as a consequence, she felt lonely in her marriage. This behaviour suggested the feature of 'conflict over speaking out'.

The SLT classified this patient as a Type 2 psychogenic voice disorder. She had run into problems of vocal misuse in her singing with obvious increased laryngeal tension and her use of alcohol and cigarettes were obviously unhealthy for her larynx. Significantly though, she was an emotionally vulnerable lady and her poor vocal technique in her singing was inextricably linked to her thoughts and emotions and in particular to whether she was liked by her audience.

A course of voice therapy was planned with three areas of focus. First, some symptomatic behavioural work directed towards freeing her body and vocal tract, establishing centred breath, experiencing some free voice and making practical changes to her music and to her voice care. Alongside this, cognitive behavioural therapy techniques were directed at challenging her negative assumptions about her audiences and changing these to positive self-statements, anxiety management and training in rapid relaxation and a more positive approach to her time management prior to a gig so that she could prepare herself both physically and emotionally. Finally, Cathy was encouraged to explore her behaviour of holding things back from her husband and to see that her tendency of falling in with his views would

reinforce his belief that she was in agreement. Using some discussion of recent situations between them, the therapist was able to rehearse with Cathy ways that she could voice both her feelings and views and she began to reflect on the change that this would have on her husband's behaviour.

Cathy attended five sessions with the speech and language therapist. Progress was steady and sustained. She made sensible adjustments to her performances including changing the music and taking comfort breaks. She worked on her voice technique and incorporated a careful warm-up routine prior to singing. She practised changing her negative thinking about her audience to positive self-statements and became quite skilled in this technique. She began to enjoy her singing and look forward to her performances. She coped well with a less than generous audience and managed to use her positive thinking and was able to report afterwards that she sang well, despite the poor audience, and she did not feel low afterwards. By the time of her ENT review four months after her voice assessment, she was anticipating singing well and was finding her singing performance was much improved. She no longer had any anxiety about her voice and her vocal folds were normal on examination. Although she remained dissatisfied with her marriage, she recognised that she had a part to play in changing this. She opted to continue with psychotherapy which she said was becoming more useful.

## **THE TREATMENT OF CHOICE FOR PSYCHOGENIC VOICE DISORDERS**

Although there have been few studies that investigate the long-term effects of therapy and the relapse rates for patients with psychogenic voice disorder, it has been reported that 5–10% do not show improvements with speech therapy (Brodnitz 1969; Koufman and Blalock 1982). In a survey of speech therapists in the UK in 1988 (Elias et al. 1989) a high proportion of therapists estimated the relapse rates of their psychogenic patients to be between 25 and 50%. The same survey found no standard psychological techniques in use and identified that 70% of therapists would welcome more training in the treatment of voice disorders from a clinical psychologist or psychiatrist. There was a clear trend in this survey for those therapists with a longer experience of treating psychogenic voice disorders to estimate that more sessions would be needed. These same voice specialists were undertaking significantly more work with psychologists and psychiatrists than non-specialist therapists. A more recent study (Andersson and Schalen 1998) provides some evidence that combining voice therapy with psychological methods gives good long-term resolution in both effectively treating the voice disorder and the emotional stress. Andersson and Schalen point out that cognitive behaviour therapy alone is not usually effective for psychogenic voice disorders, but when combined with voice therapy, results are good in the majority of cases. There have been many papers and studies advocating that speech therapists either work with or be trained by psychologists in the treatment of psychogenic voice disorders,



for example: Hayward and Simmons 1982; Butcher and Elias 1983; Butcher et al. 1987; Aronson 1990b; Freeman 1991; Scott et al. 1997; Baker 1998. We are reminded by Baker's (2003) review of the literature that 'therapeutic approaches that seek to integrate re-instatement of the voice with an understanding of the sensitive relationship between the stressful events, relationship difficulties, and patterns of reticence in expressing negative emotions, generally lead to successful resolution of the psychogenic dysphonia' (p. 311).

In their review of the management of patients with functional dysphonia, Scott et al. (1997) advocate that clinical psychologists develop a training and consultative role for speech therapists, equipping them with additional psychological skills, leading to more effective treatment. They suggest that psychologists can make an important contribution as members of the voice clinic team. Although appreciating that psychologists can conduct psychological interviews, advise on treatment and perhaps offer cognitive behaviour therapy to this patient group, these authors suggest that they may have a greater role in training the speech and language therapists to treat these patients and to recognise when referral to mental health services is required. We would support this viewpoint.

