Psychiatric Aspects of Otolaryngology

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Most doctors, in theory at least, know how to recognize the main psychoses. It was not unusual, therefore, for a non-psychiatric hospital to believe that 'cover' might be required when a psychotic patient needed removal to a mental hospital. The first psychiatrist appointed to the Royal National Throat, Nose and Ear Hospital was only required to be available. It was soon apparent that regular sessions were necessary to cope with the larger numbers of children. Their hearing had to be investigated when there was a differential diagnosis of mental retardation, deafness, psychosis or infantile autism. When the hearing was found to be normal the child would be referred to the psychiatrist for diagnosis, treatment and advice.

Regular sessions were established and had to be extended to cope with many adult conditions that had not bee thought to be within the purview of a psychiatrist or psychotherapist. But at the same time it was evident that formal psychiatry has very little to offer. Psychoses in adults rarely occurred and psychiatric experience without thorough training in psychotherapy was valueless. In addition, experience of child and adolescent psychiatry was also required. Although it was not clear at first what part psychotherapy could play in the treatment of ear, nose throat and oral conditions, they were undoubtedly fertile areas for the expression of neurotic difficulties.

An Impasse

The psychotherapist's aid was enlisted usually when there was a diagnostic and therapeutic impasse. Either the physical findings were 'negative' (normal), equivocal, or the resources of the hospital for further investigation and/or treatment appeared to have been exhausted without satisfying or relieving the patient. Although a diagnosis without positive findings is unpardonable in organic disease it is unfortunately common for the diagnostic label of 'hysteria' or 'functional' to be applied to a patient when the physical investigations are 'negative'. The term is often pejorative and is used to convey the doctor's chagrin. It may also express his contempt for psychiatry and psychotherapy and this is often apparent to the patient who feels hurt and angry at being classified in an inferior category. Some doctors feel it is demeaning to go to a psychiatrist and, for this reason, they may delay referral or be apologetic to colleagues when it is made. In time there is a two-way learning process. The psychiatrist discovers new conditions in which therapy can help and the non-psychiatrist finds that it can help in conditions where further progress was not thought to be possible. In cancer of the larynx it may involve support and preparation before operation and later with the loss of voice and other sequelae which affect the patient and his family. Alternatively, the condition may be located in the 'ENT area' but is primarily functional because the loss of voice does not respond to speech therapy and has no discoverable physical abnormality.

Therapeutic Endeavour

Psychotherapy is a mixture of diagnostic intention and therapeutic endeavour and may result in the disappearance of the symptom, indicating a non-organic and emotional basis. Often the symptom belies the seriousness of the underlying psychopathology.

Tinnitus

This accompanies many conditions and the distress it causes can be extreme, even to the point at which suicide is contemplated. The distress may be alleviated by psychotherapy, although the tinnitus remains. Some patients discover for themselves that, when they are absorbed in an activity, they do not notice the tinnitus, and can be encouraged in a few interviews to change their life pattern so that the tinnitus ceases to be intrusive. More prolonged psychotherapy may be needed with others. Such patients have, in any event, a considerable need for help and it is as if the tinnitus becomes a focal point for everything that is allegedly causing difficulties in their lives.

Offending Noses

The presence of indeterminate physical symptoms in a setting of emotional disturbance results in regression, and the obsessive search for a physical cause, by repeated physical investigations, makes insight and progress more and more remote. A sense of urgency in the patient is then transmitted to the doctor who refers him to other specialists in the hope that something will turn up. The doctors may side with the patient against all the previous doctors and is seduced by the prospect of being the one who discovers the cause. This attracts the 'hard-headed' doctor, who thinks of himself as pragmatic and is sceptical of psychiatry and its esoteric off-shoots. If he succeeds, he can show at one fell swoop how nonsensical is psychological speculation, and rescue the patient from the impending stigma of psychological treatment. This trap is particularly evident when patients request plastic surgery on the nose. Some are disturbed and weave their delusionary system around the offending nose. They allege that they cannot go out, that their life is limited, and the paranoid state can proceed to actual illusions and hallucinations of hearing people comment on their appearance or looking at them. The trouble is that the 'bad' nose, and the 'good' nose which they hope will transform their lives, is inside their heads, and surgeons learn to their cost that no operation can correct the offending object or give to these patients the nose they have in mind. Sometimes they seduce one surgeon after another to attempt further operations, the record number of corrective rhinoplasties on one patient in my experience being 22.

When the physical problem is not obvious all those being considered for rhinoplasty are seen by the psychotherapist. This has resulted in a dramatic fall in the numbers of patients complaining after operation and virtually no demand for re-operation.

Most vigilance is required when it is a man requesting rhinoplasty. The less obvious the defect the firmer one should be in requesting psychiatric evaluation.

Deafness

Psychotherapy in the deaf would seem to emphasize their communication difficulties. Lip reading may be possible with long training and practice, but a rapid and subtle exchange is not possible and those with recent deafness cannot communicate in this way. Sign language, even in the hands of the most expert, is too crude for the exchange of concepts required for psychotherapy.

Pandora's Box of Psychopathology

Many patients with relatively minor symptoms seem to open a veritable Pandora's box of psychopathology on the therapy.

It is apparent in the ENT field, that skilled psychotherapeutic intervention can be short-term and diagnostic. It is often objected to on the grounds that it is time consuming, or 'just talking' which 'anyone could do provided they had the time'. All these patients, particularly those who had seen speech therapists in addition to social workers and doctors, came to psychotherapy usually after a lot of talking and a lot of time.

