Chapter 3
Psychosocial Correlates of Dissociative Motor Disorder of Impairment or Loss of Speech

Shyam Hanumanapura Rajanna
All India Institute of Speech and Hearing, India

Raju Heggadadevanakote Hanumanthaiah
All India Institute of Speech and Hearing, India

ABSTRACT

The present chapter is intended to elucidate the role of psychosocial factors such as stressful life events, adjustment issues in family, social, occupational, and academic setup, personality, and socioeconomic correlates in the individual suffering from functional aphony/dissociative motor disorder of impairment or loss of speech which is also called as functional voice disorder (FVD). This chapter explores a study carried out by purposively selected (N=32) case files reviews of individuals with FVD who were treated with functional voice therapy. The study results indicated various stressful life events such as marital discord, adjustment difficulties with social, occupational, family, and academic stipulation, and rapidly changing personal and health conditions were significantly associated with FVD. Majority of the cases were belonging to lower socioeconomic status and depressive symptoms were observed. Presence of the persistent role of life events, adjustment issues, and depression influencing development and maintenance along with diagnosis and management techniques are discussed.

INTRODUCTION

Speech is regulated by the operation of voice in humans and speech is the predominant human communication feature which differentiates human being from other creatures in our universe. Various nonorganic voice disorders with varied psychological causes are observed in day to day clinical practice. For these problems, many specialists rely on terms like “psychogenic”, “psychosomatic”, “somatoform disorder” or “somatization disorder” (Aronson, 1990; Kinz et al., 1988). But these terms were used too inconsistently and their definitions were not clear; it is useful to regard all non-organic voice disorders on

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a continuum, ranging from “psychogenic aphony” at the top (i.e. where the role of psychosocial factors in the causality is greatest) via “psychogenic dysphonia” etc. to “professional dysphonia” at the bottom. The latter often stems not only from vocal misuse but also from problems of dissatisfaction at work or from conflicts in private life (Seifert, & Kollbrunner; 2005). The functional voice disorder (FVD) is formerly called as psychogenic aphony, functional aphony, conversional aphony, functional dysphonia, hysterical aphony or acute sudden voice loss. In this chapter, FVD is referred as dissociative motor disorder of impairment or loss of speech as per the ICD-10 (F44.4; World Health Organization, 1992).

The functional voice disorder is a rather rare disorder with the varying prevalence of 0.4% in general population to 0.98% in a treatment-seeking United States of America’s population (Cohen, Kim, Roy, Asche, & Courey, 2012). FVDs are rare; speech-language pathologists, ENT practitioners or general physicians as they refer the individuals who are suspected of having FVD to appropriate professionals such as psychologist, functional voice therapist or psychiatrist depending on accessibility to various setups in different countries for diagnosis and intervention, most of the FVD cases need subsequent management of FVD through therapies and interventions.

In the clinical interviews, clients disclosed that some clients have been taken to faith healers because of lack of awareness of the treatment available for the problem and such cases are more reported from the rural and semi-urban areas. Studies reported that prevalence of FVD is more in adult females than in adult males with the ratio of 5: 1 (Martins et al., 2016). The most frequently diagnosed voice disorder among adults is functional dysphonia (20.5%), acid laryngitis (12.5%), and vocal polyps (12%) (Martins et al., 2016) indicating more cases suffering from FVD among the population with voice disorders.

Voice disorders are not mutually exclusive, and overlap is common. Most often FVD co-occurs with the symptoms of the depressive episode which can be elicited through a qualitative clinical interview with the client and family members.

FVD is a condition in which quality of voice, pitch and difference on loudness are inappropriate for gender, age, geographical area and cultural setup is observed is called as a voice disorder (Aronson & Bless, 2009; Lee, Stemple, Glaze, & Kelchner, 2004). Difficulty in speech or voice production or voice disorders resulting from the improper or insufficient use of the vocal mechanism when the physical and mechanical structure of speech or voice production is normal then it is called as FVD. FVD’s signs and symptoms include vocal fatigue; muscle tension dysphonia or aphony (loss of voice); diplophonia; ventricular phonation, breathiness, strained quality of voice (perception of increased effort; tense or harsh as if talking and lifting at the same time), strangled quality voice (like talking with breath held) abnormal pitch, abnormal loudness/volume, asthenia (weak voice) and other signs and symptoms include running out of breath. These signs and symptoms can occur in isolation or in combination. Chronic stressful lifestyle, acute stressful life event, anxiousness, depression and conversion reactions (including conversion aphony or dysphonia) are the major causal factors of FVDs (Baker, 2003; Rasch et al., 2005). The corresponding relationships between these organic, functional, and psychogenic influences ensure that many voice disorders will have contributions from more than one etiological factor (Stemple, Roy, & Klaben, 2014). Voice quality can also be affected when psychological stressors lead to habitual, maladaptive aphony and the resulting voice disorders are referred to as FVD (Stemple, Glaze, & Klaben, 2010). Stressful life events in the individual’s life and difficulties in adjustment to the changing life conditions or persistent life situations are the important psychosocial variables which have been studied largely in association with the FVD. Identifying relation between these psychological factors in connection with indispensable exertion to manage FVD is vital. Stressful life events are the unavoidable discrete life experiences which disrupt individual’s usual activity, causing a substantial change and creating difficulty