VII. THE NERVOUS BREAKDOWN

AN APPROACH FOR GENERAL PRACTITIONERS

ZALMON WOLF, M.B., B.Ch., D.P.M.

Assistant Neurologist-Psychiatrist, Tara Hospital, Johannesburg

'And the Lord God formed man of the dust of the ground, and breathed into his nostrils the breath of life; and man became a living soul.' (Gen. II, 7)

'Therefore, good Brutus, be prepared to hear:
And, since you know you cannot see yourself
As well as by reflection, I, your glass,
Will modestly discover to yourself
That of yourself which you yet know not of.'
(Julius Caesar, I, 2)

Considering our present stage of scientific development it is anomalous that a group of diseases should be designated by such a non-descriptive term as 'nervous breakdown', particularly when sufferers from nervous disease are variously estimated to comprise 10-20% of all illness, and to complicate about 30% of the remainder. A psychoneurosis or neurosis is an illness with specific etiology, pathology, symptomatology and treatment. For various reasons the natural history of the neuroses have as yet not been clearly defined. A vast pool of empiric knowledge exists about them and many theories of pathology, or more precisely psychopathology, have been evolved. These have permitted a clearer understanding of the diseases and a more rational management; it is unfortunate, therefore, that in the evolution of these concepts terminology was employed which tends to obscure existing knowledge.

A psychoneurosis is an illness of which the symptoms are an effort to re-establish a satisfactory equilibrium between the individual and his environment. This state of equilibrium is not static; the individual is constantly readjusting so that he remains within an optimal range, a process which may be likened to the heat-regulating mechanism of the body. Physiologically the heat-state equilibrium can be measured and a normal optimal range for the individual has been charted. When the individual becomes pyrexial, i.e. the range of heat equilibrium extends beyond the normal, the individual (though unaware of any norms) is able to appreciate that he is ill. And similarly, when behavioural patterns cease to remain within an optimal range of equilibrium, again the individual knows he is ill.

Recently Burt [1] defined personality as 'the whole system of relatively permanent tendencies which are distinctive of a given individual and determine that individual's adjustments to the material and social environment.' It is when these 'adjustments' prove unsatisfactory to a degree demanding medical attention that the individual is mentally ill, i.e. he is said to have had a nervous breakdown. Implicit in this definition of personality is the concept of a *unique* individual with innate and acquired tendencies inter-acting with his environment, which is primarily psychological or social.

Nosological designations for various psychoneurotic syndromes have been in common usage for many years. Because of a lack of precise knowledge of etiology and pathology, they are ill-defined; such names as anxiety state, reactive depression, neurasthenia, obsessional states, hysteria, etc., have been and are in common use. Many are satisfied with the use of the term 'neurotic' or 'hysteria' as a designation of all psychological illness: vaguely, a neurosis is thought of as a junior psychosis and a psychosis as a state where the patient is really mad. The exasperation exhibited towards the psychoneuroses (which stems from a lack of knowledge about them) leads to an attitude which regards the symptomatology as purely imaginary on the part of the patient; if he wanted to, and had more 'guts', he would 'snap out of it'. There is a feeling of something reprehensible about this type of illness.

The diagnosis of psychoneurosis is frequently made only after exhaustive examinations and investigations, i.e. by a process of elimination.

Because of the above attitudes and beliefs which I

think are common, and which I, as a general practitioner held, I think it desirable to make several categorical statements.

DEFINITION

Where the individual's behaviour patterns are abnormal but where their objective is the re-establishment of equilibrium within an optimal range, the individual is suffering from a psychoneurosis. Where the behaviour pattern bears no apparent relationship to the re-establishment of equilibrium, a state of psychosis exists. In these conditions the patient's symptoms (behaviour patterns) are not imaginary, nor are they under control of the patient's will. He is as distressed, and the symptoms are as real, as those of the organically ill person; and like the latter, he is unable to 'snap out of it.' For this reason, the illness merits the same respect and attention as one caused by disease of an organ.

