Knowing the Mind in Homoeopathic Practice – II

INTRODUCTION

In the first part we attempted to define Mental Disposition in its evolutionary form. We shall now turn our attention towards the understanding of another key word: Mental State.

Editor: *The Part I can be given in a future issue, if demanded by readers. This second part has been pending with us for a long time. It is given first as more relevant to clinical practice. Both parts are independent and not necessarily dependent on each other.*

EXAMPLE 1

A Clinical Interview is in progress. The patient is narrating a past unhappy event. The eyes fill, the voice falters and the gaze lowers. There is a pause in the narration. The physician reflects on what he has heard and becomes conscious of the emotional response of sadness which has arisen within him. He then endeavours to put himself at ease. The patient relaxes and is able to continue the rest of the narration more calmly.

MENTAL STATE: Definition

Let us examine the above chain of events more closely for it allows us to understand what we mean by the "Mental State". This comprises:

(a) The intellect
(b) The emotions / feelings
(c) The behaviour and
(d) The context in which the above is manifested, including the important aspect of the time - frame in which the events take place.

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(a) The intellectual component includes the memory of the past event and the faculty of casting this memory into a sequence of words or thoughts.

(b) The emotional component is the feeling of sadness experienced by the physician. Obviously, any emotion has to be felt subjectively for it to have any certainty. It is the sensitivity of the physician to the emotions experienced by the patient which contributes to the accurate appreciation of the mental state.

(c) The behavioural component is the change in tone and the tearfulness. This allows us to be certain of the emotion of sadness that we felt during that part of the interview.

There are two additional observations that we are now able to make:

(a) All the above components are in alignment with each other, i e we are able to appreciate the integrity of the intellect, emotion and behaviour. We expect the patient, who is narrating an unhappy event, to experience a feeling of sadness (as we did) and to express it perhaps in the form of tears. We would be surprised if the patient were to burst into a peal of laughter in the same circumstances. We would be equally uncomfortable if the narration was to continue in a dead-pan manner, where we would feel the emotions, but the patient shows no signs of experiencing the same. Either of these responses would be distinctly unusual and hence characteristic due to the inconsistency.

(b) The above changes have been transiently present. They remained as long as they were "required" by the situation. The state within the patient and the external environment of the interview situation demanded the expression of these effects. The physician "required" to be disturbed so that he realized the full impact of the event on the patient. When this impact was acknowledged, the patient relaxed. The mood changed. The

interview proceeded in a different direction. Imagine a situation where the patient continues to weep helplessly in spite of the physician's noting the effect. This behaviour would again be usual and would demand an investigation on the part of the Physician.

MENTAL STATE, MENTAL SYMPTOM & DISPOSITION:
From the above, we are able to see the distinction between these three categories.
The mental symptom, as we have noted previously, is a simple event occurring in any of the above-mentioned planes, ie intellect, emotion or behaviour. It changes, as does the mental state. It may be qualified symptom (Tyler) when it has a characteristic expression, or it may remain a common one.
The Disposition is a complex combination of attitudes, which evolves over a period of time in response to the external circumstance. After reaching a certain complexity, it becomes fairly stable and resistant to change. Thus, it gradually acquires certain rigidity.
The mental state, as we have seen, combines certain features of both the mental symptom and the disposition. While it retains the fluidity of the symptom, it shares the complexity of the disposition.

We have just seen the fluidity of the mental state as experienced in the Clinical Interview. Let us now appreciate its complexity in the example cited below.

EXAMPLE 2
A 26-year-old married female consulted for what had been termed as "tinnitus" by an ENT Surgeon. This is what she wrote of her complaints: "I have this noise problem, diagnosed as tinnitus? Even the TV, which is played at a really loud level at our house, irritates me. The clanking of the wheels, the cries of hawkers in local trains, my husband and one of our couple friends' loud conversations, my nephew wailing – the area affected is my head. I feel a withdrawing and a sort of spasm takes place and I feel the noise is going to engulf me. There is no sensation, just a blocked feeling in the ears. A month ago it was at its height, following my return from US in September. For a while, I was unable to even go out, so loud were / seemed the surrounding noises. Emotionally, I was undergoing a traumatic time as I had come back without doing school – something I'd wanted to do very much. I just thought my marriage wouldn't last, so I came back. Of late, I've noticed that stress (trivial really) situations at home – sister-in-law occupying both gases while my in-laws were away, seems to trigger it off. I feel lethargic, exhausted, cut-up and contemptuous towards her. Relief is found in going away from here. I do sweat a lot at those times."

