



Clinical Manual of Otolaryngology

CHAPTER 8 Psychosocial Considerations

The preceding chapters have focused primarily on the physical complaints and the clinical findings in the diseases under discussion, but these make up only a portion of the total picture. Each patient is an individual with a unique and complex psychosocial background. The physician who takes the time to develop good rapport with the patient and learn the patient's psychosocial history, and then discover how this history interacts with the patient's current complaints will be a better diagnostician and a more effective healer. There are several compelling reasons for a physician to be skilled in the psychosocial side of medicine. First, the physician who establishes rapport and expresses a real interest in the patient will obtain a far more accurate history. The patient senses this interest and is more likely to relate an accurate history, even if it contains embarrassing elements. I remember a patient referred to the gastrointestinal service with abdominal cramping and diarrhea. She had been fully evaluated previously at two well-known medical centers. None of the examiners had made a definitive diagnosis. She was again evaluated extensively, but no diagnosis was apparent. I was an intern at this time and had devoted a great deal of time and effort in establishing rapport with this patient. After 2 weeks of asking about her psychosocial history, she finally trusted me sufficiently to tell me about her disastrous marriage. She knew it was the cause of her diarrhea. Once we knew her real problem, therapy was directed at her personal life and not toward correcting a colon disorder. However, it required rapport to obtain the correct history and to make the correct diagnosis. Only then could appropriate therapeutic recommendations be made.

Second, a disease causes symptoms. The patient interprets and expresses these symptoms. This interpretation and expression accounts for at least 50% of the disease process and has significant bearing on therapeutic success. The physician who takes a psychosocial history, understands the patient, and uses this information effectively will be a far more effective healer. A good example of the way psychological factors influence physical health is provided by the common viral head cold. If you develop a cold on a day when you have a final examination in biochemistry, for example, the cold will make you miserable and you may not be able to take the test. But if you catch it on a day when you are packing to go home for an exciting vacation, the cold may hardly be noticed. Patients with diseases such as sinusitis, headache, allergic rhinitis, neck ache, backache, dizziness, and tinnitus all express different degrees of discomfort and incapacity. It is not only the

variability in disease severity that causes this discrepancy but also the patient's psychosocial situation and attitudes. Pain tolerance is another good example. If you hit your finger with a hammer on an otherwise good day, the pain is immediately intense but dissipates rapidly. However, if you and your domestic partner are having a disagreement and out of anger your partner hits your finger with a hammer, the pain will be intense and will last as long as you wish to make it last. Patients are just the same. To be an effective healer, their psychosocial and its influence on the physical must be understood.

Third, some diseases are largely psychosomatic. These must be recognized and dealt with accordingly. Headache is a good example. It is clear that many headaches are tension related. Many physicians, however, treat headache as if they were a physiologic disease. To me, it makes more sense to discover the patient's stresses and tensions and try to direct therapy at improving these problems. If you are not totally successful treating the patient's stresses, it is fine to treat the pain with drugs. Another example of a psychosomatic illness is a patient with a neurosis, such as depression, who has physical symptoms. The astute physician will recognize the depression and refer the patient for psychiatric help. The physician who fails to obtain a psychosocial history may admit the patient to a hospital with the diagnosis of "malaise and weight loss," then order a complete work-up to rule out cancer. When the evaluation is negative the patient will be discharged and told that he or she is "fine." This kind of error occurs daily with physicians who do not take the time and make the effort to understand the patient's full medical and psychosocial history.

Finally, medicine can be a rewarding experience for a sensitive, caring physician. If you allow yourself to learn about and understand your patients, a far more important relationship will develop; the physician may benefit as much as the patient. Many physicians take the time to know their patients. People frequently ask "What happened to the good old country doctor?" Although we answer that medicine has become too sophisticated and is now practiced in hospitals with MRI, CT scanners, computers, and similar equipment, this is not really answering the question. What the patients miss is the doctor who took the time to talk with them and to understand them as individuals. Many physicians today still spend time learning about their patients. For these patients and physicians, a very special and rewarding relationship develops.

