PSYCHOSOMETIC ASPECTS OF RHINOLOGY

Berthold Stockvis, M.D., Mart P. Bolten, M.D. and B. van Leeuwaarden, M.D.
Leiden, The Netherlands

Will appear in the following Number.

THE NOSE, RELAIS OF ENCOUNTER AND SELF-IMAGE

Robert Gronner, M.D.

Symposia, Conferences and Institutes are designed towards a Synthesis of the established and of the promised insofar as it is sensible. To this end disciplines that intersect the main area are asked to contribute. Psychosomatics are no longer a discipline but a viewpoint, a fundamental one to be sure, in any field of medicine. In terms of syndromes it is being excellently covered in this course and thus I feel that I have leave to address myself as a psychiatrist to the effects of the complex interaction of psychopathology, of rhinopathology, of the experience in being "nasally ill" and of the intervention by the Rhinologist. A medical situation, so is the novice instructed, has to be appraised from six perspectives each one a research approach by itself. I shall enumerate them but only deal with the last one. They are all equally important, their order is not hierarchical, rather operational :

1) The illness as a syndrome, a course, a diagnosis.
2) Pathography in terms of genesis and etiology.
3) The patient as a person, his biography.
4) The physician, his training, skill and total equipment.
5) The proposed and possible intervention (or therapy); it's potential and
6) the total transaction between patient and doctor, the "Encounter" in the remedial field. After knowing how the patient became ill, how does he stay ill. Knowing how he is treated, considerations of the total effect of the therapeutic intervention will determine prognosis and modify the goal.

Structural and functional derangement beyond adequate serviceability of the nose is considered nasal illness. Here is the first qualification "considered a problem of expectables, of personal standards and of tresholds" for pain, dysfunction and anxiety. The roles of anatomy, of trauma, of infection, and of allergy are of individual treshold, one that is not even stable at all times. They are however opportunities for maladaptive tendencies to be grasped. And when these maladaptive tendencies are more than transient we arrive soon at the stage where we see "opportunities exploited". Holmes et al. (4) in their excellent monograph "The Nose" have clearly demonstrated the use, or better the abuse of nasal reactivity for "shutting-out or shutting-in" patterns predicated on primitive defensives long outmoded in the person's life

but called on in lieu of actual and effective dealing with difficult or problematic interpersonal situations. However impressive their experimental work is, the abstractive conclusions are cogent only as hints for study of each individual instance. A true pathography requires not only recognition of all factors, pre-existent, added and reactive but their appraisal as to related weight and last but not least the difficult element of timing, the phenomenon of "convergence" so easily minimised as "pure chance." It is in this convergence that we can often trace interactions and thus understand illness as a "miscreant" of the patient's propensities.

This then leads directly to the supposedly para-medical and unscientific topic of "Values and Valuations" with philosophical shadings. But this is unavoidable. Every physician knows that the experience of "Self" is altered in illness. Conversely certain pathological experiences of "Self", chronic or severe enough, will produce objectively testable malfunctions and eventual structural changes. This is operationally mediated through the "Body Ego" a self-percept mostly unconscious. McLean (5) has shown representation of Soma in the visceral brain and Herrick noted that this area receives from the cortex and radiates into the Thalamus. All sensory fibers reach this area through the Diencephelon. Only olfaction enters directly. Psychologically the Body Ego is the matrix of the "Ego" the instrument of "Selfhood". The latter is altered in illness. Severe and personally significant stress distorts "Selfhood" and thus must alter the body scheme perceptually and functionally. This is how we can approach the problem of «Convergence of pathogenic factors." Lifestress, trauma, infection, critical phases, shape up into meaning on a "here and now" basis so that illness results. Pathography is the answer.

Hollander (3) has made a careful survey of the unconscious symbolic use of the nose by the mechanism of displacement in terms of meaning and function: as a phallus, serving the neurotic masculine protest of women, as a similar symbol of adequacy or potency in men but also as bearer of sexual guilt, creating dysfunction whenever these issues became active. As a locus for anal (coprophilic) strivings or regulatory compulsion, and last but not least as an oral-incorporative substitute organ. It is this more general "shut-out or shut-in" defense that Holmes sees as the derangement.

