
Psychogenic Spasmodic Dysphonia and Psychogenic Dysphagia Following Neck Trauma and Domestic Violence: A Case Report

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Abstract

Psychogenic spasmodic dysphonia and psychogenic dysphagia are functional disorders of voice and swallowing in which symptoms are disproportionate to structural findings and closely linked to psychological conflict or trauma. A 35-year-old woman presented with sudden inability to swallow solids, liquids, and saliva, accompanied by severe dysphonia, neck pain, dyspnea, nausea, and vomiting, three days after fever and sore throat. She denied trauma despite mild neck erythema and was treated for suspected epiglottitis with steroids and antibiotics; a nasogastric tube passed easily, arguing against obstruction. After three days, flexible fiber-optic endoscopy showed no inflammation or masses in the nasal cavity, nasopharynx, or oropharynx, while laryngoscopy demonstrated bilateral spasmodic vocal fold movements with incomplete glottic closure and no aspiration. In light of the discrepancy between severe symptoms and normal findings, repeated, supportive interviewing led to disclosure of intimate partner violence involving strangulation, lifting by the neck, and impact against a wall. Antibiotics were stopped, steroids tapered, and psychiatry initiated anxiolytics and counseling, with marked improvement of swallowing and voice within one day and safe discharge. This case underscores the need to consider psychogenic etiologies and domestic violence in acute dysphagia and dysphonia with normal structural evaluation and highlights the importance of trauma-informed, iterative history-taking and multidisciplinary care.

Keywords: *Psychogenic Spasmodic Dysphonia, Psychogenic Dysphagia, Neck Trauma, Domestic Violence, Case Report.*

INTRODUCTION

Spasmodic dysphonia, also known as laryngeal dystonia, is a focal dystonia of the intrinsic laryngeal muscles characterized by involuntary spasms during speech, leading to strained, strangled, or breathy voice with voice breaks while most non-speech laryngeal functions remain relatively preserved. It predominantly affects women in midlife, is typically chronic, and is diagnosed by characteristic task-specific voice disruption on perceptual assessment combined with laryngoscopic evidence of abnormal vocal fold movement during phonation.

The causes of spasmodic dysphonia are multifactorial and incompletely understood; current evidence supports a neurologic basis involving abnormal sensorimotor control and basal ganglia–cortical circuitry, with possible contributions from genetic susceptibility, environmental triggers, and maladaptive plasticity. Reported triggers or temporal associations include upper respiratory infections, minor laryngeal injury, excessive voice use, and psychological stress, and a subset of patients exhibit overlapping features with other forms of focal dystonia.

Psychogenic or functional voice disorders, including psychogenic dysphonia and psychogenic variants of spasmodic dysphonia, are characterized by loss or alteration of voice in the absence of sufficient structural or neurologic pathology, where symptoms are closely related to psychological processes such as anxiety, depression, conversion disorder, or traumatic stress. Clinical series demonstrate that onset often follows emotionally taxing circumstances, interpersonal conflict, sexual or physical assault, or other traumatic stressors, with laryngoscopy frequently showing non-organic patterns such as hyperconstriction, paradoxical movements, or inconsistent findings.

Both physical and psychological trauma may act as triggers or maintaining factors for psychogenic voice disorders and can interact with underlying neurologic vulnerability. Non-fatal strangulation in the context of intimate partner violence is increasingly recognized as a cause of acute

and chronic voice changes, dyspnea, and dysphagia, with both direct laryngeal injury and profound psychological trauma contributing to symptomatology.

Psychogenic dysphagia is a functional swallowing disorder defined by difficulty or refusal to swallow in the absence of structural, neuromuscular, or systemic disease sufficient to explain symptoms. It is associated with anxiety disorders, depression, post-traumatic stress, abnormal grief, and intrapsychic conflict, and patients frequently report fear of choking, sensation of obstruction, nausea, or vomiting despite normal endoscopic and radiologic assessments, often requiring multidisciplinary evaluation including ENT, gastroenterology, speech-language pathology, and psychiatry.

RESEARCH METHODS

A 35-year-old woman with no documented history of neurologic disease, prior voice disorders, structural esophageal pathology, or major medical comorbidities presented to the emergency department with sudden inability to swallow and speak that started 6 hours before arrival. She reported painful swallowing, anterior neck pain, shortness of breath, nausea, and repeated vomiting, and described a febrile sore throat three days earlier suggestive of antecedent upper respiratory infection.