A multitude of texts have been written that cover the psychosocial sciences ad infinitum and ad nauseum. I do not wish to contribute to the nausea, but I would like to illustrate some of my comments with several case examples.

CASE EXAMPLES

The first patient was a third-year medical student who stopped by my office and asked me if I would look at his sore throat. The ensuing conversation went as follows:

Q. Tell me a little about your sore throat.

A. What would you like to know?

Q. When did it start?

A. It started 2 to 3 weeks ago and has been fairly constant since then.

Q. Have you had any fever or malaise?

A. No.

Q. Any lymph node swelling in your neck?

A. No.

Q. Any other symptoms?

A. No.

At this point I looked at the patient's throat, which was entirely normal. There were no abnormal swellings in his neck. Based on the history and lack of physical findings, it was my opinion that there was no readily apparent physical basis for his complaint. I therefore explored his psychosocial history.

Q. What are you doing these days?

A. I am on Surgery at the Navy Hospital.

Q. How is that?

A. Pretty good. We are very busy and I am working very hard. There are two patients with osteosarcomas, one of the leg and the other of the arm. In addition, we have several patients with metastatic terminal cancers.

Q. I have a feeling, from the way you talk, that these cases are upsetting you.

A. Yeah, I guess so. None of the surgeons seem to spend time with these patients. The patients have no family -no nothing - and so I have been spending a lot of time with them. We begin rounds at 6:30 each morning and don't finish until midnight.

Q. Has anyone helped you with your feelings about the patients with cancer?

A. No, all the doctors just avoid the patients and the subject.

Q. So you have to fill in for them?

A. I guess so.

Q. Let me back up to your sore throat for a minute. What is the pain

like? Is it a stabbing pain, a burning pain, or more like a tightening?

A. It is a tightening or a constricting pain.

Q. Do you think this might be related to your feelings about the patients on the Surgery Service?

The student smiled at this point, as he, too, had made the obvious connection between the sore throat and the cancer patients. We then went on to talk about his feelings and how he could learn to deal with them.

This student was a healthy, psychologically well-adjusted individual. He was not neurotic or psychotic. The stress of his life had become acutely overwhelming, and he had no outlet for his tension. He developed some spasms in the muscles in his throat. These spasms caused pain and became a focus for his attention. Discovering and talking about his real problem relieved some of his stress and the physical symptoms rapidly disappeared.

I do not want to suggest that all patients with a straightforward, acute, short-term medical illness need a complete psychosocial history. You should be sensitive to the patient whose complaints are not classic. The patient just described had complaints that were extremely atypical for a sore throat. A short psychosocial history uncovered the patient's real problem. Throat cultures, antistreptolysin O titers, complete blood cell count, sedimentation rate, chest X ray, skin tests, penicillin, acetaminophen, aspirin, and even codeine would all have been costly and ineffective.

The next patient was a 45-year-old male who smoked and drank heavily; he presented with a chief complaint of sore throat of 3-weeks duration. History revealed 54 pack years (2 packs/day for 27 years) of smoking, heavy alcohol use, and a recent 10 lb weight loss. Examination revealed a very reddened pharyngeal mucosa, but no evidence of infection or tumor. The patient was reassured that nothing was wrong. He was advised to stop smoking and drinking.

Two weeks later, he returned with the same complaints. He stated he had decreased his smoking to one pack per day and was only drinking three highballs at night. Physical examination was unchanged. A throat culture was taken and a chest X ray was ordered. He was given

a prescription for antibiotics for a 2-week period.

The patient returned again 4 weeks later. His symptoms had abated on the penicillin, but had recurred soon after stopping the medication. Examination was unchanged. Again he was advised to stop smoking and drinking. He was given a prescription for viscous lidocaine and instructed to return in 1 month. He returned 6 weeks later with his throat condition virtually unchanged. Diagnosis was a mucosal irritation from the smoking and drinking. The patient was advised that his problem would not go away until he stopped smoking and drinking.

