

Encouragement to Increase the Use of Psychosocial Skills in the Diagnosis and Therapy of Patients With Functional Dysphonia

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Summary: Clinicians believe that psychosocial factors play a causal role in the etiology of many forms of functional dysphonia (FD). But for decades, all attempts to confirm such causation have failed. This paper aims to show the logic of this failure, to discuss the possibilities of employing psychology in therapy nonetheless, and to encourage clinicians to use their psychosocial knowledge and skills. The failure to confirm psychic and social factors as causal in the etiology of FD is basically a consequence of a principal shortcoming of evidence-based medicine (EBM). As the gold standard for validity, reliability, and objectivity in medical research, EBM is based on calculability and hence the processing of quantitative data. But life paths and life situations are best or sometimes only expressible in qualitative, experiential, and idiographic terms. Thus EBM-guided evaluation undervalues most psychosocial studies. This report of an experienced multidisciplinary voice team proposes alternative pathways for integrating psychosocial knowledge into the diagnosis and the treatment of FD. The difference between the fields of activity of psychotherapists and speech-language pathologists is discussed, and the latter group is shown the potential benefits of using more of their psychosocial knowledge and skills.

Key Words: Functional dysphonia–Psychosocial–SLP and psychotherapeutic techniques–Conflict over speaking out–Morbid gain–Harmony and aggressivity–Guilt and shame.

INTRODUCTION

Functional dysphonia (FD), characterized by hoarseness and/or reduced voice strength and/or disturbing laryngeal sensations in the absence of a structural or a neurobiological abnormality, is a common voice disorder^{1,2} appearing in different forms such as hypo- or hyperfunctional dysphonia, muscle misuse dysphonia (MMD), muscle tension dysphonia (MTD), puberphonia, psychogenic dysphonia, or conversion aphonia. Up to a third of patients suffering from a voice disorder referred to a multidisciplinary voice clinic receive the diagnosis of FD.^{2,3} Some forms of FD, namely psychogenic dysphonia and conversion aphonia, are clearly recognized as primarily caused by psychosocial processes. But what about the majority of FDs, in which, as in other “medically unexplained symptoms,” psychosocial factors seem to play an important role? Are hypo- or hyperfunctional dysphonia, MMD, and MTD also caused by psychosocial processes?

THE SEARCH FOR PSYCHOSOCIAL CAUSES OF FD

In an attempt to answer this question, dozens of scientific investigations have been conducted gathering hundreds of results, mostly with positive findings concerning the psychosocial differences between patients with FD and controls without dysphonia. Some of the *moderate* and the *minor psychosocial problems* that have been identified as discriminating are:

perceived stress, traumatic stress experiences, mood disorders, depression, burnout, anxiety disorder, fear in social

situations, emotional maladjustment, difficulty in the processing of negative emotions, difficulty dealing with anger, somatic preoccupation, excessive somatic complaints, somatization, neurosis, and clinical impression of hysteria.^{2,4-9}

Some of the identified *personality characteristics*, several measured by the Minnesota Multiphasic Personality Inventory, are:

temperament, extraversion, introversion, neuroticism, type A personality (ambitious, rigidly organized), type D personality (negative affectivity), social inhibition, social alienation, social competence, loneliness, interpersonal sensitivity, self-confidence, perfectionism, diffuse anxiety, control of emotions, impulsivity, suspiciousness, obsessive-compulsive trait, coping style, pessimism (dissatisfaction, sadness), and tendency toward denial.^{4,5,10-17}

In recent years, evidence has been found that FD is at least correlated with depressive symptoms and general anxiety,^{5,18-21} but probably also with high neuroticism and hypochondriasis.^{1,4} But correlation does not imply causation. The discriminating findings could be causes of FD, but they could also be consequences of FD, or both could be covariables of a third factor. The experiences of clinicians often suggest the causality of psychological elements in the development of FD, but despite countless efforts to clarify this relation, no proof has been found. So specialists state: “The etiology of FD is still unclear,”¹⁸ “the pathogenic mechanisms are still far from being understood,”¹¹ and “the interaction between predisposed and causal factors is unknown.”²¹

There are two possible explanations for this unsatisfactory state of research: Either the sought-after causalities do not exist or the search methods used are inappropriate.

Arguments against the first assumption include not only the experiences of clinicians but also the findings of modern psychoendocrinology, epigenetics, and neuroplasticity research, which all show striking causal relations between emotional states (eg, loneliness, bereavement, or suppressed anger) and

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physical illness. The validity of the second assumption is hinted at by the fact that experimentation with human feelings and private thoughts are (fortunately) subject to severe humanitarian limitations. But experimentation is the crucial methodology in modern evidence-based medicine (EBM) and evidence-based practice (EBP). Is it possible that the characteristics and dominance of EBM and EBP are impeding the proof of the causality of psychosocial factors in the onset of FD?

ARE EBM AND EBP OBSTACLES IN THE SEARCH OF PSYCHOSOCIAL ETIOLOGICAL FACTORS?

