AN INTELLIGENCE OF THE HEART*

M. B. FELDMAN, M.B., B.CH. (RAND), D.P.M. (R.C.P. & S., ENG.), M.R.C.P. (EDIN.), *Psychiatrist, Johannesburg*

I propose to review some aspects of modern psychiatric thought and practice, which have reference to those problems of the everyday practice of medicine which soon will confront you as medical practitioners. An understanding, not only of the science, but also of the art of medicine is required if you are properly to fulfil your responsibilities to your patients.

It is perhaps the possibility that psychiatry has a worthwhile contribution to make to what has hitherto been only rather vaguely understood by the term 'The art of medicine', that has determined the inclusion of a psychiatrist in this revision course.

The phrase *An intelligence of the heart,* which came my way but a few weeks ago, seems to me admirably to delineate that 'without which not' of good medical practice.

Just as general medicine has only recently come to derive benefit from the insights of psychological medicine, so has psychiatry (regrettably also only recently) come to maturation as a result of the application of that vital essence, *the scientific method,* long familiar to the physician.

The cross fertilization of the two disciplines, medicine and psychiatry, has led to a recognition of the importance of what has been called *the second question.* Our training has taught us how to try to answer the question: What sort of *illness* has the patient? We must, however, never omit to try, too, to enquire: What sort of *patient* has the illness?

We have referred to the scientific method. In basic form it consists of 5 essential and consequential steps. Let us briefly consider them:

1. Collecting information.
2. Checking the information gathered.
3. Erecting an hypothesis to comprehend the 'facts' so checked,
4. Testing the hypothesis on the basis of its ability accurately to predict an outcome (e.g. when submitted to controlled experiment).
5. Evaluating the substantiated hypothesis and determining a scientific 'law'.

* Valedictory address to Final year Students, Medical School, University of the Witwatersrand, 28 September 1960.

In medicine these steps are respectively:—

1. Obtaining a history.
2. Carrying out a physical examination.
3. Arriving at a provisional diagnosis.
4. Performing laboratory, radiological, and other tests and/or embarking on a therapeutic trial of specific medication.
5. Arriving at a final diagnosis (which in some cases may be obtainable only after operative exploration or at post-mortem examination).

In psychiatric practice, physical and neurological examination (including routine testing of the urine) is often negative. How then are we to check the information given by the patient? The answer is to obtain histories, with the patient's permission, from those who know him and have an interest in his welfare — the husband or wife, parents or children, employer or teacher, and so on.

Where this information is not readily available, a period of observation in a nursing home or hospital will enable the nursing sister in charge of the ward, the occupational therapist, relaxational therapist, and social worker to obtain the information necessary to arrive at a diagnosis.

The information obtained from sources other than the patient is extremely worth while also in cases suffering from organic disease and could usefully become routine in all branches of medicine. The old-fashioned family practitioner who had all this additional information at his fingertips by reason of his close and warm relationship with the whole family, knew how important this often-neglected information can be.

Heredity and Environment

Before discussing the psychiatric disorders, a brief reference must be made to the question of heredity and environment in their aetiology. The position has well been summarized in the statement 'Heredity deals the cards, environment plays the hand'. As you know, many a good hand dealt has been poorly played and, contrariwise, many a mediocre hand so well managed as to win the game. It is well to remember that it isn't so much the size of the dog in the fight, as the size of the fight in the dog that counts. The question is not of 'heredity *or* environment', but rather how much of one and how much of the other.

The old concept of an illness being caused by a pathology has been replaced by the modern concept of the sick person with 'built-in' tolerances and sensitivities reacting to many interacting stresses — genetically determined deficiencies, bacterial and other invasions, social and interpersonal difficulties, toxic and climatic strains, and so on.

CATEGORIES OF MENTAL ILLNESS

In presenting a more scientific framework of reference of psychiatric illness, we may start by dividing mental illness into 2 chief categories:

(*a*) Major mental illnesses — the *psychoses*
(*b*) Minor mental illnesses — the *psychoneuroses*.

