

The Psychiatric Aspects of Ear, Nose, and Throat Disorders

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Symptoms of interest to the otorhinolaryngologist are often of interest to the psychiatrist as well, and proper care of the patient requires the care of both specialists. Complaints about children, "I don't think he hears well enough", "he doesn't speak well for his age", "she has too many sore throats", "she has quite suddenly lost her voice", or symptoms such as "sinus headaches", hoarseness, dizziness, tinnitus, and difficult swallowing may have a psychological basis as often as an organic one. It is, of course, important that physicians think not in terms of either/or, but rather how much of the problem is psychosocial and how much is in the biological, physiological sphere and the interaction of these systems. Proper medical care today requires the physician to approach the patient's complaints with a biopsychosocial model of clinical investigation.

Additionally in pediatric patients the aspect of development must be considered. The importance of visual, oral, and auditory input in the human infant's growth and development is well known. Distortions in development occur when there is interference in the ability of the infant to respond to its environment or in the environment's ability to respond properly to the infant's needs. The fit between the infant and its environment, whether good or poor, will determine its development.

For instance, infants with esophageal atresia, when gastrostomy is necessary and interference with normal feeding practices occurs, show profound failure to develop gross motor skills in contrast to normal progress in visual and fine motor skills. It seems that "the physical act of oral feeding provides an important stimulus and organizing force for a variety of developmental accomplishments".

A surgical colleague with great experience feels that some of his best surgical repairs of cleft palate have not resulted in good speech, whereas other children with less than ideal repair have had very good speech. He attributes this to other factors in the child's environment, chiefly family attitudes and parent-child interaction, and spends a great deal of time talking with parents about their feelings about the child as part of the preoperative preparation.

Thus an examination of a child with symptoms or complaints referable to otolaryngologic care require not only attention to the ears, nose, and throat and their anatomy and physiologic function, but also to the child's function as a developing human being, interacting in his family with parents and siblings, and in the community and school with his peers.

Psychology of the Pediatric Patient

Psychological and social growth and development, as well as physical growth, is very rapid in children. Chronologic age is not necessarily the equivalent of psychological age, and

some children are able to behave in a more mature fashion than others. Also, the child's caretaking environment needs assessment, for parents vary in their abilities.

The three-month-old infant with croup requires special attention because of the small size of the larynx and the fact that even a small degree of edema may be life-threatening. Equal attention must be paid to the attitude of his caretakers. The more experienced, and the less frightened and anxious the mother and/or father or nurse, the more reliable will be the reports on the child's condition and his care during the critical episode. The infant whose parents are unduly anxious and unable to tolerate the anxiety of an ill infant may need to be hospitalized; whereas the more experienced parent, with a child equally ill, may be able to care for the child at home.

Separation Anxiety

As infants approach the age of 8 to 10 months, separation anxiety becomes apparent, in which the child is more acutely aware of who his caretakers are. The younger infant can be equally well cared for by his nurse or mother. However, after 8 to 10 months of age, and particularly as the child reaches the second year of life, separation from the parent is tolerated poorly. This means that the child between 8 months and 3 to 4 years who is to undergo elective procedures, such as a myringotomy, the placing of tubes in the ear, or even an examination of the ears and throat, will tolerate these procedures with greater equanimity in the presence of people he knows and trusts, provided that they are able to deal with their own anxiety and not complicate the situation for the child and/or medical specialist. Obviously hospitalization of very young children requires regard for parents as well.

By the time the child reaches school age, he is usually able to tolerate care by strangers without upset. He has learned that adults, teachers in the school, can be as helpful and trustworthy as his own parents, physicians, policemen, storekeepers, and others. Rather than being frightened by adults or strangers, the school age child is more concerned with his body integrity and is worried about "the shots" and "being hurt".

The adolescent has greater stability and confidence in others outside the home, but has concern about his own ability to deal with stressful tasks. Fear of the loss of control, "saying something" or "doing something" while under anesthesia, may be more difficult for the adolescent than any type of surgical manipulation.

Therefore, the otolaryngologist dealing with different age groups will have to deal with each of them somewhat differently and develop individualized strategies for them and for the different families in which they live.

Pain and Restraint

The otolaryngologist who deals with children is much like the pediatrician or pediatric dentist in that the young patients with whom they work often are of an age at which developmentally they are not able to cooperate for examination. Long ago, Dr C. A. Aldrich, an eminent pediatrician, in attempting to find a stimulus that would cause an infant to cry, and yet not wishing to inflict pain on the infant, came upon the use of restraint. Simply holding an infant's foot so that he cannot move will usually cause him to protest and cry.