I was aware that I did not enjoy talking to this man. I did not relate well to him and, although I felt it my responsibility to rule out infections and tumors, I did not wish to spend time on his psychosocial history. Much to my dismay, he kept returning to me-sometimes better, sometimes worse. I even suggested he see a different doctor, but he felt I knew him and should continue to treat him.

After a year of this, I finally decided to find out more about this man. His father had died a painful death of cancer of the throat. His mother had died an alcoholic. At the age of 16 years, he was left to care for three brothers and two sisters. He dropped out of high school to do this. He worked his way up in a small business and was now relatively successful.

He had married at the age of 25 years and had two children. His wife had left him 1 year ago, and he was now living with his 18-year-old son. The son did not work and was heavily into drugs. The patient's only support group was his friends at a local club, where they drank and smoked together. He was very alone, and very frightened that he, too, would die of cancer of the throat. He and I discussed all of this and how it affected his throat symptoms. With my urging and his approval, he entered a therapy group available through the hospital.

I saw him 6 months later for an ear infection. He was still smoking but had stopped drinking. He was seeing his wife and they were considering moving back together. His throat was still sore, but he knew that was related to his smoking. It did not bother him as much as it had previously.

This is an example of a real physical complaint whose perception is

greatly enhanced by the patients' psychosocial situation. I failed to deal with this effectively, and the symptoms persisted. When I finally explored his psychosocial history, I was able to direct this man to psychological help. This greatly improved his life and decreased his sore throat.

The next patient was a 35-year-old woman who came to my office for revision rhinoplasty. All her life she had wanted the size of her nose reduced and finally had sought consultation with a plastic surgeon. He told her there was "nothing to it," and the surgery was performed. The result 6 months later was unchanged from the preoperative appearance. A second procedure was carried out, and postoperatively the nose developed a serious, unsightly dorsal depression. A third procedure corrected this. The nose was now less attractive than originally, and the patient was very unhappy. A fourth procedure was recommended.

At this point, the patient had lost trust in the original surgeon and had sought a second opinion. On examination, the skin of the patient's nose was found to be extremely thick. The patient desired a refined, delicate tip. In an effort to achieve this result, the surgeon had removed virtually all of the lower lateral alar cartilages. There now was just a blob of skin held up by the patient's septum. The surgeon had made a serious error in even trying to produce a refined tip on a patient with such thick skin. The patient's goals were virtually unobtainable.

The patient's desires were still the same—namely, for a refined, delicate tip to the nose. She had always hated her nose and now she hated it even more. She could not be happy until her nose was fixed. She had decided to go from surgeon to surgeon until she found one who could solve her problem.

I then asked her about her personal life. She was unmarried and worked as a business administrator for a large firm. She had been dating the president of that firm. The relationship had not progressed, and she was disheartened by that. Her plastic surgeon was a customer of the same firm, which further complicated her life. She was therefore considering moving to a new city and taking a new job.

We talked for a long time and I explained the following to her: First,

the type of nose she wanted was not possible to create. No matter how many surgeons she sought, she would never acquire a refined nose. Furthermore, she had a wide, full face. A thin, refined nose would not even look good, as it would be out of balance with the rest of her face. I felt that she was using her nose in part as a scapegoat for some of her other problems, and I made the following remarks: "First, you are pretty just the way you are. You don't need a different nose. In any case, there is nothing you can do to get a different nose. It is not possible. You must stop looking for nasal surgery. Accept what you have, take care with your appearance, and you will look just fine. Face your other problems for what they are. Do not displace them onto your face. Running away will not solve them."

We talked about all this for some time, and then she left. Two months later she telephoned me. She said that she had thought a lot about our conversation. She realized and accepted that her nose could not be changed, and so there was no use in worrying about it further. She faced her problems and now felt better about herself. She felt good about her work and felt settled about her life.