The suffix '-osis' indicates 'something wrong with'.

In the original concept, then, the term psychosis meant 'something wrong with the psyche', whereas the term psychoneurosis meant 'something wrong with the neurones (i.e. the central nervous system) leading to disorder of the psyche'.

This outmoded application of these terms can now be abandoned in favour of that set forth above which, while maintaining traditional terms, gives them dynamic and up-to-date connotations.

A. The Psychoses or Major Mental Illnesses

These fall into two classes:

1. *The Organic Psychoses*

Whatever the nature of the brain pathology — whether due to genetic defect, intra-uterine disease or postnatal trauma, infection (bacterial, viral or parasitic), neoplasm, toxaemia (exogenous or endogenous), cardiovascular dysfunction, or haemopoietic disorder — all of these present either in (*a*) acute disturbance (the deliria), or (*b*) chronic disturbance (the dementias), or (*c*) a combination of these.

The disturbance of mind which is brought about in its 3 manifestations — *knowing, feeling* and *doing* — is dramatic and eruptive in the deliria and gradual and dilapidative in the dementias. In either the practitioner must apply himself, after consideration of the history from patient and others, and after physical and neurological examination and ancillary investigations, to the task of determining what pathology exists in the central nervous system with a view to giving appropriate and specific treatment to aetiological factors in addition to the general and non-specific care, supervision and control of the psychic manifestations. The latter are best dealt with by suitably trained and efficient nursing staff. The commonest mistake in the treatment of these conditions is an attempt to substitute sedation for nursing, with the inevitable result that a drug-confusional state is added to the underlying delirium or dementia.

2. *The Functional Psychoses*

These include the conditions in which the psychic disturbance is not due to an ascertainable structural disorder of brain. The 2 chief conditions in this group are:

(*a*) The manic / depressive psychoses. The manic patient knows everything, feels fine and is busy doing everything — the 3 functions of mind being all together elevated 'above the line' (of normality). The melancholic patient knows nothing, feels low-spirited and does nothing — the functions of mind are together depressed 'below the line' (of normality).

The outlook of the melancholic is well set forth in the rhyme entitled 'The Pessimist'.

'Nothing to do but work,
Nothing to eat but food,
Nothing to wear but clothes,
To keep one from going nude.

Nothing to breathe but air,
Quick as a flash 'tis gone;
Nowhere to fall but off,
Nowhere to stand but on.

Nothing to comb but hair,
Nowhere to sleep but in bed,
Nothing to weep but tears,
Nothing to bury but dead.'

The depressions very often come out of the blue but on occasion are precipitated by external events.

THE SORROWS OF WERTHER

'Werther had a love for Charlotte
Such as words could never utter;
Would you know how first he met her?
She was cutting bread and butter.

Charlotte was a married lady,
And a moral man was Werther,
And for all the wealth of Indies,
Would do nothing for to hurt her.

So he sigh'd and pined and ogled,
And his passion boil'd and bubbled,
Till he blew his silly brains out,
And no more was by it troubled.

Charlotte, having seen his body
Borne before her on a shutter,
Like a well-conducted person,
Went on cutting bread and butter.'

It must always be remembered that what appears catastrophic to the onlooker unaware of the total context of the situation, may have a personal significance for those involved which is quite different. For example, the case of Margaret and Augustus:

'Eating more than he was able
Augustus died at breakfast table.
"If you please", said little Meg,
"May I have his other egg"?'

(*b*) The schizophrenias. Here there is a CHAOS splintering and disintegration of the personality and the bonds between knowing, feeling and doing are, as it were, broken so that action and feeling are no longer appropriate to associated thought, e.g. the woman convinced she is the Queen of Spain, yet quite indifferent about being on her knees scrubbing the ward floor.

B. The Psychoneuroses or Minor Mental Illnesses

Lack of a more or less consistent admixture of affection ('love', 'warmth', 'security') and discipline (in the sense of tuition and example regarding the need to consider the needs of others as well as one's own) are basically important in the genesis of all the minor mental illnesses.