There is however another meaning of the nose less relating to function but as an important part of body image and the seat of narcissistic investment aside from the aforementioned other investments of partial instinct. It is one of the difficulties the rhinoplastic surgeon has in deciding on the degree of disfigurement apart from ethnic, cultural, and personal preferences. (2). The differentiation between real disfigurement or severe derangement of function as held against minor ones with obvious over-valuations by the patient is easy. But what of the severe pathology that when removed proves to have covered an equally severe psychopathology now bereft of its nesting place searching for other areas? Often causing calamity in the psycho-social life of the patient or producing a querulant. "poor result" patient? It follows then that "body image" and therefore "Ego" contains percepts and meaning of "Self", of "Identity", sexual, male or female, ill or well. The meaning of a cure and implicitly of the interaction with the doctor cannot be neglected. People with poor identity cannot be challenged in their "roles." Latent

Bisexuality might have become activated through change demanding implementation by the surgeon and then wishing for reversal. A patient was referred for Psychotherapy because a very well done Rhinoplasty was to her a "pig's snout." Why? For years this intelligent and capable woman had tried to be as successful as any man because of her particular relationship to her father. When she moved toward a more feminine posture because of a promising relationship to a man, she made the step. Hélàs, it was just too big, to her the giving up of her father's large nose was a calamity exposing something ugly in her. Often the cost of illness to a particular patient is lower than the cost of health. The most dramatic examples are of course the severe depressions and suicides after cardiac surgery or after successful somatic therapy in ulcerative colitis. In rhinoplasty however untoward results are rarely so dramatic yet observable, often slow in development. They can be divided into three main groups which have all in common an inability of the patient te redistribute and to reintegrate libido. There are those whose own narcissistic increment is accompanied by a greater range and intensity of sexual interest soon well beyond their capacity or beyond the preparadness of partners to comply or to be permissive. Then there are those whose liabilities have lost a "cover up" in their psychosocial life and who enter relationships that soon prove to be unrewarding and empty since they have oversold themselves. Lastly there are the patients who cannot handle the above stresses and who then often slowly develop depressive episodes or paranoid attitudes. These had been latent, now they have become last resorts. On the other hand I have had occasion to observe in detail a patient who had been in Analysis for over three years and continued after a successful rhinoplasty. I was impressed with the emotional work necessary for her to integrate this experience.

Paramount in rhinological intervention is the symbolic meaning of encounter on several levels of psychosexuality in the interaction between doctor and patient. Therefore "cure" or the perseveration of medical activity may be an indication of neurotic need on the part of the patient but also of the doctor. Often there is lack of any other and "less safe" gratification. Fixation of masochistic attachments on the Rhinologist can follow. This not only can lead to overtreatment, but also to undertreatment, since the demandingness and clinging of the patient can provoke neglect!

Balint (1) speaks of the "Apostolic function of the doctor" a more or less necessary pursuit of the "doctor's idea of the patient needing him," the patient becoming a mission. Sullivan (6) in his admonitions to psychiatrists reminds that initially the patient is a complete stranger and has to be treated as such. There is sagacity in this advice: it is comparatively easy to preserve detachment in the somatic inventory taking but when a complete pathography is to be done psychological probing becomes unavoidable. Not only is this intrusive and requires much skill but the detachment that pervails in the somatic area becomes untenable when data, reactions and valuations are forthcoming with potential resonance in the physician. Moralistic views might aggravate an existing sense of guilt over being ill, over a failure of health and a possible resource for ill-gotten neurotic gains. The discussion of matters sexual beyond their statistical data about physiological events or gross

disturbance of function meets often with a collusion of silence between doctor and patient. Many physicians, in all branches of medicine, need to be omniscient or omnipotent. The urge to rescue, the response to the call for help has its many neurotic distortions in the doctor often well camouflaged. This can lead to what has been called "Furor therapeuticus".

Thus when the nose is viewed as an organ of "encounter with the other" being the ancient sentinal and envoy of sorts it not only is vigilant but must be feeling scrutinized thus making the person hypervigilant. The introjection of this encounter brings about an "encounter with self" that under the shadow of disturbed function or distorted body image cannot fail to make for severe discontinuities in the psychic apparatus, in the sphere between "Subject-I" and "self object-me". If it serves to defend, the price has been high as it must be in illness or deformity. But there is always the nagging question whether without it the patient would not dread a greater calamity.