Human beings resent restriction of movement, and children, normally active, resent "holding still". It takes a fair amount of psychological stability in order for a child to cooperate with even simple medical examinations, such as mouth or throat examination.

At the same time physicians dealing with children should be aware that restraint is not all bad, and indeed, has an anxiety relieving aspect to it. The nurse who says to the six-year-old boy, "Johnny, I know you want the doctor to draw the blood sample and get this test out of the way as quickly as possible, so I will help you hold your arm still for him", is well aware of the fact that the healthy part of the child does wish to hold his arm still. The frightened and anxious part of the child would like to run from the room and keep his arm as far away from the physician's needle as possible, behavior that can be seen as noncooperative.

Explaining to the child or to the parent what is necessary and how it will be approached also relieves anxiety. For example, the explanation to the parent might be that the examination of the child's ear reveals a bulging eardrum, that the pressure is causing the earache, and treatment requires a lancing of the drum. Such an incision will be painful but short-lived. Though sedation or anesthesia could be given, restraint by wrapping of the child in a sheet, with parents involved and present, will be less dangerous and more efficient. Involving parents in the examination of their children helps the child be less anxious, and the average parent is relieved to be helpful to the physician and their child. Occasionally parents may abdicate this assistance to the physician's nurse or other helper, but they appreciate knowing that the physician would involve them if they were willing.

Not all children have had the same experiences in growing up, and some children are more anxious than others. Not all parents are the same, and some are more anxious and frightened about medical care than others. A few questions such as, "What kind of a child is Sarah? Does she get frightened easily? How does she behave with strangers? Do you think she will be able to do what I have suggested?", and talking to even very young children, are helpful. Telling a two-year-old child, "I'm going to look in your ear with my light. Let me know if you want me to stop", helps the child to feel that things are not out of his control and will help him to tolerate better the anxiety of an examination. Obviously, the physician who wishes to work quickly will not be able to do so with the pediatric population. It takes more time and energy to deal with children and their families. Children cannot be rushed, are not sophisticated, and quickly make a medical office or surgical suite acutely aware of their displeasure. The tolerant unhurried physician has a sedative effect in his very manner on both children and their parents. The physician's feelings, whether anxiety or anger, are easily communicated, and though the adult patient may "put up with" a physician's insensitive and abrupt manner, the pediatric patient and the child's parents will not.

Otolaryngologic Syndromes of Psychiatric Interest

A child's failure to develop language ability is a relatively common complaint. Although mental retardation or hearing deficit are usually first thought of in a differential diagnosis, more commonly the failure is secondary to a lack of stimulation of the child and parental dysfunction. This may range from the severe problems presented by the autistic or symbiotic psychotic child to that of the overprotected, immature child with babyish speech.

Deafness and blindness may be on a hysterical basis, even in a very young child. Abt described a three-year-old child with hysterical blindness. Some of the most difficult diagnostic problems are the differentiation of whether the child's auditory apparatus is intact or whether the child is not responding at a cortical level. The autistic child may appear to be deaf by all standards but the most sophisticated of audiologic testing, and even then the examiner may have doubts.

Lye Burns

It is a tribute to pediatrics and to otorhinolaryngology that lye burns of the esophagus have decreased as a result of public education efforts and education of manufacturers. Still, young children in less than protective environments will ingest poisons and foreign bodies and require otorhinolaryngologic attention. Such children and families also require attention to their psychosocial environment in order to prevent recidivism. Children requiring esophageal dilatation, whether for congenital stenosis or chemical stricture, may also profit from psychiatric consultation.

Case Example. A four-year-old girl suffering from severe esophageal stricture caused by lye burns was uncooperative and required anesthesia for dilatations. With psychological support by a clinical nurse specialist (pediatric nurse with postgraduate training in child development) and involvement of the mother in the preparation of the child and care over a six-month period, the child was able to be dilated without anesthesia, and eventually to be dilated by her mother at home.

Esophageal Stenosis

Case Example. Beth (BD, Nov 1965) had a history of being an occasional vomiter until beginning feeding of solid foods at six months. She had increasing difficulty and by 22 months of age would gag, tear, and vomit projectily after eating solids. She could swallow milk, baby foods, and soups. After vomiting she would smile and be comfortable.

