



Themes of Intra-psychic Conflict in Communication Disorders having Psychogenic Origin

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Abstract

Although 4-5 % of clinical population manifests symptoms having psychogenic origins, available research on the subject is scarce. There is no unanimity on its nomenclature, classification, presentation, differential characteristics or clinical manifestations. Such individual are often misunderstood by professionals and their family members as liars, fakers, tricksters, showmen, cheats, conmen, and those with evil design. The absence of an organic evidence to explain their physical symptoms does not entitle such negative and unhelpful opinions. There is need for change in this outlook. An attempt is made to redefine this erroneous perspective in favor of viewing the illness as a different rather than deviant form of communication through body language symptoms which are unconscious and symbolic. It is their profitable medium or cry for help to get over an unspeakable or inexpressible personal tragedy. Case vignettes are dotted in the text with details on ongoing research and a discussion on implications for therapy.

Key Words: Malinger-Spectatoring-Conversion Reaction-Factitious Disorder

1. Introduction

Speech, language, hearing, communication, swallowing and other upper aero-digestive disorders come in variety of forms. Speech disturbances may relate to articulation, fluency, resonance, and voice including aeromechanical components of respiration. Language difficulties may be to do with phonology, morphology, syntax, semantics and pragmatics, or social aspects of communication. It could be to do with receptive or expressive language in oral, written, graphic and manual modalities. It could also be linked to language processing; pre-literacy and language-based literacy skills like phonological awareness. Swallowing or other aero-digestive functions relate to disturbances like feeding or ingestion (Guilford et al. 2007; Hicks, 2006; Shames and Anderson, 2002). Speech disorders can arise in various parts of the nervous system, muscles and other apparatus involved in speech leading to inability to communicate effectively. Some are disturbances of language rather than speech resulting from an impaired ability to understand rather than a defect in the apparatus of speech production.

Hearing impairment or deafness may be complete or partial inability to hear. Total deafness is usually congenital. Mutism-refusal or inability to speak-is a symptom of profound congenital deafness. Professionals recognize three inter-related yet distinct areas of communication problems in speech, language and/or hearing across the life span in individuals. The clinical conditions that are addressed may include disorders of swallowing-feeding, language, speech, voice and resonance, disturbances related to pre/post head and neck surgery, patients with tracheotomy or endotracheal tube, or following certain pharmacological, surgical or rehabilitation (ISHA 2010; ASHA 1996).

2. Psychogenic Origins: Myth of Body-Mind Dualism

The ancient Greeks believed that health, beauty and happiness can be achieved by adopting a life style of moderation. Paracelsus (1493-1541), father of modern medicine, insisted on treating the whole being rather than merely the part displaying disease. This concept called holism contrasting earlier mind-body dualism evolved into notions of stress or mental states impacting physical health. Chronic physical conditions in the absence of organic pathology identifiable in medical terms are the most perplexing conditions. They pose great challenges in terms of diagnosis and treatment. The dichotomy of mind-body underpinning medical understanding is a barrier to their successful diagnosis and treatment. This duality as either physiological or psychogenic is being increasingly questioned by positing an 'integrative model'. Further, it is argued that a multidisciplinary approach is needed for a radical deconstruction of the ongoing medical model to truly address the problem and enable a real change in practice (Plog and Edgerton, 1969).

3. Communication Disorders Involving Non-Organic Conditions

Symptoms manifesting as disturbances in communication having psychogenic origins can manifest at any time in the life span of an individual. It can occur as developmental receptive-expressive speech delay during preschool owing to impoverished linguistic environments. Many clinical cases of young children, well-provided for their physical needs, but deprived of early speech-language stimulation have ended into developmental receptive-expressive speech delays. The mere provision for a fertile linguistic environment through milieu therapy has repaired such children at risk for a life-long communication disability (Haynes, Moran and Pindzola, 2010).

There are several clinical disturbances in communication due to organic involvement or structures in the brain, such as, agnosia, neurogenic stuttering, etc. These are not under the purview of this paper. There are also conditions owing to anomalies in working of the brain, such as, dysfunctional neurotransmission in schizophrenia leading to echolalia, neologisms, pressure of speech, verbal diarrhea, incoherent or irrelevant speech. These psychotic illnesses are also not addressed in this paper. The focus is only on psychogenic communications disorders.

