



Long term outcome of psychogenic voice disorders

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ABSTRACT

Objectives: To evaluate different therapy for psychogenic voice disorders.

Methods: Epidemiological data, organic and psychological symptoms, therapeutic options and outcome were prospectively analyzed in 40 consecutive patients with psychogenic voice disorders. Their voice was evaluated by subjective means and self assessment (voice handicap index) and an organic or functional disorder was excluded by videolaryngostroboscopy. Additionally, a detailed psychological examination and exploration were made. Every patient received intensive voice exercises with biofeedback by a phoniatician and counseling by a clinical psychologist. Following this, therapy options of psychotherapy or a combination of psychotherapy and voice therapy were given. After an interval (average 16 months) from first contacting our section, every patient was asked to complete a questionnaire about their therapies and quality of voice.

Results: Patients had previously received insufficient voice therapy or antibiotics. The psychological examination detected psychological disorders as a basic problem. Overall, in 70% of patients there was either an improvement or resolution of voice problems. For all patients psychotherapy or a combination of voice therapy and psychotherapy was recommended, but only accepted in 37.5%. In all cases, when psychotherapy in combination with speech therapy took place, it was successful, whereas speech therapy alone provided improvement only in 12.5%.

Conclusion: Psychogenic voice disorders are often misdiagnosed, leading to inadequate therapy. Psychotherapy (often in combination with voice therapy) was most effective also in the long term, but is often not accepted by patients. Voice therapy alone had a poor success rate.

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1. Introduction

Psychogenic voice disorders are often missed, leading to inadequate therapy [1,2]. Diagnosis is characterized by absence of an organic or functional laryngeal disorder combined with voice abnormalities (aphonia/dysphonia), whereas laryngeal sound unrelated to communicative behavior (e.g. cough) is not [1–4]. A lack of adduction of the vocal folds during phonation is observed, but normal movement and complete closure of the vocal folds during coughing is present [5]. Patients with psychogenic voice disorders often show an acute onset and reveal a history of stress-related problems [6–8]. The voice disorder may be a manifestation of psychological disequilibrium such as anxiety, depression, personality disorder, somatization, conversion reaction (cognitive-behavioral-conversion) or conflicts (e.g. in the field of their own health with a new diagnosis such as cancer and in the field of business, money or partnership), to the extent that normal volitional control of phonation is lost [1–4,7,9]. According to

Sapir, patients with psychogenic voice disorders met the following criteria: (a) the onset of the voice disorder was linked to a psychologic stimulus such as stressful life event or interpersonal conflict (symptom psychogenicity), they show (b) symptom incongruity, and (c) symptom reversibility with short-term voice therapy and/or through psychotherapy is observed [10].

Differential diagnoses of psychogenic voice disorders are aging voice with voice complaints in patients over 65 years in 58% with the most common diagnosis being vocal atrophy with incomplete glottic closure in 25% [11,12]. Furthermore Parkinson's disease (PD) [13] and muscle tension dysphonia caused by increased tension of the (para)laryngeal musculature compensating an underlying organic disease, e.g. upper airway infections with cough are etiologies for incomplete closure of the vocal folds [14–16]. Additionally hyperfunctional voice disorder often shows incomplete vocal fold closure and can be either the cause or consequence of psychological problems [16–18]. Gastroesophageal reflux or laryngopharyngeal reflux are often associated with voice disorders, too [11,16,19].

Patients with psychogenic voice disorders are primarily treated symptomatically in order to re-establish the voice quickly and avoid fixation. This acute therapy is often done by phoniaticians

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and/or speech therapists with intensive voice exercises e.g. initiating the voice by coughing or clearing the throat. Speech therapists also treat patients with psychogenic voice disorders by direct (vocal function and resonance voice exercises) and indirect voice therapy (relaxation and breathing exercises) [5,20–23].

A psychotherapeutic approach using counseling may be a useful approach, particularly in refractory cases [3,7,20,24,25]. Where psychogenic voice disorder is thought to be a conversion reaction, symptom orientated voice therapy in combination with cognitive-behavioral therapy might be a promising therapy option [4,26,27]. Additionally, biofeedback approaches (e.g. means visual endoscopic feedback of the larynx findings) may be successful [5,28]. But in all these cases little information exists about long term success and high relapse rates are observed [1,21–25].

In this study we wanted to investigate epidemiological data, organic and psychological symptoms assessed by a phoniatician and clinical psychologist, respectively. Therapy options (counseling, biofeedback and intensive voice exercises – psychotherapy, especial cognitive behavior therapy – psychotherapy in combination with voice therapy, especial direct voice exercises and indirect relaxation techniques) and long term outcome of patients with psychogenic voice disorders were prospectively evaluated.

