

## PSYCHOGENIC SPEECH DISORDER – A CASE REPORT

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### SUMMARY

**Background:** Conversion (dissociative) disorder is a psychiatric disorder in which somatic symptoms or deficits are present in the absence of a definable organic cause. The etiology of this disorder is not yet fully understood. The most characteristic presentations are: pseudosensory syndromes, pseudoseizures, psychogenic movement disorders and pseudoparalysis. Psychogenic speech disorder is a rare form of conversion (dissociative) disorder. The aim of present case study is to complete the knowledge on this subject.

**Subject and methods:** The article presents a case of a fifty year old woman who developed psychogenic disorder of speech after being degraded to a lower position at work. After excluding organic background of observed symptoms, the diagnosis of conversion (dissociative) disorder was stated and adequate therapy was implemented, within the capabilities of the Ward.

**Results:** Partial remission of presented symptoms was achieved as a result of psychopharmacotherapy and psychotherapy.

**Conclusions:** Before stating the diagnosis of conversion (dissociative) disorder, possible somatic causes of the observed symptoms should be excluded. Special attention should be drawn to the importance of studying the psychological and family context of this case and the patient's difficulty to understand and accept that produced symptoms might be triggered by a psychogenic factor.

**Key words:** conversion disorder – speech - psychotherapy

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### INTRODUCTION

The etiopathogenesis and the concept of dissociative/conversion disorder was being revised over the years. The common feature of dissociative/ conversion disorder is a partial or a complete loss of the normal integration between the sense of identity, memories of the past, sensory impression and control of voluntary movements (American Psychiatric Association 2013; World Health Organization 1992). Both diagnostic classifications - ICD-10 and the classification of the American Psychiatric Association – DSM, unequivocally require that the diagnosis of conversion / dissociative disorder should be stated only after excluding active psychoactive substance use, neurological disorders and disorders associated with somatic conditions. According to the newest, fifth edition of the Diagnostic Statistical Manual (DSM-5) (American Psychiatric Association 2013) dissociative disorders are defined as a separate category, and conversion disorders are included in the category of somatoform disorders. In the ICD-10 the terms “conversion” and “dissociation” are used interchangeably, but the latter one is used more frequently. This is due to the suggested psychodynamic etiology that is associated with the word “conversion” - that is, the suppression of unacceptable desires and their "conversion" into the somatic symptoms (World Health Organization 1992). This also enables us to avoid defining classified terms with the concepts emerging from certain psychological theories (Isaac 2005). The authors used the ICD-10 while describing the present case. According to this classification, dissociative/con-

version disorders are characterized by the total or partial loss of proper integration of memories of the past, the sense of self-identity, sensory sensations and control of body movements, combining, unlike the DSM-5, impaired cognitive and motor functions. This category includes only somatic dysfunctions that are normally under conscious control and disorders characterized with the loss of sensory perception. Disorders involving pain and other complex somatic sensations associated with the activity of autonomic nervous system are classified as somatoform disorders (F45.0). According to the DSM-5, the term "dissociation" is used for disorders of consciousness and memory, while the term "conversion" for motor and sensory impairments – hence, dissociative disorders form a separate group, while conversion disorders are included in the group of somatoform disorders. According to the ICD-10, conversion (dissociative) disorders have a psychogenic origin and are closely related in time with traumatic events, unmanageable and intolerable situations, or with disturbed relationships with the environment. The symptoms often are a reflection of patients' ideas about how a somatic disease is manifesting itself. In addition, the loss of function is an expression of psychological needs and conflicts (World Health Organization 1992). Conversion (dissociative) disorders are often associated with symptoms such as: pseudoseizures, visual disturbances - double vision, blindness, tunnel vision, impaired perception of external stimuli, vocal cord dysfunctions (aphonia, articulation disorders - metathesis, paralalia), hearing impairment, psychogenic movement disorders and pseudoparalysis and puerilism (Cottencin

2014, Verhoeven 2005). Patients do not produce these symptoms consciously and cannot control them, which distinguishes conversion disorders from factitious disorders (Munchhausen syndrome). Differentiating conversion disorder from organic mental disorders is particularly difficult and requires the additional diagnostic procedures to exclude organic causes. “Red flags” that point to dissociative conversion disorder include an interview of recurrent somatic complaints of unexplained background, frequent diagnostic procedures with inconclusive results and time correlation between the occurrence of symptoms and a traumatic factor (rape, the loss of loved ones, disaster) (Feinstein 2011, Kanaan 2011). When choosing a method of treatment for a patient with conversion disorder (range, form or psychotherapeutic technique) particular attention should be paid to the nature of the disorder and the patient's general condition.