These fall into 5 classes: (*i*) The anxiety hysterias, (*ii*) the obsessional disorders, (*iii*) the psychosomatic disorders, (*iv*) the reactive depressions, and (*v*) the character neuroses.

(*i*) The anxiety-hysterias are considered together because anxiety states rarely fail to show some hysterical manifestations, and hysterics rarely completely 'convert' their anxiety. This disorder tends to occur more predominantly in the lower I.Q. range.

(*ii*) The obsessional disorders constitute a variant of the anxiety state in which repetitive rumination and occasional ritualistic compulsion manifest themselves. This disorder tends to occur more frequently in the higher I.Q. range.

(*iii*) The psychosomatic disorders. This other variant of the anxiety state, in which emphasis is placed upon the somatic manifestations of anxiety, has proved to be acceptable as a diagnosis to both the medical practitioner and his patient.

(*iv*) The reactive depressions, as the name implies, refer to depressions predominantly the result of circumstance — loss of a loved one, or failure, as the usual causes of this grief reaction. In contrast to the endogenous melancholic depression, the patient with a reactive depression does not necessarily feel at his worst in the early morning, nor does he improve as the day goes on. His depression varies as the circum-

stances vary. He has difficulty in getting off to sleep; once asleep he sleeps through, again in contrast to the melancholic who has no initial difficulty but wakes after an hour or two, then remains awake.

(*v*) The character neuroses. The antisocial manifestations of the patient's personality disturbance are prominent in this category. The patient is said to 'act out' his conflicts in contrast with the other 4 sub-groups, in which his problems are internalized.

One of the interesting manifestations of either character neurosis or psychoneurosis is the so-called accident proneness. This is of importance in industry and on the road where it leads to the disease of road accidents. An amusing and transient manifestation of this interesting condition is reported in a recent issue of the *Lancet*.

'My friend Giles was accident-prone for a fortnight; and that, he swears, was long enough. Soon after we arrived on holiday he chanced to see a tall blonde goddess watching his tennis. This inspired him to such Hoad-like activity that he won his match. Alive to the fullness of the moment, he rushed across the court and leapt the net. Unfortunately, he did not quite make it. He met the young lady a few evenings later at the weekly dance. She was a nurse, he discovered, when she gave him first-aid for the cup of tea he cascaded into his left shoe. Probably on the principle of humouring the patient, she agreed to go sailing with him the next afternoon.

'At the appointed time Giles escorted her aboard the waiting dinghy. Despite some spirited poling with an inverted oar the boat refused to budge from its bed of sand. Nothing daunted, Giles slid over the stern and gave a few manly pushes under the expectant gaze of his lady. Still the vessel remained fast until, at last, with a superhuman heave he set it in motion. Unhappily, at the same time, he stood on a piece of seaweed. As the dinghy surged forward Giles dived headlong into the deep blue sea. The rescue operation was interesting: Giles, dazed and dripping, was hauled to the shore while a boat was launched in pursuit of his companion, who, being no sailor, was gliding helplessly out over the bay.

'How he managed to persuade her to walk with him the following evening is beyond my comprehension: but, as the sun set, they were strolling along a country lane, Giles relating how he had won a medal for the high jump at school. Should she care, he would demonstrate the style that had won him this honour. The look of awful anticipation on her face did not escape him, but, he said, not to worry, he would do no more than demonstrate on that three-foot wall. The plaintive wail and dull thud which followed his disappearance, if not new, was still alarming. Rushing to the wall and looking over she beheld Giles on his back, groaning, in a sunken field, six feet below road level.

'Giles has had fewer accidents lately. His wife, a tall blonde girl, takes good care of him: she says he evokes her nursing instincts more than any patient ever did.'

C. Intermediate Conditions

Intermediate between the psychoses and the psychoneuroses, as defined above, are the instances of:

(*a*) the minor psychoses and
(*b*) the major psychoneuroses.

