Psychogenic Dysphonia: Peeling Back the Layers

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Summary: Resolution of psychogenic dysphonia is often quick and effortless for client and therapist alike. In such instances, the therapeutic interventions are simple and straightforward, insights are reached without difficulty, and once normal voice has been established, resumption of dysphonia or other psychosomatic symptoms rarely occurs. Sometimes, however, psychogenic dysphonia is extremely difficult to overcome, requiring considerable time, effort, and determination on the part of the client, coupled with confident, skilled persistence and psychotherapeutic insight from the therapist. In such cases one feels a sense of working through many complex layers before obtaining satisfactory voice or reaching an understanding of the psychogenic factors that precipitated onset and/or maintenance of the dysphonia.

Two cases that illustrate this involved process of peeling back the layers are presented. For resolution of severe psychogenic dysphonia, the therapist must be able to recognize and establish the complex relationship between the neurophysiological, intrapsychic, and interpersonal levels of function as they affect the client’s voice and person, as a whole. This work requires considerable courage and skill on the part of the therapist to question, explore, change direction, and select alternative approaches. It is important that the problem can be resolved with a depth of understanding which is relevant for the client, and with due attention to the social context and wider systems of which he or she is a part.

Key Words: Psychogenic dysphonia—Functional dysphonia—Conversion dysphonia—Hysterical dysphonia.

Throughout the literature and in clinical practice, voice disorders that exist in the absence of organic laryngeal pathology are referred to as functional (1), muscular tension dysphonias (2), hysterical dysphonias (3), conversion reactions (4), or psychogenic dysphonias (5–7). For the purpose of this article, the broad term psychogenic dysphonia will be used to refer to voice disorders, “which have arisen as a manifestation of psychological disequilibrium such as anxiety, depression, personality disorder or conversion reaction to the extent that normal volitional control of the phonation is lost” (6).

The more specific term conversion dysphonia will be used to refer to psychogenic voice disorders that meet the psychiatric criteria for a true conversion reaction, i.e., a disorder that
1. Exists despite normal structure and function of the neurophysiological system.
2. Is created by anxiety, stress, depression, or interpersonal conflict.
3. Has symbolic significance for that conflict.
4. Enables the person to avoid facing the interpersonal conflict directly and/or extricates him or her from the uncomfortable situation (6).

Conversion dysphonias, therefore, serve both a defensive and an expressive function for the individual, providing primary and unconscious secondary gains (8).

Typically, conversion dysphonias arise postvirus or trauma, often are associated with extreme vocal fatigue, or present as an anniversary phenomenon in reaction to a significant event such as death, profound loss, or shock. Although originally thought to present only as a whispery dysphonia, the conversion reactions often present as a total aphony, mutism, ventricularis plicae, falsetto voice with pitch breaks, or continuous falsetto voice (6,9). Clinically one may observe denial of the incapacitating nature of the dysphonia with the characteristic *belle indifference* when normal voice is restored.

Traditionally, therapy for psychogenic dysphonias, including conversion reactions, proves successful in several sessions without a return of the voice problem or other conversion symptoms. The crucial initial interview often begins with an educational explanation of the nature of psychogenic dysphonias followed by the more therapeutic phase. Here, a detailed history of events is taken with exploration of the possible circumstances or interpersonal problems that may have precipitated psychogenic symptom formation. Direct voice therapy is incorporated into this first session to facilitate the return of normal voice and it is often worth persevering over the scheduled appointment time to do this. Support and reassurance are offered during the cathartic emotional response, which usually occurs when the voice returns, and further sessions will be scheduled to help consolidate the normal voice and continue counseling. When the client leaves therapy, he or she should have gained an understanding of the symbolic function of the symptom and improved emotional and interpersonal skills to deal more directly with the previously threatening situation (10).

This process is often highly charged with emotion and after such a session the client experiences a mixture of elation and exhaustion. An immediate success in one or two sessions is relatively painless, straightforward, and extremely rewarding for both client and therapist, being analogous to piercing an onion incisively through to the inner core, with minimal bruising, slipping, or sliding and only a brief smarting of the eyes.