The meaning of illness is always one of something "bad" that has happened to the "good," a miscarriage of fate at any point of unfolding life experience. Man quite early seeks causality often fanatically so. And everybody has his private personal theory about his illness. Sense of guilt makes it "deserved" or denial of this sense "undeserved", looking for a causality, for a malevolent agent. In the "System Illness" the doctor very soon is an integral part, woven into the magic causalities of illness and health, which now have become "iatromorphic." Failures tempt projection mechanisms and may lead to paranoid attitudes.

There are however safequards against all these vicissitudes of interaction in such highly charged areas. Basic is a sound conceptualization about pathogenesis and the meaning of illness to a patient. Mythology even scientific or monocausality have no place. Nor can the extremes of "bad constitution" or "born all good but cursed by capricious fate" be a basis. Beginning with a complimentary series of innate and acquired constitution in interplay with complex environmental factors one can arrive at a concept of what I prefer to call an "Adaptive Posture" a personal ecological style. It is then possible to view illness and deformity as a modality of existence and consider certain more or less salient features of this experience:

a) it can be a narcissistic blow or erosion; but also a substitute resource
b) a source of primitive sexual or agressive gratification unavailable at better integrated levels
c) a protected, partial withdrawal "shutting in or out" narrowing the field thus making life possible in other areas of lower stress
d) a primitive form of mastery over agression by having power to "sustain symptoms", to suffer to "live with it"
e) secondary gains by parasitary relationships to the environment
f) an opportunity to expiate a sense of guilt or shame over all the transgressions and failures from a) to e)

Van der Horst (7) has pointed at the difficulty of freeing ourselves from a dualistic way of thinking in psychosomatics forcing us to always look for the contact point between the subjective mental and the objective physical.

I believe an operational view allows for more unitary conceptualizations. Thus phenomenon and experience can become an objective percept as long as they can become consensually validated. This requires (1) awareness of our valuations as subjective (2) consistency of observations (3) reproduction of phenomena within a range of reasonable variability.

Illness as experience is according to Van der Horst (7) a rupture between Self and Ego, one is either ill or not, a line divides these states phenomenologically. I should like to qualify this: there is an experiencing Ego and a judging, observing Ego, hardly distinguishable. In Psychoanalysis such "doubletrack" operation is utilized to achieve moments of insight which are preceded by the working through of this insight into this "doubletrack" and followed by working through in resynthesis and reintegration of the "Me" and the "I." This is an example of rupture or discontinuity an artificial, but healing illness. The experience of illness is then but a state of discontinuity so excessive that it constantly defies the homeostatic gravitation.

Thus the therapeutic intervention of the physician is to remove such factors that make discontinuity excessive. He has to reckon with all factors to get optimal results. He fails by neglecting too many no matter how brillant his technique as a surgeon, how good his diagnosis, how adeptly he handles his patient's psychological needs. The various adaptive systems of the human person, psychological, intrapsychic, nervous humoral, immunological etc. are interlocked. Thus severe or chronic maladaptations create pathological subsystems that represent vested interests. They are difficult to dislodge and continuity is not restored automatically by removal of noxious factors but it takes considerable time and effort to disengage the patient from a state of ill health which is not an absence of health but a condition or modality of experience all of its own. A sick person becomes not necessarily a healthy person by removal of his symptoms and of their causes! This is why there often has to be preparatory treatment in one form or another before therapy becomes active and effective. Modern medicine is trying to move from episodic to maintenance medicine!

There are then three groups of patients as to interventive needs:

1) Where intervention removes noxious factors and acts as stimulus to move from an excessive to a healthy discontinuity. They need little more than competent care and reassurance.
2) They are like the above but a precarious equilibrium exists so that prospects of devaluation of pathology and the challenge of a symptom-free life are a threat. Psychotherapeutic assistance concomitant and subsequent to rhinological intervention is indicated. This can be masked conviently, be done by the surgeon, not without hazards however, or by a cooperating psychiatrist, inconvenient but safer.
3) Here the pathology is overvalued and no matter how somatic the rhinological derangement it is a psychiatric symptomequivalent that will defy intervention with a rebound of even greater problems. Many of them know it and their refusal to cooperate though neurotic is adaptive. They need psychiatric help first! They and many in the second group "latro morphize" their illness. The doctor does not liberate them but becomes part of their illness, often to the point of paranoia.