(*a*) *The Minor Psychoses*

Early stages, or minor versions of the psychoses, both organic and functional, may be confused with the psychoneuroses. The mild nocturnal confusional state occurring in the chronic alcoholic, the 'hysterical manifestations' (catastrophic reactions) of the dementing patient (whether due to senility, arteriosclerosis or the slow development of a cerebral tumour), the so-called post-traumatic personality syndrome (mild post-traumatic dementia) are examples in the organic category of psychosis. Minor melancholia (pseudo-neurotic melancholia) and very early schizophrenic disintegration (pseudo-neurotic schizophrenia) are examples in the functional category of psychosis.

(*b*) *The Major Psychoneuroses*

A special word must be said about melancholia minor. This commonly occurring condition manifests the classical hallmarks of melancholia though in mild form. Often masquerading as organic disease of bodily systems, its true nature is often not recognized until the tragic suicide of the patient.

Similarly, the chronic and severely disabling obsessional disorder (obsessional 'psychosis'), the profound psychopathic disturbance, and the severe hysterical regressions are examples from the category of the psychoneuroses of severely incapacitating illness.

TREATMENT IN PSYCHIATRY

It has been said that treatment begins as soon as the effort has been made to establish contact with the patient in an attempt to make a diagnosis, i.e. to understand the patient's problems.

The chief categories of treatment in psychiatry are: (*i*) psychotherapy, (*ii*) environmental manipulation, (*iii*) chemotherapy, and (*iv*) the so-called 'physical' types of treatment — the various electrotherapies, and the insulin therapies (low and high dosage).

(*i*) *Psychotherapy*

This is, in essence, conversation, designed to sort out, and work out, the patient's problems.

The range extends from brief, directive, face-to-face, across-the-desk, common-sense therapy, to prolonged, non-directive, on-the-couch, psycho-analytical therapy.

(*ii*) *Environmental Manipulation*

Under this heading come all the devices for separating the anxious and disturbed patient from stress and responsibility, ranging from a few days off work, or a few weeks of holiday, to admission to a nursing home to *get away from it all* for a while and permit the administration by the nursing staff of large doses of tender, loving care.

Change of employment (square peg in round hole), advice re hobbies and recreation, change of residence (flat to house or *vice versa*), change of teacher, school, boarding school, extra lessons, etc., are the various devices used by every practitioner (and psychiatrist) in addition to the other forms of therapy available.

It is important to formulate a programme of treatment incorporating in various ways the different therapies available. It is also important to discuss the programme both with the patient and his relatives, attempting to include the latter as far as possible in the therapeutic team who, working together, will assist the patient to deal with his difficulties.

(*iii*) *Chemotherapy*

Chemotherapy includes the administration of symptomatic tranquillizers, sedatives, hypnotics, and stimulants, as well as the whole new range of chlorpromazine derivatives (which have largely displaced high-dosage insulin therapy in the treatment of schizophrenia) and the 'specific' anti-depressive drugs, including monoamine-oxidase inhibitors.

(*iv*) *Physical Treatment*

Electro-convulsive therapy is almost universally administered under intravenous pentothal anaesthesia together with 'scoline', or a similar muscular relaxant. The pentothal removes unpleasant associations (mouth gag, forehead electrodes), and the relaxant obviates the risk of musculo-skeletal injury.

This technique has enabled electro-convulsive therapy to be given on an outpatient basis in suitable cases, thereby avoiding prolonged hospital inpatient treatment.

The severely agitated or depressed patient still requires the initial period of hospitalization to obviate the risk of suicide. The possible benefits of the newer anti-depressive drugs must not lull the practitioner into a false sense of security or into an attempt to avoid this most effective treatment in severely distressed cases where death appears a welcome relief from the agony of mind suffered by these unfortunate people.

Low-dosage insulin, administered daily on waking in

increasing doses to the point of sweating and tremor, can only be given in a hospital or nursing home where facilities for the immediate interruption of a hypoglycaemic coma are available. This treatment stimulates the appetite in a remarkable manner and is useful for the anorexic or underweight patient, as well as being of great use in the treatment of the addictions, particularly to habit-forming drugs.