In some cases, however, the course is not as clear and one has a sense of struggling to get past the slippery skin of the onion, only to find that, once through it, each layer then has to be peeled back piece by piece. This may take a long time with many weeks, or even months of pungent odors and weeping eyes before reaching the true center. Such a process requires considerable faith and perseverance on the part of the client and real determination, adaptability, and even creative cunning on the part of the therapist.

Two such cases of psychogenic dysphonia as a result of conversion reaction are discussed. Both were teachers nearing retirement after long and satisfying careers and both presented with dysphonias following upper respiratory tract infections with residual symptoms of extreme fatigue. Both cases also presented with a high-pitched, breathy, falsetto dysphonia that took a long time to resolve. For the 57-year-old woman, CR, this was frustrating and difficult because her voice was weak and would not project sufficiently; however, this was not unduly provocative to her students and colleagues. For the 62-year-old male music teacher, JP, however, his falsetto pubertyonic voice, a full octave above his normal voice, was both alarming and extremely embarrassing. Both cases were experienced as being very complex and difficult for the treating therapists and provided a reminder of the saying, "There is no such thing as a resistant client, only a therapist who hasn't found the right way in" (11).

These cases are presented to illustrate that:

1. Facilitating normal voice and restoring it to full voluntary control can be demanding for both the client and the therapist.
2. Overcoming the resistance to the exploration of emotional and psychological factors may require advanced psychotherapeutic skills on the part of the therapist.
3. Prompt referral to a more experienced practitioner with additional qualifications in psychotherapy or co-therapy with a mental health professional experienced in voice disorders, is necessary when persistence of symptoms and suspected psychological disturbance are evident.

4. Full resolution of psychogenic dysphonia requires an appreciation of the individual in relation to the social context and wider systems of which he or she is a part.

CASE 1: CR

CR, a 57-year-old primary school teacher, presented to my colleague with a psychogenic dysphonia following a severe upper respiratory tract infection, which also left her feeling unduly run down and lethargic. She recalled no significant events or emotional crises prior to or during onset and could not entertain the notion that her dysphonia was anything but physical. Otolaryngological examination with both laryngeal mirror and flexible nasoendoscope revealed a normal looking larynx with strong apposition of the vocal folds and normal voice on cough, but incomplete adduction of the folds and a high-pitched, breathy falsetto voice on attempts to phonate. A diagnosis of psychogenic dysphonia was made with kindly reassurance to CR from her specialist that her larynx was entirely normal. Significantly, her first words to the therapist were, "Now don't tell me it's all up here, whatever you do!" CR was very happy in the school where she was teaching and was most anxious to return to her students. She did reiterate, however, concern over her chronic state of low energy and sense of having lost her vitality and creativity. She said she had lost interest in her garden, her bird cage needed cleaning, and that these atypical aspects of her fastidious behavior were of more concern to her than her high-pitched falsetto voice, which rendered her totally ineffective for classroom duties.

Exploration of her earlier history revealed that CR was a mother of six grown children and that she had been a widow for 3 years. Her husband had died after CR had nursed him through a long drawn-out progressive illness over 10 years. After his death she returned immediately to work and she reported feeling calmly resolved to the inevitability of his death and grateful for school activities "to take her mind off things." She emphasized that, if she was going to lose her voice for emotional reasons, it would have been in the much more stressful months after her husband's death.

It was the therapist's impression that CR was remarkably stoical and rational about her husband's death and the 10 years that she had sacrificed to care for him so devotedly. She considered the dysphonia to be a true conversion reaction, serving the defensive and expressive purpose of a delayed grieving response. The primary gain was to help her extricate herself from the classroom, but the unconscious secondary gain was less clear and thought perhaps to be providing CR with an opportunity to withdraw.