3.1 Prevalence

Psychogenic Communication Disorders (PCD) are important in the practice of audiology and speech language pathology. They account for 4-5 % of clinical population and yet under-represented in literature (Kothe et al, 2003). Most prevalence studies on nonorganic hearing loss, for example, have been carried out on defense personnel thereby giving an impression of its greater occurrence in males (Burgoon, Buller and Woodall, 1989). It is postulated that women are more likely to lie to protect others, while men more frequently resort to fabrication as a means toward personal gain. Regardless of any possible gender difference in adults with nonorganic hearing loss, it is unlikely that such a difference appear in children. The prevalence of nonorganic hearing loss is reported to be below 7 % in pediatric population (Maran, 1966; Campanelli, 1963; Zwislocki, 1963).

3.2 Nomenclature

Most reported studies on PCDs are case reports (Chawla, Handa and Tripathi, 2007; Pankratz, Fausti and Peed, 1975). Their diagnosis is established only after multiple costly medical evaluations (Mahr, Yost and Jacobson, 2007). Such patients see more doctors and seek more aggressive medical workups. Speech language pathologists also lack opportunities or feel uncomfortable treating such cases (Elias et al, 1989). Their diagnosis and treatment requires a team approach. Psychogenic symptoms are called by several names: functional, histrionic, hysterical, dissociative, non-organic, and psychosomatic. None of them is apt. The term 'functional' implies a spurious dichotomy between structure and function. Hysterical and histrionic carry sexist and pejorative connotations (Zorowka, 1992).

To date, no clear classification of PCDs is available. For example, Aronson (1990) identified five groups of psychogenic voice disorders. The *musculoskeletal tension disorders* involving excess muscle tension and vocal abuse with resultant inflammation, nodules, and ulcers; the *conversion voice disorders* includes conversion muteness, aphonia, dysphonia and adductor spastic dysphonia; mutational falsetto; transsexualism; and child like speech in adults. Koufman and Blalock (1982) classified habitual hoarseness and post operative dysphonia. Morrison, Nichol, and Rammage (1986) describe three types of psychogenic dysphonia: muscle tension dysphonia; functional or psychological dysphonia; and, spasmodic dysphonia. Related syndromes identified in literature are: Hysteria, Briquet's, Manchhausen, Ganser, etc. In hearing literature, terms like 'pseudohypacusis', 'false hearing loss', 'functional hearing loss', 'losses with no organic disorder', 'hysterical deafness' and 'malingering' are used to describe various inter-related conditions of PCD.

3.3 Clarification of Terms

The terms 'Psychogenic Origins', 'Conversion Reactions', 'Malingering' and 'Factitious Disorders' are used intimately and inter-related. But, they are distinct. PCDs are meant to contrast others with organic or somatic involvement. A *conversion reaction* is viewed as unconscious theatrical performance wherein patients enact a symptom as a way of protecting themselves from emotional pain. They are unaware that they are performing. They are simultaneously actor and audience. *Malingering and factitious disorders* resemble conversion disorder though the patient deliberately and consciously feigns symptoms for secondary gain. In Munchausen's syndrome, the patient knowingly produces medical symptoms not for secondary gain but for the purpose of assuming the sick role. In factitious disorders, they are aware that they are feigning symptoms but unaware of their motivations (Doerfler and Stewart, 1946). Jonas and Pope (1985) note that conversion disorders, somatization disorders, malingering and factitious disorders are indistinguishable hence must be called as 'dissembling or dissimulating disorders' since these patients dissembled or lied. They are not real in that they lack a demonstrable biological basis.

Disorder	Symptom Production	Motivation
Conversion	Unconscious	Unconscious
Malingering	Conscious	Conscious
Factitious	Conscious	Unconscious

This paper addresses only few illustrative clinical conditions, such as, 'Non-organic Hearing Loss' or 'Psychogenic Deafness', 'Psychogenic Dysphonia or Aphonia', 'Pseudo Hyper and Hypo Acusis', 'Elective/Selective Mutism' and 'Conduct Disturbances' to highlight linkage between psychogenic or non-organic origins and manifestations as speech-hearing disorders.