Since the 1990s, the development of EBM has seen a significant increase in the validity, reliability, and objectivity of medical research. The selection of strict criteria for evidence made it much easier to distinguish valid and reliable research findings from less useful results. The success of EBM, especially in the development of pharmaceuticals, has become so convincing that its criteria have become the gold standard. EBM as “the best tool to validate clinical decisions about the care of individual and aggregate patients”²² “has meteorically emerged to dominate contemporary medical methods and practice.”²³ EBM is based on calculability, that is, on the processing of quantitative data. Its ideal is the randomized, controlled, double-blinded, placebo-matched multicenter trial. But EBM methods cannot be applied to every research question. It is unable to process qualitative, phenomenological, experiential, or idiographic data because “no mathematically driven algorithm will ever suffice for clinical reasoning,” as Montgomery and Turkstra assert.²⁴ EBM invokes instrumentalism, de-contextualization, and reductionism.²³ Therefore, EBM judges the findings of studies that provide soft and subjective data as “of little or no evidence” and therefore as untrustworthy. So in reviews that search databases of potentially relevant studies, the majority of studies are regularly excluded from further analysis because of insufficient compliance with EBM criteria. For instance, in their review of the effects of FD therapies, Ruotsalainen et al²⁵ searched seven databases using 100 keywords and found 5937 papers on the treatment of FD and prevention of voice disorders. After five steps of “cleaning” (ie, the elimination of EBM-incompatible studies), only seven papers remained for their meta-analysis. So hundreds of partially valued studies were declared to provide “minimal evidence” and became ignored. Conversely, the findings declared by EBM as “of strong evidence” are sometimes so anemic that they seem to be of little value. The low use of evidence-based findings in clinicians’ decision-making speaks a clear language: Chan et al²⁶ surveyed 58 Australian speech-language pathologists (SLPs) about their use of EBP when treating adults with FD. A total of 98% of respondents reported that they relied on clinical experience to guide their clinical decision-making. Similarly, a survey of 240 American SLPs revealed that they use clinical experience and opinions of colleagues more frequently than research studies to guide their decisions.²⁷ An online survey of 2726 SLPs in 28 states showed that 91% had no scheduled time to support EBP activities. The majority of SLPs posed and researched zero to two EBP questions and read zero to four American Speech-Language-Hearing Association journal articles per year.²⁸

In addition, the supremacy of EBP has serious general implications for the diagnosis and therapy of FD:

- In the absence of approved facts of inclusion, an FD diagnosis can only be given *via* exclusion, that is, if no organic reason can be found for the hoarseness, it must be (can be) FD. This makes FD “an undetected organic dysphonia,” which contradicts the definition of FD.
- In the absence of approved causality-related aims for therapeutic change, the success of therapy is measured almost exclusively on the level of behavioral change.
- The efficiency of EBM in many areas of scientific knowledge increases the unrealistic hope that the disorder will soon be recognized as of organic origin.

This unprovability *via* EBM keeps possible psychosocial causes of FD hidden. For although many research methods to identify psychosocial causal relations exist, and are widely used in the science of history, art, and literature, they have fallen out of favor in medical science. In contrast to the quantitative methods of nomothetic research strategies, these are the qualitative methods of idiographic research. In the nomothetic approach, large groups are investigated to find general laws of experience and behavior that apply to most people. The idiographic approach focuses on the individual; case studies, participant observation, narrative or in-depth interviews, qualitative content analysis, and semiotic data analysis are just some of the idiographic instruments. The idiographic approach takes the quality of research criteria just as seriously as the nomothetic approach, but the labels and meanings are slightly different. For example, the nomothetic concept of “validity” is replaced by the idiographic notion of “trustworthiness.”

WHY PSYCHOSOCIAL CAUSATION EMERGES ONLY IN IDIOGRAPHIC RESEARCH APPROACHES

Knowledge of isolated psychological adjectives describing a person at a certain point in time, investigated by questionnaires (characteristics of personality, psychopathology, styles of attachment, coping strategies, or employment or family conflicts) is hardly sufficient for understanding a patient’s life situation. For one patient (or his or her family), an increased degree of aggressiveness may be a major problem, whereas for another it might be a helpful way to show resistance in a manipulative social environment. Increased depression scores may be a sign of cautiousness and reservation in one patient but part of a deep inner emptiness in another. The complex of problems that is really stressing the patient only becomes comprehensible when it can be recognized in the context of the time frames of his or her development (Figure 1). The history lines through the time frames (eg, at $t^1 = 3$ years, $t^2 = 16$ years, and $t^3 =$ present) allow the meaning of the characteristics in the individual frames to be understood.

An ambivalently attached child (person A) might later, as an adolescent, look for excessive freedom to prevent from being “swallowed” by others. Thus, as an adult, he or she will presumably be afraid of any strong interpersonal ties. A patient with this background must be seen differently from a patient (person

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