

SUMMARY OF THE THIRD ROUND TABLE

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With this congress in view a questionnaire was sent to a great number of audiologists about 1½ year ago. The results of this poll strengthened our suspicion that opinions differ widely and that, first and foremost, definitions are lacking.

Now, after the work done by the members of this panel, there seems to me considerably less disagreement. If you agree with me this is already an important achievement.

The main diagnostic difficulty exists in those patients who cannot be classified as organic by the otologist or by the psychiatrist. It is in my opinion helpful here to consider several possibilities.

A. The patient's apperception of the stimulus reaching his mind is normal, i.e. he is conscious of hearing — but he chooses consciously and voluntarily out of plausible motives to alter his response either negatively - i.e. simulating or aggravating deafness - or positively by dissimulating deafness. This kind of malingering or aggravation and the counterpart dissimulation, is no deafness at all but conscious and voluntary lying for simple financial reasons or to avoid displeasure. Here in terms of Freud's psycho-analysis the "Uber Ich", the personality, directs the responses.

B. The stimulus reaches the mind normally, but because of the context of the patient's mind the response is altered. This alteration is **involuntary**. However he may be conscious of this process — and does not like to admit it. This is the malingering of neurotics. Here according to Freud the subconscious "Es" directs the responses and dominates the personality.

C. The stimulus reaches the mind normally, i.e., the perception is normal but the apperception is blocked. This is the involuntary and unconscious form of psychogenic deafness in which the subconscious "Es" is predominant. This we find in hysteric deafness, but also in apparently not hysteric children. Hunter and Cawthorne saw some of such cases which they call "sympathetic deafness".

Among others we saw a girl of 11 years who suffered from severe bilateral deafness, handicapped in school and wearing a hearing aid. Because of the inconsistency of the audiograms, psychic deafness was suspected and we sent her to a psychiatrist, however without success. Then the well-known American preacher Osborn preached one evening in Holland, and the child was led on to the platform. She was cured of her deafness as if "by a miracle". The audiogram is now normal.

I am told that among the miracles performed by these preachers many cases of cure or improvement of deafness should be present. Here one cannot help feel into confused and a little ashamed at the fact that our diagnosis and our therapy proved to be so poor. This should be a challenge to us to concentrate on this problem, beginning with believing that psychic deafness exists.

DISCUSSION OF THE THIRD ROUND TABLE

Ventry:

Does Fournier have any research evidence that supports or validates his statement that a diagnosis of malingering can be made if a patient's ".....thresholds are gradually improved..... constancy is easier to maintain and inconsistency reduced accordingly". (p. 123). In other words, how does Fournier **know** if these patients are indeed malingering? It is interesting that Kodman, Sedlacek and Powers (1959) have stated that inconsistent and variable responses are positive signs of malingering. These "operational" definitions of malingering are not only contradictory but the validity of either definition has not as yet been demonstrated. Ventry and Chaiklin (1962) have written as follows: "There are not auditory tests available that can identify malingering. An admission by the patient is the only way currently available to identify malingering....."

In more than five years' experience with over 500 patients who presented functional hearing problems, we have encountered only two patients who admitted malingering. We believe that more than two of our patients were malingering but without an admission we could not identify the others. Those who refer to malingerers (or develop tests for malingering), then are usually referring to patients who cannot properly be labeled as malingerers".

We believe that the term "malingering" should be eliminated from audiological writing.

Fournier:

First, may I point out once more that, at least to my knowledge, there does not seem to exist any test for differentiating between malingered and so-called psychogenic deafness. It is often said and printed that such a differential diagnosis is the neuro-psychiatrist task, not ours; and this is quite true, but it leads us nowhere ever since referring all our inconsistent patients to psychiatrists would not be a practical proposition. We need to make a selection among them, and therefore to be able to make a pre-diagnosis ourselves; and that is what all of us do, more or less empirically.

Unable to devise any objective test for this purpose, it occurred to me that some equivalent means of differentiation might perhaps be based on the difference of behavior in the test situation which apparently should be expected from conscious inconsistent patients on the one hand, and unconscious ones on the other. It is commonly observed that some non organically deaf or functional patients are not constant in their intra- and intertest inconsis-

tencies, while others remain unconstant and inconsistent throughout repeated testing; proved malingerers (except the severely organically deaf) are always in the first category, whilst psychopathics and mentally retarded are always in the second. However I do not intend to be dogmatic about such a statement, which cannot be validated for the obvious reason that there are no previous means of identifying conscious and unconscious inconsistencies, and what I am looking for, in order to get us out of the rut, is precisely such a means.

Now, I really do not believe that the "admission of the patient is the only way currently available to identify malingerers". One may occasionally, if only for legal motives, submit to that statement, but a great majority of audiologists will agree when I say that, especially during speech testing, some traits of behavior are sure signs of volitional non-cooperation. I am referring here to abnormally long latency and hesitating responses, half-words (only the first or the last syllable of the spondees), mimicking, etc..... That is not the way the organically deaf behaves, but the way the people thinks he should. There can be no doubt that to strike such a theatrical attitude one needs to be quite conscious of the situation. To me it seems to be even more a matter of common sense than of experience.