She denied any recent neck trauma or accidents and did not initially reveal interpersonal violence, which is consistent with literature describing under-reporting of intimate partner violence due to fear, shame, dependence, and concern for retaliation. There was no initially reported psychiatric history, although later assessment identified acute stress related to domestic conflict and features of anxiety, consistent with frequent comorbidity between psychogenic swallowing or voice disorders and anxiety or trauma-related conditions.

Clinical findings

On arrival, the patient appeared anxious and distressed, with minimal phonation and strained, nearly aphonic attempts at speech. She was unable to swallow solids, liquids, or even saliva, leading to pooling and frequent spitting of saliva and vomitus, which raised concerns for severe dysphagia and aspiration risk.

Physical examination showed only slight erythema on the left side of the neck without obvious bruising, lacerations, swelling, crepitus, or deformity, and oropharyngeal inspection did not reveal tonsillar exudates, peritonsillar bulging, or obvious supraglottic swelling. Vital signs were stable enough to allow bedside evaluation, and there were no focal neurologic deficits; however, the profound functional impairment in swallowing and voice contrasted with relatively benign oropharyngeal findings.

Timeline

3 days before presentation: Onset of fever and sore throat; no medical evaluation sought.

6 hours before presentation: Sudden onset of inability to swallow solids, liquids, and saliva, accompanied by severe dysphonia, neck pain, dyspnea, nausea, and vomiting.

Emergency department (Day 0):

History of febrile sore throat reported; neck trauma denied.

Mild unilateral neck erythema observed.

Testing with water and solid food resulted in immediate vomiting and failure to swallow.

Nasogastric tube placed smoothly, suggesting no mechanical upper esophageal obstruction.

Diagnosed with suspected epiglottitis; admitted and treated with intravenous antibiotics and systemic steroids.

Days 1–2: Persistent dysphagia and dysphonia with no meaningful improvement; patient remained unable to eat, drink, or swallow saliva despite therapy.

Day 3:

Flexible fiber-optic endoscopy performed; nasal cavity, nasopharynx, and oropharynx appeared normal without edema, hyperemia, exudates, or masses.

Laryngoscopy showed bilateral spasmodic movements of the vocal folds with incomplete glottic closure during phonation and no aspiration of saliva.

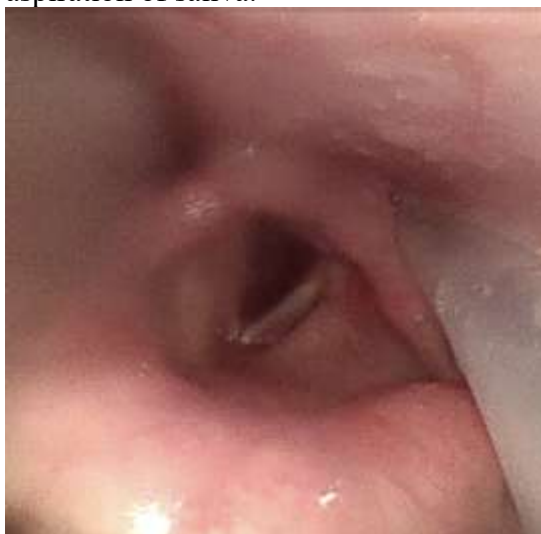


Figure 1. Opening of vocal cord during inspiration, showing the ability of maximum abduction of the vocal cord. No aspiration was observed



Figure 2. Incomplete closure of vocal cord during phonation, showing the impaired adduction.



Figure 3. Occasional complete closure of the vocal cord happening outside of phonation attempt, showing the ability of maximum adduction.

Clinician discussed the mismatch between severe symptoms and normal structural findings and conducted further, supportive history-taking.

Patient disclosed domestic violence with neck strangulation, being lifted by the neck, and being struck against a wall by her husband.

Antibiotics discontinued; steroids tapered; psychiatry consultation requested.

Day 3–4: Psychiatric assessment identified acute stress and anxiety after intimate partner violence; anti-anxiety medication and counseling initiated.