Course of therapy

Part 1

Throughout the early weeks of therapy, the clinician sought consultation with a more experienced speech pathologist with dual qualifications in psychotherapy and family therapy (the author JB) and discussed the difficulties she was having with the management of this case. She complained that, contrary to her usual practice of being able to facilitate normal voice within the first session, CR's extrinsic laryngeal muscles were extremely tight, her laryngeal carriage was high, and the high-pitched, breathy falsetto voice was tenaciously resistant to releasing into modal voice. With several joint sessions in which the consulting therapist was invited to participate, more vigorous downward and lateral manipulations of the larynx were encouraged to release the hold of the extrinsic muscles and CR was taught how to slide from a high-pitched "blown" falsetto down the full scale with strong pressure into her true modal voice. Frequently, however, the vocal quality became very rough and hoarse, sounding considerably worse than the breathy, clear falsetto. The alarmed client was encouraged to celebrate this louder, low-pitched, hoarse voice and was given powerful feedback that this was the normal voice "breaking through."

Such a pattern is commonly observed with the resolution of psychogenic dysphonia, and as long as it is anticipated by both therapist and client, it will not be frightening. More importantly, it will not be inadvertently inhibited through ignorance. (Physiologically, one sees irregular, asynchronous vibration of the
folds, often accompanied by ventricular band involvement and tension of the aryepiglottic sphincter. There is, however, a releasing function occurring within the folds due to a decrease in the cricothyroid muscle's action and increases in the thyroarytenoid or vocalis muscle activity [12].

Several weeks later, the therapist again sought consultation, this time reporting that, although CR could more readily produce the normal voice at will, she frequently failed to use it, slipping back and forth between her high falsetto and the middle range hoarse voice with occasional excursions into the normal tone and out again. CR seemed so unperturbed by this that her therapist admitted she had become tolerant of it also, to the extent that this unusual pattern became accepted as normal enough. She also expressed her frustration with her client's adherence to a clearly physical explanation for her dysphonia (relating it to the earlier viral infection) and her polite but determined resistance to exploring emotional issues. While acknowledging this reflected an incomplete resolution of the dysphonia, she persisted through the holiday break until CR was due to resume teaching. Both knew the voice was not fully settled but hoped that, once back among the children and friends, it would stabilize. Within 3 days of returning to teaching, her weak falsetto voice had returned and CR had to withdraw from the classroom.

It was only at this point, some 4 months since referral, that the therapist fully acknowledged the serious implications of the persisting vocal symptoms and finally confronted the role she might have been playing in restraining CR from fully resolving her conversion dysphonia. Although enjoying an amiable and positive relationship, she admitted feeling very young in relation to her 57-year-old client and wondered if this lowered her credibility. She acknowledged her relative inexperience with psychogenic voice disorders and reflected that she did not feel that she had the psychological skills or personal strengths to overcome CR's subconscious defenses. She eventually discussed her concerns with CR, her GP, and the referring laryngologist and recommended transfer to the consulting speech pathologist and family therapist.

Part II

The therapist taking over had several advantages that assisted in the transition period. The first was the astute appraisal given by the previous therapist that the probable basis for the conversion disorder was a delayed grief reaction with an unspoken plea for time to contemplate and regain energy. This naturally raised the possibility of a low-level clinical depression as the basis for the persisting symptoms. Exploratory interviews, however, revealed CR's overall affect to be generally cheerful and matter-of-fact with the characteristic belle indifference being the overriding feature of her demeanor. In close consultation with her GP, classical symptoms such as loss of appetite, weight change, early morning insomnia, and suicidal ideation were all excluded and referral to a psychiatrist, although considered, was not deemed necessary by her doctor or the speech pathologist. It was decided therefore to work with CR, combining both behavioral and psychotherapeutic approaches utilizing a preferred mode, which de-emphasizes pathology and focuses on harnessing the stated motivations, positive strengths, and skills of the individual with due consideration to family relationships and the wider social context relevant to that person.

The therapist's second advantage was a knowledge of the client's mind set in relation to exploring and acknowledging the psychogenic component of her voice disorder. It was anticipated that CR would be expecting a deeper and more confronting search for emotional ambivalence, repressed feelings, and unresolved sadness; more gentle and tolerant support for her variable voice; and a hasty shove back to work. It was decided that an intensification of more of the same would only serve to escalate the client's subconscious defenses further, so a number of modifications in emphasis were introduced to ensure an upset to the status quo.