Ventry:

Some of the answers to your questionnaire and some of the papers presented at the Round Table suggest that there are clinicians who view psychogenic hearing loss and malingering as separate and distinct entities. I would like to state my position on this question by quoting from a recent article written by Ventry and Chaiklin (1962): "Some clinicians believe that malingered hearing loss and psychogenic hearing loss are mutually exclusive conditions, a distinction that does not appear meaningful to us. First, the etiology of malingering presumably rests in the patient's mind, hence malingering is by definition psychogenic..... Malingering, therefore, should be viewed as a symptom of underlying emotional disturbance. Another aspect of this problem is that both conscious and unconscious dynamics may operate in the same patient to cause malingering. For example, a patient may know he is exaggerating his symptom, but the reasons for his exaggeration may be at an unconscious level. Flicker (1958) emphasizes that malingering is not a separate condition but that it may occur as a symptom in many different psychiatric conditions. He notes that the symptom of malingering must be understood in the context of the patient's general life adjustment. It is our opinion that it is psychologically naive to view malingering as a perverse deception practiced by dishonest people who are otherwise psychologically normal".

What are the reactions of the panel members to this position?

Van Dishoeck:

As already pointed out we should in non-organic deafness distinguish between two kinds of malingering, true psychogenic deafness and functional deafness.

1. Malingering as the conscious voluntary mental process for financial motives (insurance) or to avoid displeasure (military service). This is indeed a more or less perverse deception by dishonest people, who are otherwise normal. We may call this simply lying. These persons should be unmasked.
2. Malingering originating from an underlying emotional disturbance in the neurotic patient who is only partly responsible. We might call this unintentional malingering. These patients should be treated. Of course there are mixed cases of these two forms.
3. True psychogenic deafness as a hysterical conversation symptom. Every psychiatrist will confirm that they meet from time to time hearing troubles as a symptom in different psychic disorders.
4. Deafness of the poorer ear for instance in the one-sided congenital deafness, because of disuse (comparable to functional blindness of a disused eye). However we do not know to what extent this kind of deafness exists.

Niemeyer:

In PSGR audiometry practically always the reflex primarily has to be conditioned. But there is one possibility to use unconditioned auditory reflexes for threshold measuring. Hearing sensations lead to a transitory reduction of peripheral blood flow. This is so much more pronounced the more the acoustic stimulus is of affective character. The registration of this effect has been developed by Kottmeyer, since 1958, to an objective method of a hearing test of considerable accuracy and reliability. The reduction of blood flow is registered as voluminary change of the finger tip either plethysmographically or rheographically. Phase different beat **sounds**, particularly the corresponding intermediate tone according to Stumpf, have proved to be much more suitable as testing stimuli than sinusoidal tones, because of their peculiar "psycho-vasomotoric effect" (Kottmeyer). This method is most suitable for measuring hearing threshold, as the threshold of the phase different beat sounds does not differ much more from the sinus threshold than the normal standard aberration in subjective audiograms. One insurance patient, for example, had successfully deceived three university hospitals and several experts in 17 years, and somehow even managed to outwit experienced audiologists in the Stenger-test. It was not until plethysmographic examination with phase different beat sound audiometry revealed a quite good hearing on one ear lesioned, by gun shot with facial palsy and stenosis of the ear canal, that the objectively measured curve practically equalled a Stenger-curve, which was taken under special conditions.

Azzi:

I thank Dr Niemeyer for his interesting additional informations.

Berlin:

Would you discuss four things, Dr Ventry?

1. Your reasons for preferring the term "functional hearing loss" to "non-organic hearing loss" or other terms.
2. Your attitude towards the term "malingering" as a diagnostic category.
3. The findings of your article on the effect of earphones which press the pinna and collapse the ear canal.
4. Some of the motivations and psycho-dynamics of the group of resolved vs unresolved functional hearing loss of patients in your study.

Ventry:

1. Functional hearing loss is a generic term that is appropriate when there are audiometric discrepancies and/or discrepancies between observed behavior and audiometric findings **and** no apparent organic condition can be found to account for the discrepancies. The term is preferred to "non-organic" because "nonorganic" literally means "not organic" and thus is another way of saying "psychogenic". I also object to "nonorganic" on the grounds that it merely says what the condition is not and does not tell you what the condition is. It's interesting that "nonorganic" appears to be used by some audiologists and otologists but is not used (as far as I can determine) by other professional disciplines.
2. I think my attitude toward malingering has been made clear in my comments to Prof. Dr Van Dishoeck and to M. Fournier.
3. We have found that, in certain patients, audiometer earphone pressure may result in a collapse of the external auditory canal. Once the canal has been closed movements of the jaw, replacement of the earphones, and changes in the tension of the earphone headband can cause changes in the size of the lumen of the external canal. Changes in the size of the lumen can result in significant intratest and intertest audiometric discrepancies. Failure to recognize this condition may lead to a diagnosis of functional hearing loss. It's important to point out how wrong it would have been to say this patient had a nonorganic hearing loss since an organic condition caused the test discrepancies. It also would have been a serious mistake to label the patient a malingerer. This example illustrates one of the reasons we prefer the term "functional hearing loss". Namely, that the diagnosis of "functional hearing loss" allows for the possibility that subsequent examinations will reveal an organic condition to account for all or part of the patient's problem. Neither "malingering" nor "nonorganic" allows for this possibility.
4. It would be premature to answer this question before all our data are gathered. At the conclusion of the study we plan to publish a paper that will discuss the audiologic, social, and psychologic variables that appear to differentiate patients whose functional hearing loss resolves from patients whose functional hearing loss persists.

