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Spastic Dysphonia; Untieing or Cutting the Knot

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Spastic dysphonia has also been called laryngeal stuttering because voiced speech sounds are arrested in the middle of a word. The blocks alternate with explosive or croaking laryngeal noises.

In a review of 21 patients with spastic dysphonia little relation was found between organic deviations and the voice symptoms. A majority had experienced emotional difficulties at the time of onset of the symptoms. The patients are often characterized as reliable persons with a strong sense of duty and a rigid personality, sensitive and easily hurt. As an explanation of this rare voice disorder the following hypothesis is offered. When a person meets with a difficulty that transcends his capacity for solving problems by social skills, he may regress to lower level defense systems such as tenseness, inhibition and internalized aggression. This accounts for the symptoms: narrowing of the throat, respiratory inhibition, tenseness and tremor. Once this protective device has started it may be reinforced by sympathetic responses from the environment, such as elaborate medical attention. Still later it may solidify into a habitual sensomotor automatism.

This theory is supported by the pathogenetic history of many patients. The first manifestations of vocal instability and laryngeal spasm were treated by inadequate procedures such as vocal rest, steam inhalations, antibiotics and tranquillizing drugs. The disorder was thus allowed to progress to a stage of secondary organic fixation, where voice treatment and psychotherapy could not help anymore. Another supporting fact for a psychogenic theory is that there is consensus among experienced voice therapists that the incipient stages of spastic dysphonia are amenable to voice therapy and in several cases have led to a complete cure, whereas in fully developed cases a complete cure has never been attained. Therefore it seems a good advice that as soon as the possibility of a psychogenic disorder is recognized, immediate adequate help be given to the patient in the form of reeducation of his ability to cope with emotional problems and fundamental training to reestablish control over his voice. Examinations with electronic equipment (electromyography, electroencephalography, electroglottography) which satisfy the needs of the diagnostician can better be postponed till after the patient is well on his way towards recovery. Otherwise this could very well lead the patient away from recognizing the true nature of his disturbance.

Surgical alleviation of the spasm by cutting one of the recurrent laryngeal nerves, as recently reported by *Dedo* (1976), is a possibility in otherwise intractable cases. Instead of proving that the patient has had an organic disorder from the onset, as has been thought, it testifies that he has not received an appropriate treatment when the disease was still in the stage of a functional disorder.

References

Aronson, A.: Spastic dysphonia. Part 1, 2. J. Speech Hear. Disorders *33:* 203, 219 (1968).
Bloch, P.: Neuro-psychiatric aspects of spastic dysphonia. Folia phoniat. *17:* 301–364 (1965).
Dedo, H.: Recurrent laryngeal nerve section for spastic dysphonia. Annls Oto-lar. *85:* 451–459 (1976).