Day 4: Marked improvement in swallowing and voice; patient tolerated oral intake, nasogastric tube removed, and she was discharged with outpatient psychiatric and ENT follow-up.

Diagnostic assessment

The initial working diagnosis was epiglottitis or supraglottitis, given the history of recent fever, sore throat, neck pain, and severe dysphagia, which are classic features of acute supraglottic infection requiring urgent treatment to prevent airway compromise. The presence of severe swallowing difficulty and vomiting with attempts to ingest solids and liquids raised concern for mechanical obstruction, but smooth passage of the nasogastric tube suggested patency of the upper esophagus and absence of significant luminal blockage.

Flexible fiber-optic endoscopy is considered a key investigation in evaluating acute dysphagia and dysphonia, as it enables direct visualization of the nasal cavity, nasopharynx, oropharynx, larynx, and hypopharynx to detect mucosal inflammation, edema, exudates, masses, or structural injury. In this patient, endoscopy revealed normal nasal cavity, nasopharynx, and oropharynx, ruling out many infectious and structural causes such as epiglottitis, peritonsillar or parapharyngeal abscess, and obstructing tumors, while laryngoscopy demonstrated bilateral spasmodic vocal fold movement with incomplete glottic closure and no aspiration, a pattern compatible with functional or psychogenic dysphonia rather than paralysis or fixed stenosis.

The striking discrepancy between severe symptoms and absence of structural pathology prompted consideration of psychogenic etiologies; classic descriptions of psychogenic dysphonia emphasize loss of volitional control over phonation without adequate organic explanation, often occurring in temporal association with emotional or traumatic events and sometimes misdiagnosed as neurologic or inflammatory disease. Psychogenic dysphagia similarly presents with disproportionate swallowing difficulty and fear of choking despite normal imaging and endoscopy, and is frequently

linked to anxiety, depression, post-traumatic stress, or grief, making careful psychosocial history-taking essential.

Only after empathetic re-interviewing and explaining that the physical findings did not match an infectious etiology did the patient disclose non-fatal strangulation and assault by her husband. Non-fatal strangulation has been documented as a severe form of intimate partner violence associated with immediate airway, vascular, and neurologic risk, as well as persistent voice changes, dysphagia, and profound psychological trauma including post-traumatic stress disorder. In this case, the absence of structural laryngeal injury on endoscopy and rapid improvement after psychiatric intervention supported a diagnosis of psychogenic spasmodic dysphonia and psychogenic dysphagia, rather than organic post-strangulation damage.

Therapeutic interventions

Initial management focused on presumed epiglottitis, including hospital admission, airway monitoring, intravenous broad-spectrum antibiotics, systemic corticosteroids, and nasogastric tube placement to maintain hydration and nutrition while minimizing aspiration risk. This approach was appropriate to cover life-threatening infectious etiologies in the early phase when complete diagnostic clarification was not yet available, particularly given the report of fever and sore throat.

Once endoscopic evaluation demonstrated no inflammatory or structural pathology in the upper airway or pharynx and revealed a functional laryngeal pattern, and the history of domestic violence with strangulation was uncovered, the treatment strategy shifted toward addressing psychogenic factors. Antibiotics were discontinued to avoid unnecessary antimicrobial exposure, and steroids were tapered, while the nasogastric tube was maintained temporarily for safe nutrition until swallowing improved.

A psychiatry consultation was obtained, consistent with recommendations that suspected psychogenic dysphagia or dysphonia be managed by a multidisciplinary team including mental health professionals. The patient was started on anti-anxiety medication and received supportive counseling focused on acute trauma, emotional responses, and coping strategies, and she was encouraged to speak about her experiences in a safe environment, which may help restore volitional control of phonation and swallowing in psychogenic disorders. Safety planning and referral to appropriate social and legal support services are also advised in cases of intimate partner violence, although specific legal interventions may vary by jurisdiction.

Follow-up and outcomes

Within one day of initiating psychiatric treatment and providing a clear explanation that her airway and swallowing structures were intact, the patient experienced marked improvement in both swallowing and voice. She was able to swallow saliva, liquids, and gradually advancing textures without vomiting or signs of aspiration, and her voice became audible and functional, although still mildly strained initially.