The pressure of returning to work had been a constant focus for CR, so a full term off work with the option of a second was negotiated with her worker's compensation officer and warmly supported by the school principal. CR expressed enormous relief with this extension of time. But then, in contrast to the more open-ended time frame, her weekly appointments were increased to two and three per week, each for an hour. The message in this was, "You and your problem are being taken very seriously." CR recalled thinking, "This woman really means business—no more languishing at home!"
The therapist carefully outlined the nature of psychogenic voice disorders, leaving no ambiguity about the powerful role played by deep feelings and thoughts in influencing behaviors such as voice, albeit at subconscious or unconscious levels. The therapist wanted CR to receive a fresh and very clear message that the virus was no longer the culprit and wanted her to understand how one part of the brain can, without conscious knowledge or permission, inhibit and control another part of the brain, i.e., the part responsible for voluntary control over voice. (It is thought that the frontal lobe and limbic system, which are responsible for personality and emotions, relay messages to the motor cortex inhibiting vocalization; such messages occur only if the individual senses a threat to life, albeit at an unconscious level.)

At the point when CR’s anxiety level had reached its peak, with her eyes wide open, her cheeks very pink, and her mouth tightly set, a paradoxical contradiction was introduced, which argued that although this implied to some that “it was all in the mind,” it was undeniable and absolutely irrefutable that, in her case, real changes were also going on in her larynx. The folds were not functioning normally, and these changes were physical. The therapist insisted that her preferred way of treating, therefore, was to work first with the voice and later, once this was firmly under control and fully stabilized, further exploration of the psychodynamics could be undertaken, if the client wished to do so. It was stressed, in a matter of fact manner, that all kinds of feelings and ideas seemed to come to the surface as dysfunctional voices returned to normal and that, in CR’s case, “some might come up in relation to her husband’s death, some in relation to other matters that might be concerning her—who was to know—it would all happen in good time.” Embodied in this ostensibly educational explanation were many hypnotic suggestions, which the client could use or discard, but more importantly, for the time being, she learned that the focus would be on the physical. CR reacted with visible relief, sighed loudly, put her bag on the floor, and said, “Well, thank God for that; now I can drop all this psychological stuff and get on with making my body well again.” The tight tough skin of the onion had split.

Discussion

In working with all psychogenic voice disorders, the technical and psychotherapeutic work are inseparable. One can, however, appear to be focusing on one area more than the other, which is crucial for some clients if they are to lower their defenses. If a problem is continuously defined in terms of the therapist’s construction, this can be very alienating and lead the client to withdraw psychologically and retreat more deeply into his or her own frame of reference. In this sense, the therapist’s behavior can be a major restraint to change. If the therapist can join with the client to find a way of defining the problem such that the “reframe” has a certain fit with that of the client, then defenses are likely to lower and new information with different constructions of reality will be permitted into the psyche.

Being prepared to listen to the language used by the client can permit a confrontation of the therapist’s own mind set, allowing an alternative focus. CR said, “make my body well again,” not “my voice.” It was at this point that the therapist acknowledged that, in the scheme of things, CR’s dysphonia was only part of the picture, the larger canvas being feelings of weakness, tiredness, and lack of vitality without any passion or creativity. A vital shift in the therapist’s thinking took place as she began to construe CR’s conversion dysphonia—her “disembodied falsetto voice”—as symbolic not only of grief for her husband’s death, but also symbolizing her own dying away, and that for full resolution, CR would have to grieve, not just her husband’s real death, but her own inner death over the last 3 years. Before she could get “body back into her voice,” she had to get her body back.

Part III

Returning to full physical and psychological health entailed several stages. CR joined an exercise group and walked three times a week, increasing her fitness and stamina. At first she resented joining these senior citizens, but when she realized that the 74-year-olds were walking farther and faster than she could, she kept quiet about the “oldies.” On the recommendation of her GP, she attended fortnightly hypnotherapy sessions to assist her with stress management and help with relaxation. Although at first this was considered somewhat superfluous and, to a degree, could
have been construed as overservicing, advantage was taken of these hypnotherapy sessions. CR would often relay messages to the hypnotherapist from our voice therapy sessions about things we wanted incorporated into her subconscious and these sessions assisted her greatly in coping with the anxiety of using her voice in more demanding social settings and in preparation for return to the workplace.