Ewertsen:

I subscribe to Prof. Van Dishoeck's description of the various sorts of functional hearing loss, and I admit that psychogenic deafness is rather rare

in the clinic. In Copenhagen the diagnosis psychogenic deafness is made, when the following three criterions are fulfilled:

1. Normal hearing that may be stated by means of objective measurements as impedance-test and skin-resistance-test.
2. A history of psychogenic trauma with a hearing loss that often develops in the course of hours or days.
3. Restoration of hearing due to psychiatric treatment alone.

I do not agree with Dr Ventry's opinion of the Stenger-test and most disagreements originates from different or wrong procedures. The proper Stenger-test is performed by presenting a tone from **one** oscillator to both ears absolute simultaneously. With this technic it is the most valuable test in estimating unilateral hearing loss.

If Dr Ventry has used two tonegenerators with a simultaneous presentation, the tones may be out of phase or even beating and this explains why he is not satisfied with Stenger's test.

Ventry:

The following is a very brief description of our pure-tone Stenger procedure. Two tones of the same frequency are presented simultaneously to each ear. One tone is 5 dB above the admitted threshold in the better ear and the other tone is at the same hearing level in the poorer ear. After the patient has responded, the tone is gradually (and completely) withdrawn from the better ear and the patient's response is noted. The tone is then gradually re-introduced to the better ear. Both tones are then interrupted. If the results are negative at this level, the intensity of tone in the poorer ear is increased by 10 dB and the procedure repeated. We continue to ascend in 10 dB steps (in the poorer ear) until a positive result is obtained or until we are at or above the patient's admitted threshold in the poorer ear. Two of the most common responses observed when the Stenger test is positive are (1) that the patient may cease responding in both ears or (2) that he may continue to respond even through the tone in the better ear has been withdrawn. We consider the test positive if either form of behavior occurs significantly below (15 dB or more) the admitted threshold for the apparently poorer ear.

Tegtmeier:

In the Universitätsklinik HNO in Bonn in all cases of audiometric testing for a medical certificate the Stenger test is performed in several frequencies.

Always we come across single cases, inwhich there is surely no malingering, but Stenger test is positiv.

We have discovered two main factors responsible for these findings:

1. A disturbed function of directional hearing, the Stenger test being based on a phenomenon of directional hearing.
2. When the Stenger test is performed with permanent tones, it may be, that the better ear is fatigued within every short period of time so severely, that the patient reports perfectly correct not to hear the tone any more, without the tone being centrally masked by the louder tone in the other ear.

That is why at our clinic no patient is thought of being malingering when

with a positiv Stenger test as only evidence. As a criterium for exakt audiometric measurements the agreement of the dB-values of:

1. the AC threshold in an absolute dB-rate with
2. the threshold for white noise and
3. the threshold for speech-hearing acts.

Azzi:

I wholly agree with Dr Tegtmeier in so far as the influence of stress in Stenger test, carried out with continous pure tones is concerned. From this starting point, this question is of interest also to Dr Ewertsen and Dr Ventry. We also attempted to increase the effectiveness in Stenger test and I consider as excellent Dr Ewertsen's suggestion of presenting pure tones for short periods of time. A variation to Stenger test which we have found extremely satisfactory consists in using speech. The advantage of using speech probably rises from the non-periodic nature of sounds making up the spoken word. Fatigue is limited and in addition to that it is more difficult for the subject to distinguish exactly if the sound is perceived by one or both ears.

Hennebert: (discussion not received).

Dr Hennebert describes some EEG experiments in cats and asks if these experiments are of interest for the EEG in humans.

Derbyshire:

I would like to respond to Dr Hennebert.

The changes that occur in the EEG as the subject changes state (I am thinking now of the human not the cat) are most fascinating and most complicated. I want to offer this idea. We don't know yet what component of the whole hearing act any particular brain wave response represents. When we know what any one wave represents in the psychological processes then we can probably predict more precisely what it means when one particular EEG wave appears or doesn't appear. These experiments you refer to are most intriguing but in all our current experiments the problem seems to be that with the cat the psychology of the animal is not available for correlation with the EEG and in the human experiments the psychology of the subject is too complicated for simple correlation.