The nasogastric tube was removed after confirming adequate oral intake and safe swallowing, and she was discharged with instructions for outpatient follow-up with psychiatry and ENT/speech-language pathology to monitor sustained recovery and address any residual voice or swallowing issues. Psychogenic dysphagia and dysphonia can relapse under renewed stress, so ongoing psychological support and monitoring for recurrence of domestic violence are important components of long-term care.

RESULTS AND DISCUSSION

Mismatch between signs and history

In this case, the patient's severe dysphagia and dysphonia, combined with minimal objective findings and normal endoscopy, did not fit the initial history of uncomplicated upper respiratory infection. Psychogenic voice and swallowing disorders should be considered when there is a mismatch

between symptom severity and structural findings, especially when investigations exclude major neurologic, structural, and infectious causes.

Psychogenic dysphonia is defined by loss or alteration of voice without sufficient organic pathology, with symptom onset often temporally linked to psychological conflict or traumatic events and sometimes reflecting symbolic themes related to the trauma (“conflict over speaking out”). Psychogenic dysphagia similarly presents with disproportionate fear of swallowing and choking, often linked to anxiety, trauma, or grief, and requires exclusion of structural causes by endoscopy or imaging before a functional diagnosis is made.

Barriers to accurate history in domestic violence

Physicians’ attempts to obtain an accurate history can be hampered by social and emotional factors, especially in the context of intimate partner violence. Survivors of non-fatal strangulation may conceal abuse due to fear of retaliation, economic dependence, emotional attachment, or shame, leading to incomplete or misleading histories that delay diagnosis.

Studies on non-fatal strangulation in domestic violence show high rates of physical and psychological sequelae, including voice changes, dysphagia, cognitive impairment, anxiety, and post-traumatic stress, yet disclosure to healthcare professionals is often limited unless clinicians ask sensitively and repeatedly in a safe environment. Trauma-informed care emphasizes validating the patient’s distress, avoiding blame, ensuring privacy, and using open-ended questions, which can gradually increase willingness to share personal information that is critical for accurate diagnosis.

Role of endoscopic evaluation

When encountering patients with dysphonia and dysphagia, endoscopic evaluation of the vocal folds and swallowing, when feasible, is crucial to differentiate organic from functional etiologies and to assess the coordination of laryngeal movements. Flexible fiber-optic laryngoscopy and, when indicated, fiberoptic endoscopic evaluation of swallowing (FEES) allow direct visualization of supraglottic structures, vocal fold motion, pooling, penetration, and aspiration.

In psychogenic voice disorders, laryngoscopy often shows inconsistent or non-physiologic movement patterns—such as excessive supraglottic constriction, paradoxical vocal fold motion, or variable spasmodic activity—without structural lesions, helping distinguish them from paralysis, structural stenosis, or neoplasms. Similarly, in psychogenic dysphagia, normal mucosa and biomechanics with absent aspiration despite reported severe difficulty support a functional diagnosis, provided that subtle neurologic causes are excluded.

Psychogenic mechanisms and rapid response to therapy

The rapid improvement in this patient’s swallowing and voice after disclosure of trauma, reassurances about structural integrity, and initiation of psychiatric treatment is characteristic of psychogenic disorders, where symptoms often resolve once intrapsychic conflicts are addressed and the patient regains a sense of safety and control. Multidisciplinary management combining ENT, psychiatry/psychology, and speech-language therapy is recommended in psychogenic dysphagia and dysphonia to address both functional patterns and underlying psychological stressors.

CONCLUSIONS

Psychogenic causes of dysphonia and dysphagia must be included in the differential diagnosis when clinical manifestations are severe but endoscopic and neurologic evaluations are normal and the patient’s history is incongruent with objective findings. In such scenarios, repeated, trauma-informed, and empathic history-taking is essential, particularly where domestic violence and non-fatal strangulation are possible, because social and emotional barriers may initially prevent disclosure of critical information needed for accurate diagnosis and safe management.

Clinicians should systematically perform laryngeal and swallowing endoscopy when available in patients with dysphagia and dysphonia to assess structural integrity and functional coordination,

helping to distinguish organic from psychogenic etiologies and avoid unnecessary antimicrobial or surgical interventions. Sometimes there are limits to how far physicians can probe for personal history at a single encounter, and time, trust, and ongoing support are required for patients to feel safe enough to share experiences of trauma that underlie psychogenic communication and swallowing disorders.

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