She attended speech therapy twice a week for 3 months and we worked solidly on establishing and consolidating normal voice, first into automatic sequences and routine greetings and then into more challenging emotionally charged topics. Although CR could now readily switch from her falsetto voice to the low-pitched, hoarse voice and back to normal tone at will, she was strangely oblivious and indifferent to this pattern as it occurred involuntarily in conversation. The therapist noted the client’s developing sense of dependency and avoidance of responsibility during this phase of stabilization and, with the assistance of the otolaryngologist, provided CR with powerful laryngeal biofeedback of this phenomenon. With the flexible scope in place, she was able to produce all three voices on request and reviewed the playback video with considerable interest. As she stepped outside, she turned and said, “I know why you wanted me to do this; it’s up to me, isn’t it? I’m responsible for this and I’ve got to take charge of it.” CR had peeled back this next layer herself.

Final sessions were focused on maintenance of her normal voice in more intense psychotherapeutic conversations. These linked her earlier thoughts and feelings about her relationship with her husband and his illness and her own life being on hold with her renewed physical vigor, her greater insights, her considerable inner strengths, and her enthusiastic resolve to return to work. She role-played reading to children, teaching children, and finally taught the therapist some new math concepts. This proved a powerful way to alter the dynamics, giving CR the “in-charge” position and a healthy preparatory activity to symbolize separation and regaining of autonomy. The therapist then accompanied CR to school where generalization and reinforcement of her normal voice were encouraged in the school yard and finally in the classroom. CR returned to work in the third term of that year, beginning with 2 mornings a week where there were no pressures on her to actually take charge of a class. As she became able to manage this with confidence, her responsibility for classroom activities was increased and she finally resumed working full-time.

CASE 2: JP

JP, a 62-year-old music teacher with the Education Department, developed an acute laryngitis following an upper respiratory tract infection at the beginning of Term 3. His GP prescribed gargling and three courses of antibiotics, and his voice returned sufficiently for him to teach a further 7 weeks, despite a persistent tickle in the throat and constant loose cough. In the last week of the term, he lost the use of his normal speaking and singing voice altogether and developed a high-pitched falsetto voice, typical of puberphonic dysphonia.

Otolaryngologic examination with both the laryngeal mirror and flexible nasoendoscope revealed a generalized redness and swelling of the larynx, copious mucous secretions in the hypopharynx, and a marked sensitivity to the presence of the scope with paroxysmal coughing. Normal adduction of the vocal folds and appropriately pitched vocalization were elicited by cough; however, on requests for phonation, only a high-pitched falsetto dysphonia was possible with incomplete adduction of the vocal folds.

In view of the marked erythema of the larynx and the persisting symptoms of tickle in the throat, loose productive cough, and aggravation from excessive mucus, comprehensive medical investigations were undertaken, including a detailed history regarding acid reflux, barium swallow, and sinus and chest X rays. These, somewhat surprisingly, all proved negative, ruling out chronic sinus or lung infection and, more significantly, gastroesophageal reflux, which could well have accounted for these troubling symptoms. A diagnosis of chronic laryngitis secondary to the patient’s severe upper respiratory tract infection and heavy vocal demands was made with referral to the speech pathologist/family therapist for assessment and management and, in particular, her opinion regarding the unusual nature of the high-pitched dysphonic voice.

JP’s initial presentation was complex. The infection and persisting medical symptoms had been, and
still were, a powerful force and returning to a heavy vocal load with his aggravated larynx had undoubtedly contributed to his chronic laryngitis. However, his somewhat flippant affect coupled with his high-pitched falsetto voice (with normal voice on cough) suggested a purely psychogenic dysphonia and it was considered essential to investigate his history carefully and to look for psychological or social factors that may have left him voiceless—in a profession requiring him to speak and sing continually.