It is amply clear from the lucid write up of this journalist – patient that her problem does not belong to the organ of hearing but speaks volumes about her mental state. She herself has spoken of the state of the different components mentioned above; viz. the state of thinking, the feeling and the behaviour.
How long has this state of the mind lasted? And in what context was it manifesting itself? These were the questions posing themselves to the investigating physician. It transpired that the patient was the youngest of three siblings, the other two being boys, and come from a fairly rich business family. The women folk had just to be around to attend to the needs of the males.

SENSATION
1. Head – feeling of withdrawing, a spasm.
2. Ears – blocked feelings.

MODALITIES
1. Agg: loud noises, clanking of wheels, cries of hawkers, loud conversation of husband – friends, wailing of child, immediately after return from USA
2. Amel : In the USA.

Thoughts
Contemptuous towards S-I-Law.

Emotions
Feeling of being engulfed by noise.
Disappointed at coming back from the USA empty handed.
Insecurity about future of marriage.
Feeling cut-up.
Behaviour (inclusive of Autonomic changes.)
Unable to move out of the house due to noise problem.
Lethargic, exhausted.
Sweating profusely.

After her birth, her mother started putting on weight, probably due to some endocrine problem. She gradually confined herself to the home and vented her ire on the patient whom she accused of being the cause of her physical disabilities. From the description, she could have been suffering from depression as well. The patient recalled her childhood to have been full of strife, with the mother constantly screaming and shouting, well beyond the limits of her tolerance. On these occasions too, she would suffer from a similar condition to now – she was unable to distinguish between different sounds- all were just one big mass of noise.

The patient went on to do her BA in Literature and in the process got interested in Journalism as well as the Visual Arts. She had started writing since her high school days and was considered to have a flair for using words. A number of her articles were accepted by reputed magazines and newspapers then too. She experienced a feeling of creativity and enjoyed it. In this period, the noise problem mysteriously lessened and became almost imperceptible.

After graduation, her desire was to go abroad to study Fine Arts, but she found her father lukewarm to the idea. While in College, she had became friendly with a boy who was not interested in his family business of textiles but wished to do something in computers. They were contemplating a possible marriage when tragedy struck and the boy's mother suddenly expired in unnatural circumstances. The pressure for marriage on the boy mounted. Her family was not in favour of the match, but they did not actively object since his family was well placed.

Her marriage was followed shortly by that of her brother-in-law. The new entrant could not get along with the patient and bickering began. The patient had to give up her sub-editor's job in order to maintain peace, but to little avail. Her father-in-law married a second time. All this increased the demands for mutual adjustments. The "noise" was becoming unbearable and the patient decided to give the US option a fresh try. To her surprise she secured admission to an Arts School as well as a visa. Her husband, however, was denied one. She got a loan from her father and departed.

Things in the USA were vastly different. The noise problem again disappeared. She liked the atmosphere and felt that she would be able to study and be and do what she wanted. But she was alarmed when she noted a change in her feelings for her husband who was not going to join her for quite sometime. She was not sure that she would retain the same feelings for him at the end of two years. She consulted her husband who left the decision to her, but threw up her admission and retuned to her husband, her sister-in-laws, her loud family friends and to her "noise".

MENTAL STATE : IMPLICATIONS

What does this example illustrate about the Mental State?

(a) A state can persist for 15 long years, expressing itself when the appropriate conditions exist and lying dormant otherwise. The patient, in her childhood, had experienced a rejection, which had made her vulnerable and insecure. The "bombardment" from her mother must have had a deep impact upon her and rendered her nerves hypersensitive to loud noises. When the limit was stretched, the self protective instincts were aroused and the patient shut off the re-

solving capacity – thus making it impossible to distinguish between the different variety of sounds. Whenever the external conditions have put her in a vulnerable situation, this difficulty has surfaced and rendered her helpless. Whenever she has found security and comfort, the sound resolving capacity has been restored.

(b) The Mental state can masquerade under the cloak of a physical symptom and it requires a sound clinical sense and sensitivity to various nuances of emotional expression to decipher this. The "tinnitus" is really not a tinnitus. The patient's own history was enough to disprove the diagnosis. But it required some imagination on the physician's part to hypothesize a series of past situations, sharing some similarity and a tenacity to explore these in depth.

(c) We cannot afford to focus on the symptom alone; nor on trying to understand the mental state in isolation. The problem of difficulty in hearing sounds makes sense only when integrated with the overall state of the mind as described above. And this acquires a deeper meaning when the life situation is available in disposition can be derived and suitable steps instituted to resolve the problem. Needless to say, the measures required may be in addition to the indicated Homoeopathic remedy.

CONCLUSION:

Thus, we see that the threesome, viz Mental symptom, Mental State and Disposition form an interconnected whole. An understanding of the Mind presupposes a thorough grasp of this whole. Having grasped this, we should be able to attend to the concept of Mental Health.

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Some USG continued from Uterine Tumours Page 180.