3.4 Non-organic Hearing Loss or Psychogenic Deafness

This includes overt symptoms of hearing loss with underlying psychological disturbances. The apparent hearing loss has no evidence or has insufficient evidence to explain it. It is of two types: (a) Psychogenic or Conversion Reaction; and, (b) Malingering. The former is hearing loss associated with psychological conditions. The patient is unaware that he is simulating deafness. On the other hand, the malingering individual is consciously pretending to be deaf to avoid some responsibility or for seeking a concession despite normal hearing. It occurs suddenly and disappears equally suddenly. It is often associated with Mutism when bilateral (Ban and Jin, 2006; Martin, 2002; Andaz, Heyworth and Rowe, 1995; Kinstler, 1971).

Sonu, aged 14 years, was brought with unilateral hearing loss having a sudden onset and lasting since 3-4 weeks. All possibilities of head injury, abrupt exposure to blasting sounds, viral infections having been ruled out along with ENT clearance and following inconsistent audiology reports, the case was referred for psychological evaluation. Detailed assessment showed average level of intellectual functioning having poor grade level performance on tests of academic achievement at around class three for a student in high school. Case history revealed that the hearing loss commenced the day following a setback at school and a session of severe scolding by the parents for the poor school performance.

In actual diagnostic practice, the earliest signs of such conditions are *disagreement among test results*, such as, between SRT versus PTA, or audiometric versus AR thresholds. There will be an evident *lack of crossover*, such as, no shadow curve in the unmasked results. There can also be *odd results* like repeating half of the spondees. Some tests to help differentiate nonorganic hearing loss like the Stenger – for unilateral hearing loss, Delayed Auditory Feedback Tests, Tone Tap Test, Delayed Speech Test, Varying Intensity Story Test, or Objective tests like AR, AEPs and OAEs. Malingering is identified by the normal quality of voice, present cochleo-auricular/ pupillary/palpebral reflexes (as evidenced by twitching of pinna or contraction of palpebral muscles on exposure to loud noise), and when there is gross discrepancy between pure tone audiometry and speech audiometry. The lack of cross over (shadow effect) in pure tone audiometry should cause suspicion. A few tests for malingering are available elsewhere (Holenweg and Kompis, 2010; Hiraumi et al, 2007).

3.5 Non-organic Disorders of Speech Motor Control

Psychogenic factors come into play, not necessarily in the domain of hearing alone. They also influence the genesis of disorders of speech and motor control as in psychogenic developmental dysarthria, apraxia of speech, fluency disorders, acquired stuttering, cluttering, voice disorders, puberphonia, hoarse voice, spasmodic dysphonia, etc. Sapir (1995) reports a case of 26-year-old female psychiatric nurse with spasmodic dysphonia which was alleviated within one session of voice therapy. Psychogenic etiology was established based on three diagnostic criteria—*symptom incongruity*, *symptom reversibility*, and *symptom psychogenicity*. Recorded voice samples of PCDs were identified as characterized by staccato-like speech, effortful phonation, interrupted flow of speech, intermittent voice arrests (voice stoppages), hoarse-harsh voice and with waxing and waning, strained-strangled phonation. These are the salient features of spasmodic dysphonia. Psychogenic correlates like depression, anxiety, difficult school/home conditions have been reported (Kothe et al, 2003; Sapir and Aronson, 1990). Venkatesan, Pushpavathi and Purusotham (2010) found greater adjustment problems at home particularly in the areas of health and emotionality in men as well as women respondents with voice disorders. Males with puberphonia typically scored high on ‘femininity’ as women with hoarse voice inclined towards ‘masculinity’. Venkatesan, Pushpavathi and Purusotham (2007) found greater types and frequency counts of reported ‘stressful life events’ over the last one year in respondents with voice disorders against matched normal controls with even larger proclivity for the affected female than males in the clinical sample. Draw a parallel to this with Psarommatidis et al (2009) positing that girls outnumbered boys (16: 10) for sudden hearing loss as pseudohypacusis.