JP was 2 years from retirement, having enjoyed a rewarding career as a music teacher in the Education Department for 14 years. His social and family life were steeped in the church where he had been, and still was, a renowned organist. He came from a background with a love of English literature and the classics, and a particular strength in Latin. He had a quirky sense of humor where he enjoyed playing word games, chuckling youthfully over puns and double entendres, and loved best of all to discuss the nuances of Bach’s contrapuntal fugues and the riddle of the dominant 7th in Beethoven’s piano sonatas.

With the instigation of a new ruling in the Education Department of South Australia, teachers are now forced to leave their schools after 10 years of service and transfer to any school offered by the department. If there is no demand for their particular subject area, they are forced to teach whatever is required, regardless of their interests, qualifications, or background. In the 2 years prior to JP becoming ill, he was transferred six times, each time to a school where music was of a low priority; therefore, his time was filled teaching subjects of which he had no knowledge or interest. When he did teach music, the students’ musical aspirations were such that “Heavy Metal” would have been their favorite musical group and Andrew Lloyd Webber the pinnacle of their classical music experience.

Two weeks after settling into his final placement and again teaching music along with other subjects not in his field, he was transferred a further time without warning to a school where he was expected to teach music, history, geography, and social issues. He found the classes extremely unruly and difficult to manage, spending all of his time in the evenings preparing to teach unfamiliar material. His wife observed that the uncontrollable coughing and retching occurred early in the morning on days when he was due to teach this academic material and JP noted that it was in these classes that the cough and tickle aggravated his throat the most.

It was the opinion of the therapist that JP was presenting with a true conversion reaction, not denying at all the infection, the coughing, and the tickle in the throat as being valid contributing factors. The conversion symptom was an understandable defense against a work situation that was intolerable, the primary gain being to help him take time out to regain his health and for the larynx to heal. The secondary gain, although completely unconscious, was to extricate himself from an intolerable classroom situation, which threatened his professionalism and rendered him impotent on a daily basis. It was hypothesized, therefore, that the expressive function of his conversion symptom was highly symbolic and suggestive of castration.

Course of therapy

The therapeutic dilemma was a serious one. If JP were to regain his normal voice, it would be necessary for him to return to an environment that would inevitably diminish him further. If he failed to regain his normal voice and retained his falsetto dysphonia, which he referred to as “my constant counter-tenor voice—my Mickey Mouse voice,” then he faced loss of his job, humiliation and ridicule, and loss of fulfillment from his church life, which included singing. JP was adamant that he wished to get back his normal voice and return to work, singing, and church activities. He clung strongly to the notion that his dysphonia was directly related to the infection and the heavier vocal demands required by teaching geography, history, and social issues. In light of the above very powerful double-bind that faced JP, the therapist decided to go ahead with therapy accepting the construction as a valid enough explanation. The alternative was to confront the issue of his having been rendered totally impotent and ineffectual by the school system, which was not considered a very helpful insight to offer a man in his early sixties as he ended a successful career. It seemed more appropriate to help JP recover his voice and then support him with recommendations to the Education Department that protected him from unsuitable class placements. It was also considered important to help prepare JP for easing himself out of teaching when he
felt ready. It was considered essential to help this man retain his dignity rather than move in cleverly with embarrassing and threatening interpretations of his situation. Therapy, therefore, focused primarily on the return of his voice and later on helping him negotiate with workers’ compensation and rehabilitation officers for the best possible school placement. Such a degree of cooperation with the employer is not always possible, but with occupational health and safety measures such a major issue in Australia, rehabilitation officers now work very closely with medical specialists and speech pathologists to find the best possible workplace solutions when the employing body is deemed to carry any responsibility for either precipitating the onset of or aggravating an existing medical condition.

