

PSYCHOGENIC STUTTERING - CASE REPORT

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INTRODUCTION

Stuttering is a speech disorder characterized by the involuntary repetition, prolongation or cessation of sound (Almada et al. 2016). The prevalence in the general population is approximately 1% (Tran et al. 2011, Garnett et al. 2019). The incidence among adults (21-50 years) is 2.1% (Tran et al. 2011). Stuttering can be developmental or acquired and acquired can be neurogenic or psychogenic (Almada et al. 2016). Psychogenic stuttering is a conversion symptom whose cause is of an emotional nature. A conversion disorder suggest a physical disorder but is, in fact, an expression of a particular mental conflict.

For stuttering to be diagnosed as a conversion symptom, the change in speech pattern must be symbolically related to an emotional conflict in the presence of a primary or secondary gain and a lack of organic etiology, and it must fulfill at least one of the following associated symptoms: a history of mental health problems, lack of an emotional response to stuttering, consistency of stuttering in different situations (Mahr & Leith 1992).

Stuttering often occurs in comorbidity with major depressive, anxiety, somatization and personality disorders (including the histrionic type) (Iverach et al. 2009a,b, Boyle 2016, Tran et al. 2011). The existence of comorbidities adversely affects the course of treatment and the prognosis of stuttering symptoms and should therefore be recognized and treated as soon as possible (Iverach et al. 2009b).

CASE REPORT

This paper shows a 50-year-old patient, married, mother of three, a clerk, who has been on sick leave for the last 4 years. She was born after an ordinary pregnancy and birth, into a complete family consisting of a mother, father and an older half-sister. She was breastfed and her early psychomotor development progressed unremarkably. The father was an alcoholic who physically and mentally abused his wife and the patient from a very young age. The mother attempted

suicide several times by cutting her wrists, but the patient found and rescued her every time. She completed elementary and secondary school with a very good grade point average and dropped out of university due to a lack of interest. She had adequate interactions with her classmates. She was married for the first time at the age of 19 and two children were born from that marriage. During her second pregnancy, her husband died in the workplace. After a few years, she remarried and gave birth to her third child, and has been in a harmonious, but loveless, marriage ever since. She currently lives with her husband and children and takes care of her infirm parents.

She contacted a psychiatrist for the first time eight years ago, after experiencing an armed attack in the workplace. She has been hospitalized three times so far and is undergoing regular outpatient and/or day-hospital psychiatric treatment for recurrent depressive disorder, post-traumatic stress disorder and histrionic personality disorder. In the course of treatment, we learned of a series of somatizations for which she has been treated so far by a large number of different specialists. No organic or physiological causes of most of her disorders have been detected. The psychologist's findings state: the patient's anxiety manifested by the occurrence of somatic problems, a depressive affective tone, lowered self-esteem, emphasized issues in relationships within the primary family, a tendency to feel guilty, the dominant mechanisms of defense are intellectualization and negation, no developed compensatory mechanisms.

The patient lost consciousness a year ago, suffering a concussion. The aforementioned occurred after ingestion of a larger quantity of prescribed psychotropic medication which she took in an attempt to subside polymorphic locomotor issues. She has since started to stutter. She has never stuttered before in her life. The otoscopic findings were bilaterally good. A computed tomography (CT) of the brain was performed that did not show the presence of recent brain changes. The electroencephalogram (EEG) finding was also good.

The patient has been treated with a combination of psychoactive drugs (antidepressants, antipsychotics, anxiolytics, hypnotics) and individual psychotherapy.

DISCUSSION

Stuttering in adulthood is a relatively rare clinical entity. In order to be diagnosed with psychogenic stuttering, it was first necessary to exclude the organic and/or physiological causes of stuttering, which was done on the basis of neurological and otorhinolaryngological examination, as well as an EEG and a CT of the brain.

Repetitive and prolonged traumatization within the primary family, beginning at an early age when the defense mechanisms of the ego were still immature, adversely affected the emotional development and subsequent adaptive capacity in the patient. Parental abuse of authority and neglect have led the patient to a desperate need for love and security. All of the above resulted in a deficit and distortion of intrapsychic structures and object relations, and a cumulation of unconscious psychic conflicts reflected in numerous somatizations. Stuttering occurred at a stressful time in the patient's life when somatizations were no longer a sufficient "outlet". Probably, it has a symbolic meaning and represents the patient's difficulties in expressing her own hidden thoughts and feelings.

Stuttering as a conversion symptom allows for the symbolic resolution of unconscious psychological conflicts by keeping them unconscious (primary gain), and provides the patient with additional attention from important others which she has been desperate for since childhood (secondary gain).

The patient's stuttering pattern is reflected in the repetition of initial or stressed syllables, it is consistent in all situations, and there are no attempts to inhibit stuttering. In view of all the above, the patient meets the previously mentioned criteria for the diagnosis of psychogenic stuttering.

CONCLUSION

Differential diagnosis between psychogenic and neurological stuttering is complex and requires an individualized and multidisciplinary treatment of the patient. Psychiatric comorbidities can significantly affect the ability to maintain fluency after speech restructuring treatments and therefore need to be treated concurrently with (speech) stuttering therapy as well as after it. In

addition, the patient should be included in an intensive psychotherapy setting that would allow for the processing of unconscious emotional conflicts and their mature integration into the personality.

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Ana Došen - examination of the patient and taking a medical history, manuscript writing;

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Klementina Ružić - literature searches, manuscript writing;

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