A positive diagnosis must be arrived at by an intelligent appraisal of the clinical features. This is stressed by Paul Wood [2] in his Goulstonian lectures: 'Medical officers . . . . must learn to diagnose neurosis on positive grounds: no greater blame can be attached to a psychiatrist who fails to make a physical examination than to a physician who fails to probe the mind. A few pertinent questions and the ability to listen to the replies are all that is required; lengthy details are not needed for diagnosis.' On this statement the *British Medical Journal* observed:[3] 'The place to prevent psychological casualties is in the front line, and the methods are those of *general practice rather than the hospital ward*' (the italics are mine).

Psychological illnesses present in varying degrees of complexity and intensity, and accordingly varying methods of treatment are necessary; the general practitioner is able to deal adequately with most cases he encounters, though some will require reference to a psychiatrist.

In order to deal with the psychoneuroses it is necessary to have (1) an awareness of the condition, (2) some knowledge of the disease, and (3) a discipline with regard to history, examination and treatment. These factors will now be dealt with:

THE CLINICAL APPROACH TO PSYCHONEUROSIS

1. *An Awareness of the Condition.* This implies the regarding of the individual as a *unique dynamic personality*, one constantly interacting with his environment and who brings genetic and learned behaviour patterns to each situation. His behaviour has meaning in terms of these forces. The basic patterns of behaviour are learned early in life and, with slight modifications, are those used to engage the stresses of life as they appear in the evolution of the individual. They are like the handwriting, the basic pattern of which one learns in childhood, and which one modifies as the years go by.

This awareness implies that the approach to the patient's complaint will take into consideration psychogenic as well as organic factors.

2. *Some Knowledge of the Disease as a Clinical Entity.* In reviewing my case histories from general practice, I found groups of symptoms presented by patients. In these cases I ultimately arrived at a diagnosis of psychoneurosis only after exhaustive examination and investigation. These symptoms rarely occurred singly—they usually consisted of several of the following:

Feeling of lassitude, tiredness, no energy.
Sleep disturbances—always sleepy, inability to fall asleep, waking after a short period of sleep.
Sighing and breathing disturbances—asthma, inability to take a deep breath.
Headache—usually on vertex; very common.
Gastro-intestinal disturbances—lump in throat, abdominal pain, constipation, diarrhoea, anorexia, wind.
Emotional disturbances—feeling pent up, nervous, anxious, worried, afraid, irritable, depressed.
Pain—precordial, in limbs, back.
Heart—palpitations, heavy feeling, heart conscious.
Dizziness, tremor.
Genito-urinary—impotence, premature ejaculation, vaginismus, dyspareunia, frequency of micturition.

Case 1. A 44-year-old female, complaining of feeling tired; periods longer than usual; severe palpitations particularly at night; choking feeling on walking fast; headaches; deep sighs and heart conscious. Duration: 3 months.

Case 2. A 23-year-old female, complaining of shakiness, lack of energy; depression, tightness around the throat, palpitations and domestic unhappiness. Duration: 3 months (since birth of child). Diagnosed as an 'anxiety state'. The importance of the depression was not appreciated until a suicidal attempt was made.

These case-histories can be matched by any general practitioner from his own files. Neither case had an organic basis. Case 2 is valuable because it illustrates the importance of a depression immersed among the other complaints. Here the depression was thought to be a reaction to domestic unhappiness, but this case was in fact a psychosis; suicidal threats were not given the respect they merited—a common attitude. *It cannot be sufficiently stressed that a patient who threatens suicide will probably attempt it. He is as seriously ill as anyone with a disease where death is a probable end-result.*

Most psychoneuroses present a cluster of symptoms which, if taken together, indicate the probable psychological origin. Any single complaint alone may be a symptom of a non-psychogenic disease; whereas the picture formed by all the symptoms grouped together is unlikely to be produced by organic disease. This is illustrated by case 1, in which there was mitral stenosis, though none of the symptoms were referable to this cause; marital infidelity on the part of the husband and financial stresses existed at that time, and when these improved, so did the patient's clinical state.

While it is desirable to recognize nosological entities, it is important to be able to recognize a syndrome as having a psychogenic origin. The severity of the condition can be assessed by comparing the intensity of the illness with the magnitude of the provoking stressful features.

3. *Discipline with regard to History, Examination and Treatment.* A rational discipline implies some rational concept of the genesis of disease.