High-dosage insulin (insulin coma treatment) is less used today than it was. It is still useful for those cases of schizophrenia or melancholia where response to the other therapies has proved unsatisfactory.

IATROGENIC HAZARDS

Before the unfortunate psychoneurotic patient can receive the treatment that will help him, he has several hurdles to surmount. Concern with the stigma associated with mental illness and its treatment is unfortunately compounded by the medical man's attitude to these disorders. Iatrogenic difficulties are added to those arising from illness and social prejudice.

(*a*) When the physician, having failed to elicit evidence of organic disease, uses such phrases for the melancholic as 'There is nothing wrong with you' or 'pull yourself together', or 'It is all up to you', the evidence of the absence of understanding, patience, or compassion on the part of the medical attendant may result in the patient abandoning hope of help from doctors, thus fortifying his resolution to 'end it all', or it may lead to his seeking help elsewhere, turning to the hosts of *non-medical* practitioners, ranging from naturopaths to spiritual healers who will be only too ready to receive these medical rejects sympathetically.

(*b*) If the patient is warned that 'unless he stops his nonsense and gets on with the business of living, he will land up in the mental hospital', this offensive, almost negligent, advice will certainly tend to have the effect of keeping the patient away from psychiatrists and from all the advances in modern therapy that they have to offer for the relief of this unfortunate condition.

An example of this sort of thing occurred in the case of an unfortunate woman aged 63, who was first seen in March 1956, with classical symptoms of melancholia. One of her complaints was epigastric pain, present on waking at four o'clock in the morning and improving towards afternoon. She had been admitted by her physician to a nursing home during which time the proposition had been put to the physician that the patient see a psychiatrist. His response was, 'Keep away from them or you will land up in Tara'. The general practitioner felt he ought first to have removed some gallstones which had been present for many years and which he had determined were likely to be responsible for her abdominal pain before allowing her to have ECT. Following cholecystectomy, her agitation and distress became very much more marked and, while convalescing at home, she threw herself into her swimming pool and, for the first time, I was allowed to take over and go ahead.

(*c*) If the condition is mistaken for an anxiety state either because agitation or hypochondriasis masks the depression, or because (as in melancholia minor) the depression does not appear profound enough to be 'psychotic', and the patient is given long-acting barbiturates (which tend to depress him further) or bromides (which in effective dosage tend to confuse the patient), then he is once again apt to come to the conclusion that the cure is worse than the disease.

(*d*) Finally, if the medical practitioner believes that the newer anti-depressive compounds are invariably effective when given for a period of up to 6 weeks, then not only must the unfortunate patient suffer a further prolonged period of anguish, but at the end of this period there is an appreciable chance that he will be no better at all. A recent study, for example, indicates that a certain chemotherapeutic agent (not a monoamine-oxidase inhibitor) has, at the end of the so-called effective period of time, a substantial failure rate (in the neighbourhood of 30% - 40%). Furthermore, all these drugs are liable to cause various side-effects, some uncomfortable, some dangerous, during the period that their beneficial effects are being awaited. The unfortunate patient cannot always wait as long as this and tolerates poorly any symptoms over and above those he already has.

In this connection Sir Robert Hutchison had this to say: 'I think there should be a new petition in the litany to be read in hospital chapels or wherever doctors and nurses do, or ought to, congregate. It might be as follows: "From inability to let well alone; from too much zeal for the new and contempt for what is old; from putting knowledge before wisdom, science before art, and cleverness before common sense; from treating patients as cases, and from making the cure of the disease more grievous than the endurance of the same, Good Lord, deliver us".'

To conclude, I have demonstrated that psychological medicine, scientifically disciplined, has a contribution to make to the practice of the art of medicine.

May I mention the final ingredient in the mixture which makes for harmony between patient and doctor, and doctor and doctor? I refer to courtesy based on a consideration of the needs of the other person — a true appreciation of the necessity of the golden rule — 'To do unto others as you would have them do unto you'.