## **CASE REPORT**

A 50-year-old patient was admitted to the Closed Ward of the Clinic of Psychiatry and Psychotherapy of Silesian Medical University in Katowice in May 2014 with a diagnosis of mixed dissociative (conversion) disorders (F44.7 according to the ICD-10). It was her first psychiatric hospitalization. Since August 2012 she had been treated in an outpatient mental health unit. Objective findings on mental status examination included the following: full orientation; maintained eye contact and cooperative behavior, difficult verbal contact due to speech disorders, depressed mood, tearfulness, slightly reduced psychomotor drive. She denied suicidal or homicidal ideations or psychotic symptoms. She complained of severe anxiety during the day (with no identified cause), problems with concentration, disturbed first and third phase of sleep. During the study, the patient presented speech disorders: stuttering, nasal speech, replace the consonants (g → d, k → t), she used similar-sounding words denoting something else, she used many diminutives, she modulated her voice and body poses as seen in puerilism.

### **Family history**

The patient was brought up in a full family as a single child. She was born and grew up in a big city, in an industrial district. When she was in the primary school, she had to move with her parents to the countryside due to their jobs. The patient identified it as a particularly difficult experience - after returning to the previous place of residence she has been experiencing difficulties in adapting to the new environment and in establishing relationships with peers, which lead her to skipping classes in secret from her parents. The possessive attitude of her parents also disrupted her contacts with peers, as she was being made to spend all of her free time on education and household responsibilities.

She was often punished physically by her father on her mother's command, even for minor misbehavior. The patient presented her mother as a raw, emotionally frigid person, focused mainly on the patient's results in education, applying physical and mental violence to the patient even in adulthood and constantly interfering in her personal life and intimate relationships. She described her father as indifferent to her problems, subordinated to her mother's decisions and abusing alcohol to alleviate negative emotions arising from the domestic situation. As a teenager, the patient made several attempts to rebel through secret meetings with friends and her first boyfriend, which ended quickly due to the intervention of her mother. Being in her early twenties, she married a man after a brief relationship and got pregnant, which she now identifies as an attempt to escape from her parents. Two years after they decided to divorce, according to the patient due to her husband's emotional immaturity. In order to prove to her mother that she can manage, the patient made a successful attempt to bring up her daughter without any support, at the same time working and constantly raising her qualifications. The relationship with her mother has changed to a more reserved one when the patient happily married her second husband in 2005.

### **History of mental health problems**

Patient's mental health problems began in July 2012 after she was moved to a lower position at work in connection with a long period of being on a sick leave due to rehabilitation treatment of spinal osteoarthritis. The patient has been working for nineteen years for an insurance company, eight years of which in an executive position as a supervisor of ninety agents. While being on a sick leave, she received a phone call from her employer who informed her that she has been degraded to a lower position. The patient reported that after that conversation her speech became incomprehensible, but she was unaware of that. She was also experiencing generalized anxiety, tearfulness, hands sweating, and a significant reduction of sleep quality. Three days after this event, the patient was found unconscious at home by her daughter and taken to the Department of Neurology. Predominant symptoms were headache, spine ache, and slurred speech. Neurologopedic consultation was performed, which described distinctive slowing of speech due to the difficulty in pronouncing words, a tendency to chant and/or clonic stuttering of variable severity, impaired naming and repetition, and functional phonation disorder. Further diagnostic tests included head imaging (computed tomography, magnetic resonance imaging), which showed no brain pathology, electromyography (nerve conduction in the upper and lower limbs within normal) and vascular Doppler ultrasound of the neck (correct carotid and vertebral flow). After eleven days in the Department of Neurology, the patient was discharged with a diagnosis of

somatoform disorder (F45.0) with a recommendation to continue treatment at a mental health clinic. After leaving the hospital in August 2012, she began outpatient mental health treatment, where she was diagnosed with mixed dissociative (conversion) disorders (F44.7). Psychopharmacotherapy was administered: 20 mg of fluoxetine per day and 1 mg of lorazepam in case of a panic attack. After the treatment the patient reported no improvement. In February 2014 there was a worsening of anxiety symptoms with panic attacks (F41.0) (it used to be her main ambulatory diagnosis at that time) mainly in public transportation and worsening of speech disorders which the patient associated with the death of her mother-in-law and being called as a witness in the case of one of her subordinate insurance agents. Then, due to the severe breathlessness, bronchodilators were administered. In addition, she was experiencing anxiety in the morning and in the evening, agoraphobia and the fear of being in the house alone. According to the patient's daughter, before the symptoms started she was an energetic and feisty person, the change which took place was so radical that the daughter decided to give up her own veterinary practice to take care of her mother. The patient was hardly ever leaving the house, she neglected self-care and was spending most of the time in bed, paresis of the lower limbs occurred.