This is a prevalent problem in all areas of medicine and is particularly common in the field of cosmetic surgery. A patient has a personal problem, either at work or at home. Rather than facing that problem, the patient focuses on some real, slight, or even nonexistent physical problem or deformity for which correction is sought. An astute physician should recognize this when only a slight or nonexistent physical deformity or disorder is present. It is far more difficult to recognize the underlying psychological problem when the patient focuses on a very real physical deformity. A patient may just as easily focus on a problem such as complaints of sinus symptoms. As physicians, we must fully evaluate each patient. When there is psychological pain, we must recognize this. Psychological pain cannot be cured by treating a physical illness, and in these cases we must first diagnose the problem and then direct the therapy appropriately.

A 56-year-old woman was referred to me to rule out sinus causes for headaches. Her history is long and is summarized briefly here. The patient was well until 10 years prior to this consultation, when she began having headaches on the left side of her head. She took aspirin for these, but over the years the headaches had slowly increased in intensity. The patient saw her family physician on occasion and he told

her they were just nerves and prescribed diazepam and aspirin. About a year ago, the headaches became so severe she consulted another physician, who obtained a complete history and physical examination. He ordered a complete battery of blood tests. He also concluded it was just nerves, but told the patient that if she wished further examination she should consult a neurologist. At first she hesitated to do this, but the headaches were becoming unbearable. The neurologist obtained a complete history and physical examination and then ordered a skull series, electroencephalography, and CT scan. He concluded that she had atypical migraine and prescribed an ergotrate. This made the patient quite dizzy, but did not alleviate the headaches. He then tried propranolol hydrochloride. This too failed to cure the headaches. He then sent the patient to a surgeon for a temporal artery biopsy. In the preoperative evaluation she was found to have a guaiac-positive stool specimen. An upper and lower gastrointestinal tract study was ordered. The patient also had a sigmoidoscopy and a gynecologic consultation. All these yielded negative results and she finally had the temporal artery biopsy. The results were nondiagnostic. By this time, her medical bill had reached \$9000 and she still had headaches. She was advised to seek psychiatric consultation.

Instead, she returned to her family physician, who suggested she consult first with an ophthalmologist to rule out eye problems and with a head and neck surgeon to rule out sinus problems. The ophthalmic consultation was negative. She next came to see me. After obtaining the history just described, I asked her where it hurt and she pointed to the side of the head. The head and neck examination was normal. Pressure over the temporomandibular joint elicited some tenderness, which radiated up to the side of the head. Her teeth were ground flat due to bruxism.

Her psychosocial history revealed that her husband had had a heart attack 10 years earlier and had retired. He now sat around the house, and she spent her whole day caring for him. His retirement and disability checks were not sufficient and so they had to watch their money carefully. This patient felt miserable. As she put it, she just gritted her teeth and did the best she could. She had always ground her teeth in response to stress and over the past years had been doing it more and more.

I made the diagnosis of temporomandibular joint pain resulting from

bruxism. I explained the mechanism of this disorder to the patient. I referred her to a dentist to have a plate made for her to wear at night and sent her to a Crisis Center for help with her home situation.

I received follow-up letters from the dentist and the psychiatrist. The patient's symptoms had greatly decreased with the bite plate, which she wore at night and through much of the day. The Crisis Center employed a home visiting nurse who visited the couple, and the husband now was learning to care, in part, for himself. The patient had joined a therapy group. She was now working during the day and was feeling much better about herself.

It is interesting to note that in this case, several physicians had made the diagnosis of nerves but none had effectively communicated to the patient the cause and mechanisms of her pain nor had they helped the patient to deal with her stresses. Had her original physician done so, he might have saved this patient years of unnecessary suffering. He would have also saved society at least \$9000 in medical bills.