Depression

Referrals may be made by young doctors without a reason being given or with a very terse statement that the patient is depressed. Medical training is embarrassingly limited to describing psychotic states and physical treatments, and interviewing techniques are never scrutinized, taught or experienced. It is not surprising that, when it comes to describing states of mind in ordinary people in these circumstances, formal psychiatric descriptions are found to be inappropriate. Psychotic reactions are, in any event, very rare. In this state of ignorance, recourse is had, too often, to so called antidepressants. The patient is then helped merely by taking them off these drugs and protecting them from their depressing effects. In such cases, very little in the way of interpretative psychotherapy is required.

Head and neck operations are particularly mutilating. The stoicism of most laryngectomy patients is something to be wondered at and may account for the relatively small number of psychiatric referrals. Total and mute withdrawal is rare but is often attributed to physical and not emotional changes. For relatives who want to help, but cannot, the anguish is extreme.

Understanding the Deaf

One feature of these situations is that people of all types become aware of psychotherapy and its ethos. Perhaps *their* lack of sophistication is a help rather than a hindrance whereas the sophisticated scientist may reject it because he has no experience of psychotherapy. This is nowhere more apparent than in the understanding and treatment of deaf and partially deaf children and adolescents. A misunderstanding of the psychopathology of deaf children results in a large number of them being treated as if they had the same primary defects of character as are

found in the psychopathic child and adolescent who can hear. Child and adult psychiatry has done very little to improve matters. Children with deafness of varying degrees present frequently with a behaviour disorder that is manifest at home and at school. They may have violent tempers and cannot tolerate frustration. At the same time, they seem impervious to the commonplace measures applied by parents and teachers to produce co-operative behaviour. Despite their manifest behaviour problems they have usually an essentially normal potentiality for character development. These patients, particularly if they are boys, are especially sensitive and suspicious of what their contemporaries and others say about them.

Because the earliest influence on that part of character which we call conscience is the *tone* of mother's voice, rather than explicit meaning of her communications, the deaf or partially hearing infant is at a disadvantage. With the normal, hearing child, approval and disapproval is conveyed by the nuances of tone, timbre and volume of the voice. One can overhear little children talking to themselves, or to their dolls with mother's voice, reproducing her tones of censure and approval. Their parents' range of feelings is very much alive within their minds, guiding them around a world of 'approved' and 'disapproved' objects and actions. The visual expressions of feeling without the voice is not so effective or subtle, and the attention cannot be caught or held at a distance. The deaf child, therefore, may be without this internal control and may not have his parents in mind, as objects of his feelings, to which he refers. Thus the deaf child operates on impulses and does not spontaneously feel the guilt and concern of the hearing child. The depression which is normal and arises from an awareness of actual or potential destructive and harmful behaviour motivates the normal individual to take care, redress and make amends. This does not arise readily in the deaf child, although it is often not too difficult to mobilize it with psychotherapy whilst giving parents and teachers a greater understanding of the psychopathology, so that they can act constructively.

During psychotherapy, the individual is encouraged to mobilize all his resources to face, identify and modify the destructive intent within his or her self. As the parents mean so much to the child, and they spend the greatest amount of time together, it is important to convey an understanding of the deaf child's psychopathology to them. This must include a description of healthy depression and how to encourage its development. In their own way they can then act to modify the destructive behaviour and encourage the development of character. It is also important because a child may be rejected at school, and goes from one school to another. The parents frequently feel hopeless, as nobody appears to accept or understand their child.

Feelings of Persecution

An understanding of the psychopathology of persecutory feelings and depression is particularly important in otolaryngology. Cancer of the face may lead to grossly deforming operations, and loss of normal speech may occur after operations on the trachea and oesophagus. This leads to difficulties in coping with life and new relationships, and with real and imagined persecution. People do actually shout at patients who have no voice or who whisper, are actually afraid of strange looking people with tracheostomies or the mechanical sounding voices from a vibrator, and really presuppose that those who cannot hear or talk are unintelligent, and thus

speak down to them in condescension. The difficulty for the sufferer is the realization that he is seeing himself as *he* might have been before the operation. If in his real or imagined persecution the patient becomes independent of what others think and makes his own self-evaluation, he develops and matures.

The patient with tinnitus also has a cross to bear, in that his life may be disrupted by the noises but there is no evidence of disability or illness for others to see and appreciate. He suffers alone and there is no doubt in his mind that no one can share the burden or take some of the load. The patient not only feels persecuted and oppressed but, quite erroneously, that others with more obvious disabilities necessarily get more sympathy.

Gaining an Identity

There are others who appear to want help but feel that they have no reason to claim it. They are referred to the psychotherapist because nothing physical can account for their symptoms. It may be an obvious delusion such as a bad smell emanating from themselves or they hear references to their severe halitosis and attribute all their social difficulties to it. In others it appears to function as a means of gaining entry into the hospital world with its interesting and dramatic associations. There an identity is gained with a number, a file, a condition, and a special hearing from all the doctors in the hospital hierarchy. The hospitals is at war with disease, illness, infection, and suffering and, as in real war, people find a purpose, exhilaration, a cause, and, albeit temporarily, cease to be neurotic. Without psychotherapy, there is an unending trail of negative investigations and inconclusive examinations in different departments and frequently at several hospitals.

A Rewarding Venture

This account serves to indicate some of the work done by the medical psychotherapist. It has proved to be a most rewarding and interesting cooperative venture with the ENT specialist. It is in this anatomical region, where the special senses and the core of the body-image is located, that psychoanalitic psychotherapy finds its greatest use. Emotional difficulties are thrown into relief and essentially healthy people are assailed by the consequences of dysfunction in these sensitive areas. The most important point, however, is that psychotherapy in otolaryngology produces vivid illustrations of psychosomatic relationships and of all the specialist fields, affords us the best opportunity for teaching psychodynamic principles. The pragmatic general practitioner and surgeon are quite rightly impressed with, and guided by, results which he can see and understand, rather than by the theoretical constructs which may have produced them.