Obtaining his true modal voice was extremely difficult, taking many weeks of intensive therapy with two and three sessions a week. (In the author’s opinion, this is very rare with psychogenic dysphonia.) Whenever a hint of true voice would threaten to break through, he would tighten the true vocal folds, the false vocal folds would constrict, his throat would lock, and he would heave violently. Many techniques were used, the most successful eventually being manipulation of the larynx both downward and laterally while he attempted to sing down from his high falsetto voice and “crack” into his modal voice a full octave below. He also went into an extremely low-pitched hoarse voice stage where ventricular band involvement was clearly implicated. His singing was of primarily importance to him and so this too was incorporated into the sessions, often accidentally triggering normal tone. The therapist used a keyboard and sang loudly with him to enhance the Lombard effect, which is an old and familiar trick known to reduce the client’s auditory feedback and hence diminish inhibitions (13). Once normal tone was established, he was encouraged to revert back to his falsetto voice to assure him he could now control the voice and use either voice at will.

Throughout the entire process, JP’s efforts were exacerbated significantly by his paroxysmal coughing, the dry retching, and the laryngeal constriction. This was so severe that the therapist referred him back to his otolaryngologist on two occasions for further medical investigations to exclude any sinister pathology and to request assistance in the management of his copious mucus and irritated throat. Atrovent nasal spray and some Sudafed were recommended to assist with the troubling secretions, and fortunately, medical investigations again proved negative.

JP’s normal voice was gradually consolidated and he returned to teaching. No suitable full-time music placement was available but because medical recommendations had warned against nonmusic classes, JP no longer had to face the humiliation of teaching subject areas that were not in his field. Although his falsetto voice never returned, he continued to report hoarseness after extensive vocal use of any kind and he attributed this to residual weakness of his voice due to the infection and the months of coughing. This perfectly legitimate explanation has assisted JP in seeking early retirement and he has now negotiated an acceptable package and finished on terms that suit him better. This is not an ideal resolution, but it is one that holds dignity for a man who was treated in a totally unacceptable way by a system that is hard to beat.

CONCLUSION

Two complex cases have been presented that highlight problems that can be faced when the unconscious fears of clients are greater than their more rational feelings and thoughts.

Although many clients with psychogenic disorders are treated very successfully by speech pathologists, there are times, especially with conversion reactions, when it is better to hand clients over promptly to either more experienced clinicians or practitioners with dual qualifications in psychotherapy. Since this is a relatively rare combination, immediate consultation with credentialed mental health professionals such as psychiatrists, psychologists, or social workers (preferably with experience of voice disorders) should be considered, either for complete management and/or as co-therapists with the treating speech pathologist. In the two cases outlined in this article, the consulting therapist (called in to take over with case 1 and responsible from the outset with case 2) was both a speech pathologist and a credentialed psychotherapist with further qualifications in family therapy. This strongly influenced the approaches used and proved a valuable combination for the management of these demanding cases.
Therapists need to have a thorough knowledge of the different ways in which psychogenic voice disorders may present and understand that the resolution of normal voice often goes through many stages, often perceptually more dysfunctional than the former dysphonia. It is also important to know about and be able to use, in a creative and nonthreatening way, a wide repertoire of techniques to help facilitate voice and, once voice is established, the persistence to ensure that the normal voice is consolidated completely into conversational speech in a variety of settings relevant to the patient.

Cases such as these highlight the need to remain vigilant to situations in which psychogenic dysphonias may co-exist with medical conditions. This may have a direct impact on the progress in and eventual outcome of therapy or may indirectly influence aspects of the therapist’s judgment. With psychogenic voice disorders, it is important not to be sidetracked by the client’s physical and medical symptoms, but it is essential to acknowledge the role that they may play in influencing the outcome of therapy. In the presence of persisting medical symptoms, the therapist needs to be willing to refer for medical opinion until a satisfactory outcome is achieved.

Finally, therapists must consider very carefully the symbolic function of the symptoms and the possible unconscious secondary gains attached to this symptom formation. Only then can full consideration be given to the implications of therapy assisting in removal of the symptom. If the symptom is to go, something has to take its place, either the clients’ psychological skills and capacity for resolving interpersonal conflicts have to be strengthened or the situation to which they are returning needs to be construed as less threatening.

REFERENCES