Myna, aged 44 years, was referred with suspected dysarthria associated with psychological disturbances. Psychometric evaluation on a battery of tests passive dependent personality traits along with currently measured moderate to severe depression following elopement of her only daughter and consequent domestic discord owing to what was perceived as a family ignominy. Finding own self left alone at home and without any forthcoming spousal support, the ‘tremulous or broken’ speech symptom became an occasion for outings during visiting of doctors or hospitals. Reportedly, the speech was relatively better when she was in the company of familiar friends when discussing on topics unconnected with the daughter’s events.

4. Child & Adult Psychopathology

PCDs, somatization symptoms, conversion reactions, and malingering or factitious disorders show characteristic differences in etiology, occurrence, clinical presentation or psychopathology across children, adolescents and adults. The naiveté of young children in responding at normal levels with speech audiometry and exaggerated threshold levels with pure tones usually makes identification of non organic hearing problem easy. It is rare that any classic auditory tests for functional hearing loss used with adults need to be used on children (Stach, 1998).

There are differences in the psychopathology and genesis of adult ‘pretence’ and the ‘cry for help’ in children. Northern and Downs (2002) define malingering as ‘a feigned, functional or nonorganic hearing loss for some consciously desired purpose’. The pediatric audiologist runs into such children who respond as though a hearing loss is present when no problem really exists. Such a child is quite different from a malingering adult. Their underlying motives and impelling factors are usually more obvious. The needs that drive the child to give inaccurate hearing test results are probably more honest and certainly engender more sympathy than in the adult. Whether transient or lingering, it is usually a symptom of some other problem. It should never be disregarded or dismissed as a temporary foible. It is usually a cry for attention or help, an apology for poor performance, or a rebuff to a hostile world. Children with some basic unfulfilled needs manifest them through language of symptoms as aches or pains, poor vision or hearing. It may be also shown as withdrawal, delinquency or aggression. It may erupt as eczema or chronic stomach problems. The audiologist and speech language specialists must learn to recognize the child with non organic hearing loss through exaggerated behaviors such as verbosity, brashness, exaggerated straining to hear the test tones, and inconsistent intra-test results (Leshin, 1960).

5. Characteristics

Irrespective of the nature or type of final diagnosis for PCDs across life span, certain common characteristics of such clients that must be in the knowledge of diagnosticians and therapists are:

5.1 Camouflaged Communication Disorder:

It is common for professionals and lay people reacting to patients diagnosed with PCDs as though they were liars, fakers, tricksters, showmen, cheats, conmen, and even those with evil designs. This approach and attitude must be corrected. Children, adolescents or adults with PCDs are as much ill as are clients with identifiable organic basis for their overt complaints. The presenting complaints must be viewed as a masked or disguised communication by the affected individual. For example, the child with an abrupt psychogenic voice loss is trying to communicate that s/he has no voice in a given stressful milieu or an ongoing frustrating experience. Often, the symptom is a symbolic expression of an unspeakable or inexpressible tragedy. The precise form of symptomatic expression of the underlying psychic conflict could be shown through periodic or chronic anxiety states, conduct disturbances, high pitched or croaky voice, localized

or generalized hyperhidrosis or excessive sweating, irritable bowel syndrome, obsessions-compulsions, possession attacks, pruritus, school phobia, stuttering, tics, tinnitus, voice loss, vomiting, writer's cramp, etc. Many problem behaviors are covered expressions of another hidden problem at home or school. They are expressing a psychological need for favorable attention. Something may be disturbing them at home (a pending divorce) or at school (a bullying peer or perceived pressure for greater academic achievement) or in the neighborhood, which must be defined and addressed prior to determining their hearing status (Zhao et al, 2008; Leshin, 1960).