Many physicians would tell you cases like these are uncommon; they would state that all patients have problems, but that the medical diseases they bring to their physicians are real problems and are not linked, as I suggested, to their personal lives. I disagree. Although half of the patients I see have a disease unrelated to their psychosocial history, my interest in their personal lives enhances our relationship and their trust in me as a physician. The other half of the patients I see do have a disease intimately connected to, if not directly caused by, their psychosocial situations. For these patients, taking a psychosocial history and responding appropriately is a critical or crucial aspect in diagnosing their disease and in prescribing appropriate treatment.

Mr. G. was a 70-year-old man who developed an epidermoid carcinoma of the palate. This was treated with radiation therapy, recurred, and was treated with cryotherapy. About this time, he developed multiple cranial nerve deficits. Extensive evaluation failed to identify any cause. It was suspected that he had metastatic tumor to the base of the skull. After 6 months of progressive agony, repeat CT scans and tomography documented the existence of metastatic disease.

It had been the belief of all the physicians treating this man that some

central nervous system lesion must exist, but we had been unable to demonstrate it. For these reasons, we worked with the family intensively toward an ultimate cure. When the tomograms finally showed the destruction at the base of the skull, it was clear that cure was not possible.

The evening before he died, I spent 2 hours talking with his family. After a lot of soul-searching, the family members all agreed that they did not wish to prolong Mr. G.'s agony. We discussed autopsy and funeral plans. The family lived 120 miles away. They asked me when he might die and I replied that I didn't know - it could be tonight or next week. I told them they had been tremendously supportive for Mr. G. and had done everything possible to help him. They should not feel guilty if he died peacefully when they were not there. They had been present and helpful in his lifetime. In fact, sometimes patients do not die until the family leaves. It is almost as if they hold on for the family. Once alone, they can let go.

The family accepted this and decided to drive home. Mr. G. died in his sleep that night. When I notified the family, I restated how supportive they had been and how kind it had been not to fight and prolong his agony. Two weeks later I received a card from the family thanking me for my kind care.

This case represents one of the most important functions we perform as physicians-helping not only the patient but also the family. When a person dies the family suffers, too. As a physician you can help them in their grieving. Family members frequently feel guilt. You can help them understand and deal with grief, guilt, and anger.

A 29 year old x-ray technician/instructor complained of a sore throat. On the small clinic desk, beside his brand new University Medical Center chart, was a 2-inch thick chart of records, copies of his medical care from a neighboring institution. I chose to disregard the chart and asked him what was wrong, wherein he replied he had a sore throat that had been going on for years. He mentioned he had brought with him the records of his evaluation and care and gestured to the chart on my desk. I had no idea how one could possibly generate a 2-inch chart for a sore throat. I asked him if I could read the chart to which he assented.

The chart was of particular interest for it began with copies of all of the bills generated for this sore throat; I quickly added up the various pages and came to a sum exceeding \$30,000. The medical portion of the chart indicated that this individual had presented to a primary care physician with a complaint of a sore throat. The examination at that point indicated some mild pharyngeal inflammation. The diagnosis of pharyngitis was made, a culture was taken and the patient was prescribed penicillin. He reported no real change in his pharyngeal pain and a second antibiotic was prescribed, a little broader in its coverage and a little more expensive.

A note 2 weeks later indicated that the sore throat had not changed and a laboratory investigation was begun. The throat culture and initial sampling of blood failed to enlighten the treating physician. The patient was then referred to an ENT physician who performed a much more elaborate examination, found nothing, spoke of endoscopies and biopsies, mentioned smoker's pharyngitis and ultimately cultured the patients' throat and prescribed a new antibiotic. This too failed and hence a tonsillectomy was recommended and performed.

Following recovery from the tonsillectomy the sore throat persisted and a more rigorous laboratory examination was requested. Sinus x-rays were obtained as was a barium swallow. The radiographs were all interpreted as negative. The head and neck surgeon concluded that this was a psychiatric disturbance and referred the patient to an infectious disease consultant. The infectious disease physician cultured the throat several times, skin tested both arms and when all results were normal again requested antibodies and titers to all known pathogens. The results from these all were read as negative or normal. Additional esoteric tests were ordered. Allergy/immunology consultation was obtained, desensitization was initiated, all to no avail.