#### THE TREATMENT OF CHOICE FOR TYPE 1 (CLASSICAL HYSTERICAL CONVERSION)

As we have said earlier, a Type 1 is unlikely to resolve. The speech and language therapist needs to be able to recognise these patients and to consult a psychiatrist or a clinical psychologist in order to plan an appropriate way of managing their care.

#### **Identifying The Type 1 Conversion**

There are features of the Type 1 personality and features of the conversion that may be quite transparent in the therapist's contact with the patient. These features provide helpful diagnostic signs for the speech and language therapist to be alert to a Type 1 patient. Typically this patient will be resistant to exploring a psychological cause for the voice disorder or to discussing emotional topics. The patient tends to 'want a fix' to the problem. Because of this low motivation for change (motivation would require an acknowledgement of the conflict) the patient does not take ownership of the voice problem and will put the responsibility for improving the voice onto the therapist. Consequently the patient may present as demanding and controlling. The patient's controlling behaviour is indicative of personality type and the repression of the inner conflict as a mechanism of defence. The patient may appear angry and frustrated but typically will not complain of anxiety and depression so commonly seen in the Type 2 cases. In some cases, despite being aphonic or having a significant dysphonia, patients can show a surprising lack of concern for the symptoms, i.e. *la belle indifférence*.

In turn the therapist may find little empathy for this patient who seems to be someone with whom it is quite difficult to relate and sympathise. Indeed, the therapist may feel angry and frustrated towards the patient who seems both resistant and ungrateful.

### THE TREATMENT OF CHOICE FOR TYPE 2 (COGNITIVE BEHAVIOURAL CONVERSION)

Having confidently diagnosed a psychogenic Type 2 dysphonia, the speech and language therapist needs to consider an appropriate therapeutic treatment approach. The decision to treat a Type 2 patient with traditional, symptomatic voice therapy techniques focusing on the body and voice and/or psychological methods, is largely determined by the weighting and complexity of predisposing and precipitating psychological factors within the history and their contribution to the maintenance of the voice disorder. However, as we cited earlier, we agree with Baker (2002) that a diagnosis of a psychogenic voice disorder implies ‘that for true resolution, predisposing, precipitating and perpetuating psycho-emotional or psychosocial issues will need to be explored and addressed’ (pp. 84–5). Perhaps the extent of the psychological therapeutic input versus the time given to symptomatic voice therapy will be influenced by the complexity of the predisposing, precipitating and perpetuating factors and of the insightfulness of the patient. We illustrate this in the case studies in Chapter 10.

Where a psychological approach is considered appropriate for the Type 2 group we would suggest cognitive behaviour therapy (CBT) as the treatment of choice since it is sympathetic to the Type 2 cognitive behavioural conversion features. Speech and language therapists also usually find this treatment modality is compatible with their own training background and enhances voice therapy. Collaboration in the workplace with a clinical psychologist skilled in CBT is an excellent way of accessing training. We have previously published examples of our work that illustrates both how using CBT with patients with a psychogenic dysphonia has led to improvements in both the inner conflict as well as the dysphonia in a group of patients who had been unresponsive to voice therapy alone, and have also illustrated how speech and language therapists can become more skilled and knowledgeable in psychological therapy through joint working with a clinical psychologist (Butcher et al. 1987; Butcher and Cavalli 1998).

### THE TREATMENT OF CHOICE FOR PATIENTS WITH TYPE 3 (PSYCHOGENIC-HABITUATED)

Since the significant and precipitating stressful event or conflict will have diminished or resolved for this group, yet the patients will have developed a habituated faulty vocal muscle set, they are likely to respond well to symptomatic voice therapy. This approach, for treating both aphonics and dysphonics is detailed in Chapter 5.

There may be some value in including a degree of psychological therapy for these patients as a preventative measure to avoid recurrence. We would suggest that cognitive behaviour therapy would offer a framework and strategies that would be sympathetic to the needs of these patients. This might involve providing an understanding of the precipitating factors, such as recognition of stressful life events and their interplay with emotional and physical responses, and some exploration of predisposing factors such as the patient’s rules for living and difficulty with

self-expression. Psychological therapy for these patients is likely to be brief and will aim to provide understanding and closure of the original voice disorder as well as reducing the likelihood of recurrence. The SLT is well placed to provide this therapy, alongside symptomatic voice therapy, with a level of clinical supervision for a novice in this work.