5.2 Primary, Secondary and Tertiary Gains

Primary and secondary gains correspond to the direct or indirect benefits that individuals receive from their illness. They are the typical psychological motivators for reporting the symptoms. Primary gain produces positive internal motivations. For example, a patient might feel guilty about being unable to perform some task. If he has a medical condition justifying his inability, he might not feel so bad. Primary gain can be a component of any disease including communication disorders. Most dramatically, it is demonstrated when stress converts into physical symptoms without organic causes. For example, a person becomes deaf after hearing some terrible news. The "gain" may not be particularly evident to an outside observer. The secondary gain is an addition to the primary gain. It comes into play at a later stage and consolidates the disorder. It can also be a component of any disease, but is an external motivator. If a patient's disease allows him/her to miss work, gains him/her sympathy, or avoid a jail sentence, they are examples of secondary gain. These may, but need not be, recognized by the patient. If s/he is deliberately exaggerating symptoms for personal gain, then it is malingering. Secondary gain is simply an unconscious psychological component of symptoms. Thus, primary gain subdivides into two parallel aspects. In the internal part, illness remains the most economic solution for conflict, and this is the "flight into illness." The external part is linked to profitable arrangements occasioned in the individual's relational life. The secondary gain "helps the ego in its effort to incorporate the symptom." It procures a narcissistic satisfaction or is linked to self-preservation. Tertiary gain, a less well-studied process, is when a third party such as a relative or friend is motivated to gain sympathy or other benefits from the illness of the victim (Sapir, 1995).

5.3 La belle Indifference

Literally meaning 'beautiful indifference', this phenomenon refers to a condition in which the person is unconcerned with symptoms caused by the disorder. It involves a naive, inappropriate lack of emotion or concern for the perceptions by others of one's disability or the symptoms that have made him to seek medical help. A systematic review of 11 studies published since 1965 on reported rates of *la belle indifference* in patients with psychogenic/organic symptoms found only 21% (range 0–54%) in 356 patients with conversion symptoms, and 29% (range 0–60%) in 157 patients with organic disease showed this sign. Thus, available evidence does not support the use of *la belle indifference* for differential diagnosis (Stone et al, 2006).

Sudip was brought by parents with complaints of stuttering, which the 16-year old himself stoutly denied. It was the father, the teenager said, who had the problem since childhood and needed testament. Throughout the clinical interview, he was defensive and preferred to communicate only through body gestures, single words or short phrases. He was circumspect and claimed that he loved being so. He confessed a dislike towards making friends or talking to people. The more he opened up, he seemed to indicate that others would dub him as 'stutterer', an adjective he detested to be tagged.

5.4 Somatic Compliance

This somewhat enigmatic notion helps explain why certain body organs in preference for others are unconsciously preferred for attachment of the frustrated libidinal impulses in the individual with PCD. It is an unclear attempt to leap and link body-mind or from mental to somatic level. Psychologists frequently invoke various primitive, infantile or childhood forms of thinking, including symbolic or dream thinking, autistic, anthropomorphic, animistic, egocentric, or the like to explain part of the body that becomes susceptible to be affected during an unresolved psychological crises. For example, an ear-discharge in childhood can become a vulnerable site for psychogenic hearing loss in the face of a troubled psyche (Lipowski, 1987; Laplanche and Pontalis, 1973)

5.5 Unintended, Unconscious and Involuntary:

It is critical to accept that the symptoms of the child, adolescent or adult with PCD are unintended, unconscious and involuntary psychic mechanisms. This is in spite of an immediate tendency or impression that such presenting symptoms give as being conscious, deliberate, intentional, willful or well thought out design by the patient (Wang et al, 2006).

5.6 Spectatoring:

Spectatoring refers to the tendency in individuals with PCD to become hyper-vigilant concerning their internal body environment. Any trifling ambiguous sensory changes in the larynx, for example, as a result of infection, edema, reflux, or even an occasion of having had a cold shower bath, or eating an ice cream may be perceived as the threatening cause of the present predicament of voice loss. Some factors in the origin or sustaining of such psychogenic symptoms may be also induced unwittingly by the clinicians. The author is aware of an instance when a casual comment made by an over enthusiastic student-intern made matters worse. The naïve informed a client that literature states that almost half the clinical population diagnosed as stuttering are bound to remain so throughout their lives. This prompted the affected person to browse the net, draw his own inferences and reach a point where he confessed that there was no worth in staying alive. Highly suggestible clients or those who harness an unconscious hostility towards health care providers are highly vulnerable.