### **The course of hospitalization**

During the hospitalization on the Closed Ward, neuroimaging and neurological consultation were performed, which excluded organic background of presented symptoms. Psychological examination was performed (Minnesota Multiphasic Personality Inventory (MMPI), Structured Clinical Interview for DSM-IV Axis II Disorder (SCID-II) and an interview with a psychologist). The description of psychological examination indicated a conversion reaction under severe stress, as the symptoms were causally related to the traumatic event (being moved to a lover position at work and subsequent impairment of speech the next day with an occurrence of infantile features in her behavior). In relation to superiors the patient functioned as a child and was trying to "earn love and praise." Cognitive functions tests did not indicate any impairments. The patient showed features of histrionic and dependent personality style, but she did not meet the criteria for personality disorders. The patient was consulted by a speech and language pathologist, who described presented speech abnormalities as logoneurosis. Compared to the state described two years before at the Neurology Department, cluttering was predominant, stuttering remitted, speech became more fluent and speech rate was significantly accelerated. The articulation of individual sounds, syllables, words, sentences still contained numerous extensions and inclusions of sounds, inversions, anticipations, perseverations and palatalizations.

In stressful situations the above-mentioned speech abnormalities escalated and verbal communication was becoming much more difficult. During the stay, lorazepam was gradually discontinued (initial dose was 2 mg per day). The patient was discharged in June 2014 in stable condition (anxiety level decreased, the patient claimed better concentration, no problems with falling asleep and less frequent waking during the night) with a recommendation to undertake individual or group psychotherapy.

The continuation of treatment started in July 2014. During the hospitalization, the patient was focused mainly on somatic symptoms, such as back pain, headache and mild vertigo. The patient presented no problems in relationships with other patients and actively took part in therapeutic activities (psychodynamic group psychotherapy, music therapy, art therapy, psychoeducation with elements of psychodrama regarding neurotic disorders, relaxation - mainly autogenous techniques), although therapists noticed that the patient was reluctant to work on her own problems during the group meetings – she was more eager to discuss other patients' issues. When she was being motivated to undertake the work on her own problems, she presented worsening of the speech disorders symptoms, which was especially noticeable when the patient presented her life history. During individual talks with the therapist, the patient worked on the explanation and her better understanding of psychological mechanisms of forming and meaning of her symptoms. Over the course of the therapy the patient obtained a partial insight into the psychological background of her symptoms. She was discharged home in August 2014 in stable psychosomatic condition, speech impairments became slightly less severe and frequent than on admission. According to the patient and confirmed by the staff, also the symptoms of anxiety and sleep disorders resolved themselves. During the second hospitalization the patient was not receiving any psychiatric medications. The patient was recommended to continue individual psychotherapy in an outpatient setting.

### **DISCUSSION**

In the present case, the negative patterns of family relationships – emotionally cold, strict, mother, who was violating boundaries and father addicted to alcohol, indifferent to the domestic situation – which at the same time provoked the patient to revolt and to strive for acceptance by her mother. During the hospitalization, it was noticed that she functioned as a child towards the superior and was trying to "earn the love and praise", which manifested itself in being overly nice and polite and frequently apologizing for her behavior. The patient felt that her mother created an emotional distance and coldness, blocking tenderness and closeness. Losing her

position at work (90 subordinates, 19 years of work), while her co-workers appreciated, respected and liked her – can be interpreted as a loss of a mother figure and a collapse of the existing mechanisms of functioning, which could be a cause of regression and conversion reaction. The occurrence of speech disorders may also suggest problems with expressing anger verbally – she was given no opportunity to disagree ("right to speak") with her parents, she also lost it after being degraded at work. The lack of complete remission of speech disorders in our patient may result from the difficulty in understanding and accepting the psychogenic background of the symptoms produced and confirms the fact that the treatment of conversion disorder requires long-term psychotherapy. Existing literature on conversion disorders of speech is limited (Nazarov 2015), therefore this case aims to complete the knowledge of various forms of conversion disorder.

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**Conflict of interest:** None to declare.

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