At the time of her first hospitalization at age 23 months she was in the 10th percentile for height and 50th percentile for weight. She had iron deficiency anemia with a hemoglobin of 7.0 gm and a hematocrit of 29. An esophagogram performed in November, 1967 revealed "a well-defined area of stenosis of the esophagus at the junction of the distal and middle third; the findings clearly indicate congenital stenosis of the esophagus".

After treatment of the anemia and esophageal motility studies, esophageal dilatation under anesthesia was begun. Dilatations were done March 27, April 10, April 25, and May 18, 1968. During the May, 1968 hospitalization psychiatric consultation was requested because of the concern about frequent dilatations and anesthetic risk. It was the psychiatrist's opinion, based on previous experience, that if the family could be helped to be less anxious and more relaxed, the esophageal function could be improved. A parent of another child handled in similar fashion agreed to talk with Beth's parents, the psychiatrist, and a pediatric nurse specialist (graduate training in child development). Follow-up care and counseling were offered, and a home visit was planned. This mode of treatment was agreed to by the otolaryngologist. At the home visit following discharge, the child and family seemed to be coping well.

There was no further contact from the summer of 1968 until a follow-up call was made to Beth's mother in the spring of 1980. She reported, "It was such a help to talk to that mother! The next day I decided to give Beth bacon and eggs and she did just fine and has continued to do so. She does have some trouble occasionally if she doesn't chew food well. If she eats too big a piece to swallow, she may have to vomit, and if she gets upset she also may not be able to swallow".

Beth has coped with her parents' divorce subsequently when she was 8 years, the mother's remarriage, and the birth of a brother at age 12 years. Today at 14.5 years of age, she is described as an active adolescent, good student, cheerleader, physically healthy, and "doing just fine". The mother did not wish for her daughter to have further medical contact or x-ray examinations of the esophagus.

Seal Bark Cough

Seal bark cough is a clinical syndrome that can be diagnosed "from the doorway". These children, usually of latency age and boys, have a characteristic barking, explosive cough. We have seen this cough in children we feel are compulsive and whose parents have high expectations, and regard the cough as a tic. Reassurance of parents and child that the etiology is primarily psychological rather than organic, and that the cough is a response to a tense environment, usually causes symptoms to disappear. The underlying personality, however, remains.

Hoarseness

Likewise hoarseness, with or without vocal nodules, is often associated with psychological tension.

Case Example. A five-year-old girl, the second of three children, having brothers ages seven and four, was seen with a complaint of "hoarse voice and immature speech". Laryngoscopy revealed bilateral thickening of the cords. The child was seen in psychiatric consultation as "the angriest little girl I've ever seen". Her parents were not very giving or sensitive to this child's needs. In therapy over a matter of months she was able to express her anger more appropriately and to ventilate her feelings. Her parents also were able to modify their behavior to some degree and the child's voice returned to normal quality.

Aphonia

Aphonia on a hysterical basis usually occurs in the adolescent female.

Case Example. Susan, 12, had a history of voice strain at an athletic meet 4.5 months prior to being seen and then "lost her voice". Seen by an otorhinolaryngologist several times for inflammation of the vocal cords, she was treated with medication. Though on a final visit the vocal cords found to be "clean and mobile" with no structural abnormality, the hoarseness persisted.

Susan was the fourth of five children with two older sisters and an older and younger brother. Her mother had died during childbirth, and she and siblings had been raised by her

mother's sister and her husband, though it was reported that she believed her aunt to be her natural mother in spite of different surnames.

Susan's mother-aunt had a very hoarse voice, much like Susan's, saw the girl as "happy, active, evil", and seemed impatient with the girl's inability to talk.

This girl related well and talked easily, but in a loud whisper. She was a striding, bright girl, more concerned than she needed to be about performing well. She had many friends, male and female, and tended to deny negative feelings about anyone or anything.

It was explained to her that her symptoms could be explained on the basis of psychological tension and difficulty in expressing feelings. This patient regained her normal voice one week after the diagnostic interview. Whether this was a "flight into health" or a transitory developmental conflict could not be determined on the basis of the limited evaluation.

Summary

Diagnosis and treatment of children with complaints or symptoms referable to the ears, nose, and throat require not only an examination of those organs, but also of the child as a developing psychological, social being, living in a family and interacting with a psychosocial environment. Once the physician approaches these problems with investigation of the various symptoms involved and some understanding of child development, management is clearer and more effective.