5.7 Dramatis Personae:

The symptomatic presentation of PCD often attempts to unconsciously represent the predicament of the affected

client, albeit off stage, in a manner this is similar to characters in a dramatic work. Their world of experiences and the background life setting become the stage, the people around are the co-actors and the client with his or symptom is the protagonist with the role play carrying an inner message.

Komala, a 25 year old rustic woman was presented with voice loss of sudden onset since five days following an intense verbal argument with her mother-in-law which culminated in the older lady casting a curse that the younger one will lose her voice for disrespecting an elder. True to the spell, there was initially a change of voice into hoarseness, then whispers, and eventually a complete Aphonia. Apparently, in this case, affected lady had to be moved out from the village by her spouse and close relatives for a short stay in the city for medical treatment. She could not only escape from the troubling domestic discord and drudgery, but also, have the benefit of eating out and sightseeing in the city although for a short tenure. At the same time, the symbolic protest through silence also allowed the senior lady to be presumably avenged.

5.8 Cognitive Aspects:

Cognition, especially in developmental perspective, recognizes a series of changes in quality and quantity of mental activities related to sensation, perception, thinking, imagination, comprehension, intelligence, reasoning and problem solving. The contributions of cognitive psychologists require no reiteration here. The child thinks, reasons, imagines and views the world differently at each stage. Obviously, the child cannot and does not view the world like adults. Clinical symptoms with PCDs cut across all developmental stages. It could reflect as swallowing/feeding difficulties, apnea or breath holding spells in infancy; or as separation anxiety disturbances or elective/selective mutism in toddler and preschool age; conduct disturbances in middle school years; and/or overt aggression covering an unacceptable covert depression or psychogenic amnesias during adolescence. At every stage, it is vital to consider the developmental age of a given case before exploring its genesis, psychopathology, and planning an interventional strategy for the same.

A child in Piagetian cognitive sensor motor stage (0-2 years) with a typical world view of 'here and now' is limited in existence with belief only of what is in front as true and real. This is typical of autistic or dereistic thinking. The things or persons outside this range do not exist in the view of the child. The mother in front is existent. She moves out of sight, she is out of the child's existence. Thereafter, with object permanence, the baby realizes that people and things exist in their own right even if they are not in front of him or her. In the second preoperational stage (2-7 years), the child begins to use more of symbols and language to represent the real world outside. However, their thinking continues to remain self-centered. They cannot think or imagine like others by placing themselves in other perspective. In the next concrete operational stage (7-12 years), the child thinks or operates only at concrete level. For example, when asked to tell similarity between 'cow' and 'horse', the child in this stage is likely to say visible resemblances like both have legs or ears. They are unlikely to give abstract answers or say that both are animals. In the next formal operational stage (11-15 years), the child has reached adult forms of thinking. He can reason, interpret, perform abstractions, make reversals, carry out deductive operations and define concepts. Other forms of adult thinking typically unseen in children are lateral or non-Linear, vertical thinking, parallel thinking, analogical thinking, and forecasting (McLeod, 2015).

Children who enter adolescence without cognitively reaching formal operation stage are likely to have difficulties in performing these higher cognitive activities. All this goes to highlight the importance of developmental perspective in understanding the origins and psychopathology of psychogenic disorders. An understanding of various stages of cognitive development is important for planning/programming appropriate therapy interventions for children with PCDs (Kent, 2004; Mace, 1994).