Basic behaviour patterns are established during the early phases of development. In considering their evolution, one should start from the moment of fertili-

zation, at the time of union of the sperm and ovum, for each brings with it its genetic heritage. The fertilized ovum exhibits an inherent drive which through growth and differentiation is directed at the full potential evolution of the individual. The ultimate individual cannot achieve more than this inherent potential; e.g., if the potential height of the individual is 5 feet 8 inches he will not evolve to be a 6-footer. The full potential of the growing organism can be realized only if its needs are adequately met. For example, adequate nutrition and oxygenation is necessary *in utero* for the development of the foetus into a healthy baby. Experimentally-induced anoxic states in pregnant mice are followed by congenital abnormalities in the litter. Rubella in the pregnant mother may be followed by congenital abnormalities in the infant.

At birth the needs of the organism change. It now requires air *via* the respiratory passages, food *via* the gastro-intestinal tract. It has emotional needs as well as bodily. Where the needs of the organism are not satisfied, then part of the energy of the inherent drive to development is deflected in compensating for the lack of satisfaction; e.g., where the need for vitamin D is not satisfied, part of the developmental drive is deflected to thickening the bones so that they can meet stresses more adequately. In this deflection of the drive by the non-satisfaction of a need, there is obstruction, and an obstructed drive builds up tension. The emotional accompaniment of this tension is termed anxiety and its basic method of expression is by restlessness and crying. In the adult anxiety is expressed by restlessness; crying has largely been culturally suppressed. The picture of the restless, crying, ill-fed baby becoming placid and pleasant on correct feeding is familiar to all. One need of the infant is the establishment of an emotional bond with one important person (usually the mother), and failure to satisfy this need in infancy can lead to cachexia and death. This is graphically illustrated in Bakwin and Bakwin's book.[4] The behaviour of the evolving child is so determined as to keep the swing of anxiety resulting from varying obstruction to its drive (because of denial of its needs) within an optimal range.

HISTORY AND EXAMINATION

Thus an adequate history must take into account:

A. *Previous Influencing Factors*

(i) *Family History and Constellation:* The genetic heritage is explored by enquiring into familial illness; intra-uterine influences by considering the maternal health and age during pregnancy; the patterns learned by considering the social status and cultural restraint of the family; and the state of 'happiness' and its goals provides the initial group-stresses encountered.

(ii) Development during infancy and pre-school years is evalued. It is during this period that basic behaviour patterns are established.

(iii) School, occupational and marital histories indicate the patterns used by the individual and his adequacy in these environments.

(iv) The health of the patient and previous handicaps imposed by ill-health are noted.

B. *The Premorbid Personality of the Patient*

According to our definition, the distinctive tendencies which determine his adjustments to his environment are considered. These are evalued by considering his effectiveness socially, domestically and at work. His values and habits are reviewed; characteristic traits and temperamental features are noted; his fantasy life is considered as an index to his objectives.

C. *History of Present Complaint(s)*

This is usually taken first. During this period the patient is best allowed to speak with little interruption, and it is here that a friendly, sympathetic relationship with the patient is established. Particular note must be taken of the circumstances of origin of the complaint as described by the patient.

D. *Examination*

(i) *Physical.* This must be complete and exhaustive. It should not be repeated during subsequent interviews, for this would be interpreted by the patient as indicative of uncertainty on the part of the examiner.

(ii) *Psychiatric.* Behaviour, talk (form and content), attention, association, mood, compulsive thoughts, orientation, ideas of reference, hallucinations, memory, intelligence, general knowledge, judgment and insight are each considered. Psychiatric text-books set out satisfactory methods for this: Curran and Guttman's is a useful short work for this purpose.[5]

(iii) *Investigations* which may be indicated as a result of the above.

TREATMENT

This implies the management and care of a patient or the combating of his disorder.

Every patient, whether psychologically or physically ill, should be approached with the awareness that treatment commences at the moment of introduction. The patient believes that he is organically ill; he is anxious and takes a critical attitude with regard to his doctor. A non-critical, sympathetic approach is essential; the patient must feel that he is being accepted by the therapist. This may be difficult for the doctor to convey, particularly because many patients assume a potentially hostile and rejecting attitude. The patient is a unique dynamic individual; acceptance is conveyed to him when he feels that the therapist recognizes him as such.