2. Materials and methods

We included 40 consecutive patients with a psychogenic voice disorder who visited the Section of Phoniatics and Pedaudiology from February 2009 to April 2011 in this prospective study. The diagnosis psychogenic voice disorder, caused by a severe underlying psychological problem, was made by a phoniatician and clinical psychologist according to the criteria of Sapir. The onset of the voice disorder was linked to a psychologic stimulus such as stressful life event or interpersonal conflict (symptom psychogenicity) and symptom incongruity was observed. The symptoms should be reversible with short-term voice therapy and/or through psychotherapy.

The medical history contained information about voice impairment, dependence on voice, profession, associated medical conditions and treatment. At first presentation voice quality was evaluated by a phoniatician when the patient read a standard text and rated by roughness R, breathiness B, and hoarseness H (RBH) scale: RBH were scored from 0 to 3 points (0 = normal, 1 = mild, 2 = moderate, 3 = severe/highly) [29]. Self assessment of their voice-related quality of life was done by the German version of the voice handicap index. The overall voice handicap index score (raw score) can be used to grade subjective handicap from no handicap [raw score, 0–14], mild handicap [raw score, 15–28], moderate handicap [raw score, 29–50] to severe handicap [raw score, 51–120] [30].

In addition, the phoniatician made a videolaryngostroboscopic vocal fold examination (90 degree endostroboscope 5052, Wolf, Hamburg) and documented these findings (rpScene[®], Rehder, Hamburg). Additionally a detailed psychological examination and exploration of biographic history, psychosocial symptoms and functions were made by a clinical psychologist. This included the evaluation of the following items: social network, stressors, contentment at the working place and mental disorders (according to World Health Organization ICD-10 classification of mental and behavioral disorders) [31].

The psychogenic genesis of the disorder was explained to the patients with the aid of videolaryngoscopic findings by the phoniatician as a kind of biofeedback method. Organic findings (e.g. inflammation, paralysis, tumors or atrophy of the vocal folds) were excluded and a lack of adduction of the vocal folds during phonation is observed, but normal movement and complete closure of the vocal folds during coughing [5]. All patients were

immediately given an intensive voice therapy (e.g. initiating the voice by coughing or clearing the throat) with the aim of recovery by the phoniatician. Afterwards counseling was undertaken. In this procedure the linkage between the underlying psychological problem and psychogenic voice disorder was explained to the patients by the clinical psychologist.

Additionally, a recommendation for further therapy was made by the clinical psychologist and the phoniatician: psychotherapy alone or a combination of psychotherapy and voice therapy, if intensive voice therapy in combination with biofeedback and counseling failed. A blinded randomization group placement was not pursued, as we thought that all patients needed psychotherapy as the most effective basic therapy approach, because all our patients had an underlying psychological problem. The psychotherapeutic intervention was made in the form of a cognitive behavior therapy that includes a reflection of the biographical history and analysis of current relationship conflicts. The voice therapy included direct voice therapy approaches (vocal function and resonance voice exercises) and indirect voice therapy (sensory awareness, relaxation and breathing exercises). Voice and psychotherapy were performed by different therapists, who were not employed in our section. Psychotherapy and voice therapy started simultaneously and the sessions were about equally distributed.

A follow up was made at an average of 16 ± 8 months [range 6–32 months] after the last visit to our section by contacting the patients with a questionnaire containing the following items: (a) What is your actual quality of your voice? No – mild–moderate–severe handicap. (b) How often did you experience an event of psychogenic voice disorder after the visit in our section? Never, if yes, how often? (c) What therapy did you receive? None, antibiotics, antipsychotic drugs, voice therapy, psychotherapy, combination of psychotherapy and voice therapy. Additionally self assessment of the voice was again done by the patients with the VHI questionnaire. Statistical data analysis was performed with the Wilcoxon signed-rank test for checking significant differences of the parameters between before and after therapy (SPSS 19, IBM, NY). The study was approved by the local Ethics Committees at the University of Ulm.

3. Results

3.1. Demographic data

Thirty four of the 40 patients were women (85%) with a mean age of 39.2 ± 15.9 years, (range 20–85 years, only one women was older than 60 years).

A history of (mental) disorders was noted in 27.5% (11 out of 40). Four had a depression, four mental stress, two phobia and one bullying. A history of acute laryngitis/rhinitis/bronchitis immediately before the onset of the psychogenic voice disorder was noted in 16 out of 40 patients (40%) (Table 1). An occupational history was taken: about one third of them had professions with a high demand on the voice (businessmen and businesswomen, students

Table 1
Number of patients with associated medical conditions are listed in Table 1.

Associated medical conditions	Number of patients
Laryngitis/rhinitis/bronchitis	16
Oncological disease	1
Reflux	10
Asthma	3
Depression	4
Mental stress	4
Bullying	1
Phobia	2

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