5.9 Regressed Communication:

In short, the cognitive perspective is explained by realizing that everyone creates their own subjective world view of reality. If the view created by an individual is flawed, then unhealthy thoughts create dysfunctional behavior. Poorly adapted personal world views are the result of inaccurate assumptions which leads to negative attitudes. Illogical thinking processes are a source of destructive thinking patterns. Once they manifests as over-generalization one draws negative conclusion following even minor events. In short, such unconscious body language manifestation is PCDs (Lewis, 1926). In sum, features like absence of hard neurological signs, the presence of other non-organic signs, or psychogenic signs like fluctuations during examinations, increase of symptoms with attention and suggestion, decrease with distraction, unusual incongruent presentations, discrepancy between objective signs and disability, marked and persistent improvement with placebo effect are essential ingredients to be considered in the pathogenesis and psychopathology of these disorders.

6. Interventional Guidelines

While identification of patients with PCDs may be the first challenge, it is equally important for speech-hearing professionals to be conversant with psychological dimensions of its management (Veniar and Salston, 1983). Clinical experience suggests that diagnosticians and therapists dealing with PCDs adopt either, what is called, the 'machine gunner' or 'skeptical' approach. The former is the tendency in some diagnosticians to exhaustively, and often, invasively investigate such patients for every possible organic illness however remote the likelihood maybe. The machine gun approach is time consuming, carries risks and reinforces the sick role of such patients. The skeptical approach is equally flawed wherein the patient is doubted as liars, fakers, tricksters, showmen, cheats, conmen, and even those with evil designs. A ten-year follow up study on patients diagnosed with hysteria showed 50 % developed clear cut psychiatric or organic involvement (Slater, 1965).

Once the problem has been identified, the impression of PCD must be conveyed tacitly. There should be no direct confrontation, interrogation or cross examination. This would divest the already weak defenses and leave clients more vulnerable in their own eyes. Clinical experience suggests that it is rare for preschool children to exhibit PCDs. Typically, it maybe that their elevated thresholds in the presence of normal hearing maybe also due to non-auditory reasons, such as, "failing" to properly instruct, or not placing earphones or inserts properly, or testing too rapidly,

improper equipment calibration, poor test site acoustics, inadequate comprehension of test instructions or owing to their unpreparedness or overwhelming awe of the testing procedures. However, at or beyond primary school age, the child may be indeed conscious of the benefits derived from failing in the hearing tests (Veniar and Salston, 1983).

It would be worthwhile to explore and understand PCDs as means to obtain an advantage, benefit, utility or reward. The symptoms are means to convey a felt psychological stress or distress in an individual. The child or individual could have had a previous legitimate hearing loss. The current symptom picture could be a reinstatement of benefits the disorder provided in terms of teacher and parental excuses for, and tolerance of, reduced academic performance. The functional-utilitarian approach to explaining the psychogenesis of PCDs uses factors like attention-seeking, escape, skill deficits, direct rewards and/or even self-stimulation as possible reasons that benefit the affected individuals (Venkatesan, 2004; Rintelmann and Schwan, 1999; Butcher, Elias and Raven, 1993). Otherwise, they may have seen the benefits received by others who have legitimately failed a hearing test before simulating their own. By virtue of fewer life experiences in general, children are not as sophisticated as adults regarding fabricating the appearance of their symptoms (Ventry, 1968). Usually, a non-threatening, non-confrontationist and empathic approach brings about patients to realize their ruse. Those who continue to give inaccurate test results have a greater need and that arguably goes beyond the scope of practice for the audiologist or speech language pathologist. It can be highly beneficial to the child if the professionals and the family see these persons, in these circumstances, as resourceful, not deceitful. It is a communication of felt stress through a body language than sickness or a feigned illness.

7. Conclusion

In sum, this descriptive paper highlight the need to arrive at an unanimity among professionals on or about *Psychogenic Communication Disorders* in all aspects covering their screening, identification, nomenclature, classification, presentation, differential characteristics or clinical manifestations. Given a negative public opinion about such individuals by professionals and their family members as liars, fakers, tricksters, showmen, cheats, conmen, and those with evil design, the challenges are far too many. The outlook fostered by the medical model that there cannot be an illness in the absence of an organic involvement needs change. An attempt is made with case illustrations to redefine this erroneous perspective in favor of viewing the illness as a different rather than deviant form of communication through body language symptoms which are apparently intra-psychic, unintentional, unconscious and symbolic cry for help to get over an inexpressible personal tragedy.

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