There are certain prerequisites for treatment, viz. (1) a sincere interest and desire to help the patient; (2) confidence on the part of the doctor that *he can help* the patient; (3) an orientation that the target is not 'cure' but the solution of an immediate problem; and (4) knowledge that the patient gains considerable relief from being able to 'objectify' his problems by pouring them out to a receptive non-critical ear. Listening is more important than questioning.

Treatment, as stated, commences from the moment of introduction to the patient. From this moment the above attitudes must be brought into operation. During the physical examination it is wise to remark casually on the normal findings as they are encountered, since fears concerning the integrity of the heart, blood pressure

and lungs can thereby be unobtrusively allayed. When the history and physical examination have been completed and an assessment of the patient's state arrived at, a provisional hypothesis of the causation of his symptoms are given to him. It is stressed that this hypothesis is purely provisional and that modifications will be made as subsequent facts emerge.

During the recital of his history the patient has probably reviewed his personality for the first time. The evolution of behaviour patterns is explained to him: they may be likened to dress in that they clothe his self. Writing is discussed as an example of behaviour patterns; this aids the concept of altering behaviour patterns and the time necessary for such a change to be learned. The therapist is described as a mirror in which the individual can view his patterns. Once the patient perceives the reflection he can strive to adjust them.

Whatever the patient's basic behaviour patterns may be—and their importance should not be minimized—the cause of his neurosis lies in the present. It is the result of a conflict between his wishes, strivings and desires on the one hand and restraints—cultural and social—on the other. The patient may exhibit varying degrees of awareness towards these conflicts.

Case 3. A 23-year-old married man complaining of frequency of micturition, anxiety, restlessness and tiredness. His main concern was frequency of micturition, which had commenced 4 months previously. He found it particularly embarrassing when in company or at work, and he was sure that he was being ridiculed by others because of his frequent visits to the toilet. At the time of the appearance of this symptom, his wife had suffered a miscarriage, in the sixth month of their marriage. While discussing this, he expressed the doubts that he had suffered as to his fertility because of a previous attack of orchitis following mumps. Reference was also made to masturbation, which he felt might have impaired fertility.

He was the only son of wealthy parents. He felt that he had been spoilt and somewhat mollycoddled as a youth, but in spite of this he was a virile athletic man, popular with his fellows. Recently he had negotiated a partnership, and he felt that he was too junior to occupy a position of the responsibility that it entailed. Since childhood he had been guided by his mother, and he still saw her daily and discussed his difficulties with her.

Before consulting a psychiatrist he had been treated by his general practitioner, by a urologist and by a physician. He had then become desperate about his condition, and been advised by his mother to see a psychiatrist. (In passing, it is worth noting how often the psychiatrist is visited on a note of desperation!)

Treatment: The initial interviews were devoted to the taking of the history and to the examination. During this period few questions were asked. The patient experienced much relief from anxiety during this narration. This allowed him to revert to parts of the history already covered and to supply information withheld in the first telling.

It was postulated that he was a dependent personality with a strong achievement drive; that in the presence of this dependent attitude, anxiety was engendered by his having to arrive at decisions demanded by his domestic and business environments. His fears with regard to sex and consequent infertility were related to his attitude towards his mother, previous masturbatory activity and the traumatic effect of the mumps orchitis.

The symptoms could be explained on the basis of being the somatic features of fear. This hypothesis was submitted to the patient, who was not able to accept or discard it. It formed the basis for subsequent interviews, where his history was examined in relation to this hypothesis. The genesis of behaviour patterns which emerged were then discussed. The factors leading to attitudes of dependence and feelings of inferiority and of not being accepted were brought to attention. No dogmatic attitude was adopted; the patient was allowed to come to his conclusions with little influence on my part.

At the end of each interview a summary of our discussion was given. He was seen for an hour once each week for 10 weeks. At the end of that period he felt relieved of his symptoms and was once more able to engage in his activities without discomfort.

CONCLUSION

Perhaps this article has not dealt with what is popularly conceived as a nervous breakdown, but the clinical picture envisaged here is commonly encountered; it is diagnosed positively and not by exclusion. It results from an inability of the individual to express his unique personality in his environment. An approach is described which takes this concept into account and which is calculated to aid satisfactory expression of the personality.

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