## THE TREATMENT OF CHOICE FOR PATIENTS WITH TRAUMA CONVERSION

The group that has its origin in an early or previous traumatic experience is more likely to respond to a combination of symptomatic voice therapy and psychological therapy. These patients will usually require input from someone experienced in psychotherapy and the course of treatment might well be extensive. However, if the therapist and patient can unearth and establish the link between the traumatic event and the PVD, a resolution is likely. These cases have not been widely reported or studied but the encouraging and thoughtful work from Baker (2003) provides helpful guidelines when thinking about and working with these patients. It highlights how important it is to consider not only whether there has been a trauma to the throat or voice or breathing in the near or distant past from which the person is now dissociated, but also to consider whether something has more recently reawakened the original trauma and triggered a conversion reaction in the form of PVD.

## CLINICAL SUPERVISION

In the following chapter we describe the framework of cognitive behaviour therapy. We anticipate that speech and language therapists will find that both the structure of CBT, as well as the essential counselling skills required, fit comfortably with the way that voice therapists work. Nevertheless, although behaviour modification principles/theory are taught to undergraduate speech and language therapists, CBT is not.

First of all, before embarking on CBT, we would recommend that the speech and language therapist had at least trained to have competencies in basic counselling skills. Indeed we would expect all speech and language therapists working in the field of voice to have these.

Second, once the speech and language therapist has chosen to use CBT and to employ the treatment strategies we would suggest that there are options of clinical supervision that the SLT should consider. In all cases we advocate that best practice requires the speech and language therapist to have regular supervision from a clinical psychologist or CBT specialist, wherein the therapist becomes familiar with the framework, the method of assessment and the various treatment strategies. As mentioned earlier, we have found that a model of co-working within therapy sessions is particularly beneficial in skilling the SLT. However, this is unlikely to be a model available to most therapists. We also recommend that the speech and language therapist have access to a clinical psychologist during the management of complex cases with CBT. This should preferably be through regular one-to-one or group

supervision sessions although once a degree of supervision and learning has occurred it could be maintained through telephone supervision.

## SUMMARY

- Psychogenic voice disorders are described as a dysphonia or aphonia where the causative or perpetuating factors are largely psychological or emotional conflict. The voice problem may manifest itself with musculoskeletal tension and hyperkinetic behaviours and these may eventually give rise to laryngeal pathology, these being products or symptoms of the underlying psychological cause.
- It is helpful to consider different categories of psychogenic voice disorder. Two main types of conversion voice disorder are discussed; Type 1, Freudian hysterical conversion disorder, which is rare (about 5%) and Type 2, a much more common conversion disorder (95%) that is closely linked to anxiety and where the locus of the precipitating conflict is closely associated with expression of feelings.
- The different types of conversion, Type 1 being *repression* and Type 2 being *suppression*, represent different coping mechanisms employed by the patient in the face of emotional conflict. Although each group of patients will have a predisposition to psychological problems as a result of life experiences and traumas, it is the personality type that will importantly influence their coping strategy and type of conversion.
- There is evidence that in some cases severe and persistent psychogenic dysphonia may eventually be traced back to a major traumatic stress experience associated with the voice or throat. In some cases of earlier traumatic experience the individual appears to cope with the experience through dissociation and the conversion reaction occurs either at the time of the original trauma or at a later date when an event briefly reawakens memories and emotions connected with the trauma. Because of the dissociated state, it is difficult for the patient and therapist to access and process the painful memories of the trauma, thus making therapy difficult.
- Furthermore, SLTs should recognise a Type 3 Psychogenic-Habituated voice disorder. Originally the person acquires an aphonia or dysphonia as a result of a psychogenic Type 2 aetiology, but in these cases the precipitating stressors or conflicts have diminished yet the person has developed a faulty vocal muscle set that has become habituated, thus prolonging the voice disorder. These patients respond primarily to a symptomatic voice therapy approach, although there may be some merit in providing brief psychological therapy in order to help the patient to understand the original conversion voice disorder and to prevent a recurrence.
- These three types of psychogenic voice disorders are distinct from a muscle misuse voice disorder that develops in the absence of significant psychological conflict or stress.

- To diagnose a psychogenic conversion voice disorder it is necessary not only to *exclude* significant laryngeal or neurological pathology, but also to positively *include a psychological aetiology*.
- Common aetiological features are discussed (pages 3–6) and these are categorised as Types 1 or 2 conversion (pages 10–15).
- The application of cognitive behaviour therapy (CBT) within the context of solid clinical supervision is recommended for the SLT when treating a Type 2 psychogenic conversion voice disorder.
- An understanding of the Types 1, 2 and 3 classification is useful because it helps the SLT identify some of the psychological processes operating. It also helps indicate which patients may be responsive to therapy and suggests why a minority are resistant to therapy of all persuasions. Finally, this classification helps the therapist determine when a symptomatic versus psychological therapeutic approach is best, e.g. a high number of presenting features of Type 2 may make CBT the treatment of choice.