I asked the patient to describe his sore throat which he described as a pain or soreness in the back of his throat, a fairly typical middle pharyngeal muscle spasm. It was a pain that hurt with each swallow but did not feel like a lump in the throat. At no time had he felt systemically ill and there was no history of fever, sweats or any other symptoms commonly associated with infectious illnesses.

I asked the patient about the stresses in his life; he questioned how I could consider a stress-related problem when I had not even looked at

his throat. I asked him if he would like me to look at his throat and he responded that he would. I performed a very careful head and neck examination, all of which were entirely within normal limits.

I again asked him about the stresses in his life and commented, "you have been through one of the most elaborate, expensive workups for a sore throat I have ever had opportunity to read. You have had every test I have ever known for a sore throat, including many I have never known. You have had a constant sore throat for a period exceeding 1 year. It has been unresponsive to most of the medications known to affect disorders of the throat. Your symptoms have remained unchanged for an entire year and you have a completely normal examination." The patient replied, "I was always worried that it was going to turn out to be stress related. Where do I go from here?" I responded that he would need to obtain a psychiatric evaluation and that he and the psychiatrist could explore these matters.

Each physician had at one time entertained a diagnosis of a mental health illness, none had communicated this as a possibility to the patient. The patient had exhausted the physicians, the laboratories and himself and so self-referred to the university.

The following is a summary of the psychiatrist's evaluation. The psychiatric diagnosis would be best categorized as

The patient was initially highly resistant	Axis I:	1. Psychogenic pain (sensory conversion) 2. Dysthymia (depressive neurosis)
	Axis II:	Mixed compulsive, passive dependant personality.
	Axis III:	Sore throat (functional)
	Axis IV:	Stress factors: intrapsychic solely.
	Axis V:	GAF = 58

ant to any form of psychotherapy. After much working through the history it emerged that this young man was the oldest son of a high-school principal father who consciously decided to make this son the model young man in his community. All of the son's choices were made for him with no input from him. The patient had a younger sister with whom he felt a significant bond but shared no emotional intimacy. The patient also felt dominated by his mother. The patient still phoned his father weekly and sought his advice on all aspects of his life.

The patient was treated with modified short-term therapy, focusing on the present and the relationship between the patient and the psychiatrist. The psychiatrist pointed out the patient's subtle ways of avoiding emotional contact with him. During the challenge phase of his resistances he redeveloped the acute pain in his throat (severe motor tension caused by compulsive inhibition of aggressive impulses) whenever he wanted to verbally lash out at the psychiatrist.

The treatment did not go smoothly. The patient frequently wanted to terminate. However, he began seeing a woman and began a romantic relationship. The phone calls to his father decreased and he began to make his own decisions. He grew fond of the psychiatrist and related his feelings in a spontaneous way. The students in his class saw the most profound change. They previously taunted him relentlessly, and he was incapable of standing up for himself. One day he broke out in a rage at them and insisted on proper respect and decorum in his classroom.

The psychiatrist's summary of the psychodynamics involved is as follows. The patient's sense of self was damaged by his parent's need to control him. He was not allowed to separate, individuate, rebel and make his own mistakes. He suffered from enormous castration (retaliatory) anxiety from all authority and peer figures so his only answer to his perceived dilemma was to appear cooperative but to passively rebel by both withholding and sabotaging his own life. The meaning of the sore throat is complex. The patient was appearing to the medical profession because he was in pain and he was hoping (and frightened) that some physician would recognize the true source of his pain. At the same time as each clinician missed the actual cause of his suffering he took great delight in retaliating secretly by castrating the clinician through his own treatment-resistant symptoms.

This kind of sadomasochistic patient is extremely common in medical and surgical practice and is frequently misdiagnosed and mistreated at great expense to the patient, the profession, and society.