Again the dividing line between illness and health is not fixed, it is fluctuating, relative and value ridden. Therefore it is not a "way of being," rather a state. It is ecological in the truest sense of the term. The individual responses on all levels of adaptation by inmates of Nazi concentration camps bear ample testimony.

While one must respect the hidden reasons for resistance to help, after the patient has been begging for it with a deviated septum, a cosmetically catastrophical nose or an allergic rhinitis often in one person, one needs not capitulate. But the hierarchy of the pathogenic elements has to be respected, studied and proper strategy for remedy advised. Else calamity is being courted.

In conclusion, I emphasize again that the nose when deranged structurally or functionally, congenitally or through noxious factors of all sorts including interpersonal experiential ones becomes an overloaded relais station of the encounter between Self and world and the reflection of Self. This is essentially due to its primal function in infantile experience, its eligibility for displacement of anatomically prejudiced partial instincts, its amphimix character of protrusion and hollowness and its sentinel gatekeeper function. (2) Emotional proprioception overlaps with Exteroception in the nose as it functions or fails to function and as it looks when looked at. Therefore all nasal pathology and remedial intervention has to be viewed against the overt or hidden meaning of the illness and of the cure.

LE NEZ, RELAIS DE COMMUNICATION ET IMAGE DE SOI-MÊME

En dehors de l'étiologie, de la pathogenèse, de l'évolution des éléments accessoires, de l'habilité du médecin et des antécédents du malade, l'expérience de la maladie ou de la malformation et de la guérison est un élément crucial dans la dynamique et la phénoménologie du contact médical, connu sous le nom de diagnostic et de traitement.

Une maladie du nez, qu'elle soit congénitale ou structurale, ou un dysfonctionnement de n'importe quelle origine sont chargés de sens multiples et complexes et de valorisations pour le malade en rapport avec l'importante signification symbolique de l'organe, accasionnée par sa forme et son emploi en tant que sentinelle et portier. Il s'agit donc d'un relais de communication entre le monde extérieur et les états affectifs internes, mais il s'agit également en terme d'image de soi ou de «Ego corporel» d'un relais de communication avec soi-même. De par ce fait, l'intervention du médicin doit tenir compte des significations conscientes et inconscientes de la maladie et de la guérison. Ceci signifie qu'il faut prendre en considération les objectifs du malade et aussi du médecin. Il est aisé de reconnaître la psychopathologie dans les cas où la rhinopathologie est minime par rapport aux plaintes. D'autre part une rhinopathologie tout à fait nette et importante peut souvent camoufler de sérieux troubles émotionels, qui se manifestent après une intervention, couronnée de succès, comme négation d'un bon résultat objectif ou comme une maladie psychiatrique caractéristique, généralement après un long laps de temps.

La collaboration avec un psychiatre augmente les chances de succès.

BIBLIOGRAPHY

1. **Balint, Michael,**
«The Doctor, The Patient and His Illness», (p.p. 216—227)
International University Press - 1957
2. **Gronner,** Robert,
"The Rhinologist's Patient" in
"Manual of Corrective Surgery of Nasal Septum and ext. Pyramid" by Maurice Cottle, American Rhinologic Society, 1960
3. **Hollander,** Marc H.,
"Observations on Nasal Symptoms"
Psychiatric Quaterly, July, 1956
4. **Holmes,** Thomas H.,
"The Nose"
Chas Thomas, Springfield, Illinois, 1950
5. **McLean,** Paul,
"Psychosomatic Disease and the Visceral Brain"
Psychosomatic Medicine, Vol. XI, 6
6. **Sullivan,** Harry S.,
"Conceptions of Modern Psychiatry", pp. 46
Reprint from "Psychiatry" Vol. III/I and Vol. VIII/II
7. **Van der Horst,** Ludwig,
"Psychosomatic Medicine and Phenomenological Anthropology"
Symposium on Psychosomatic Research - Ed. Jores and Freyberger - Robert Brunner, New York.

Dept. of Nervous & Mental Diseases Northwestern University Medical School.
Institute for Psychiatric & Psychosomatic Research, Michael Reese Hospital, Chicago, Illinois.

Prof. Dr. Robert Gronner,
670 N. Michigan Avenue,
Chicago 11, Illinois, U.S.A.