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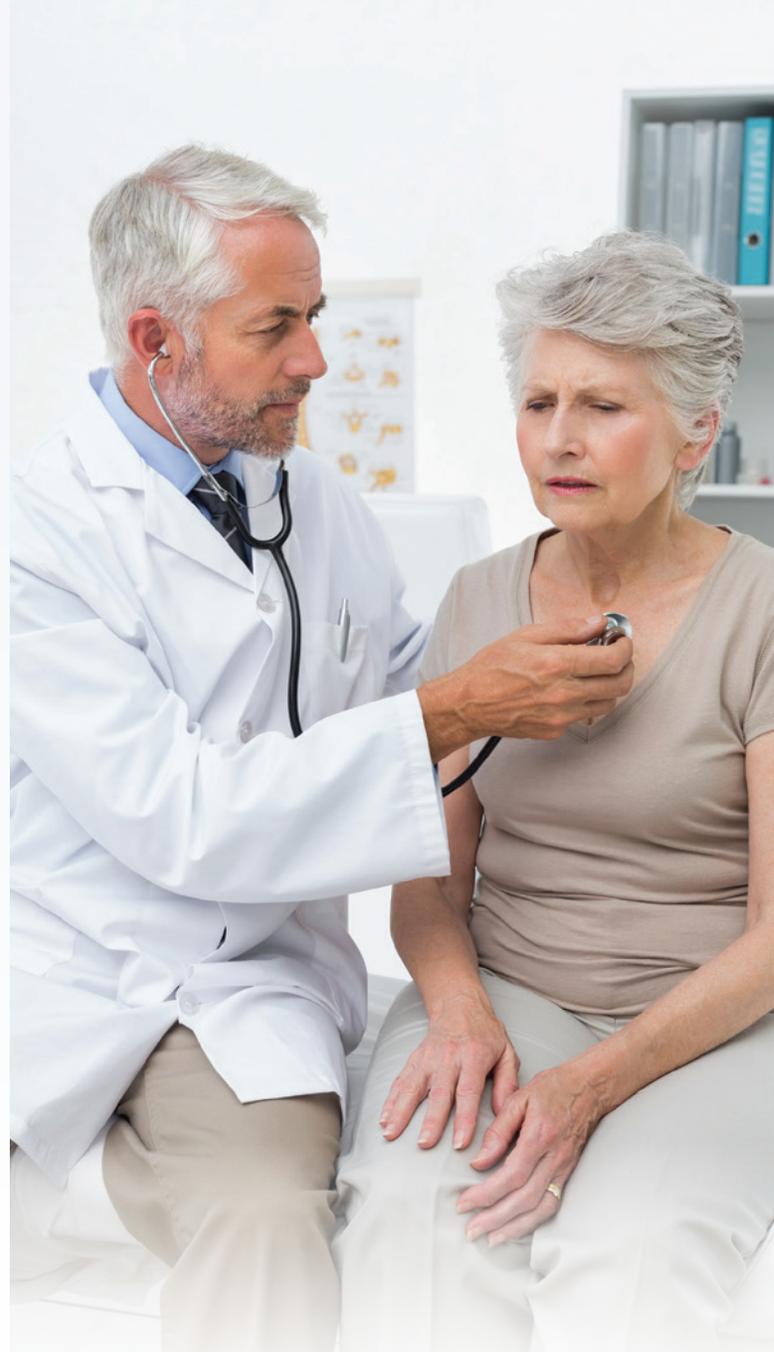
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Self-perception and insight

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THE POET ROBERT BURNS' most famous lines probably were:

*O would some power
the giftie gie us
To see ourselves as
others see us.*

Whenever I think of these lines, I think of a Twilight Zone episode in which a pair of old eyeglasses turns up one day, with the word, *veritas*, engraved on the bridge. The glasses at first provided the wearer with the ability to read superficial thoughts of the people he interacted with. He starts using the glasses when playing poker and stops losing because he knows when he's being bluffed. He then starts seeing a bit deeper into others' thoughts and getting feedback on himself, which is, of course, not always pleasant. At the end of the story he looks into a mirror and sees a monster.

Insight, up to a point, is probably a good thing. Aristotle opined that, "the unexamined life is not worth living," and how can one examine one's life without having some insight? Obviously some of us have more insight than others and those with less often don't mind, precisely because they may be insulated from some of the effects of their actions. If I interact with someone pompous and a bit bombastic, I may say some mildly unpleasant things, but later start to worry that I've insulted the



person. As I think about it more, I console myself with the thought that the person is bombastic because he doesn't have the sensitivity to pick up social cues. His insight into my responses to his utterances and actions, both vocal and covert, are missed.

Psychologists have studied these sorts of things for many decades, and, to be honest, I'm not terribly interested in the topic, being low on the insight/sensitivity rating scale myself, but what is intriguing to me is the parallel between "insight," as we usually think of it, that is understanding our behavior, especially as it is reflected off the people we interact with, and physical perception of ourselves, which is another form of insight.

In the movement disorders field it has been observed for a very long time that people with chorea, a random, jerky, involuntary movement disorder; athetosis, a smoother, continuous, writhing sort of continuous movement disorder, and their combined form, "choreo-athetosis," are often under-perceived by those with it. On the other hand, people with tremor almost always are aware of it and are bothered by it. It is common for patients with chorea to say that they don't know how long it's been present. They came to see me because they were hounded by their family to

find out what that twitching was due to. Patients with tardive dyskinesia, usually a choreo-athetoid movement disorder induced by anti-psychotic drugs, hence seen primarily in people with schizophrenia, often deny that they have any involuntary movements, although any observer would guess that they were chewing gum. Many of these patients are assumed by their doctors to be under-recognizing their disorder because they're schizophrenic, but this

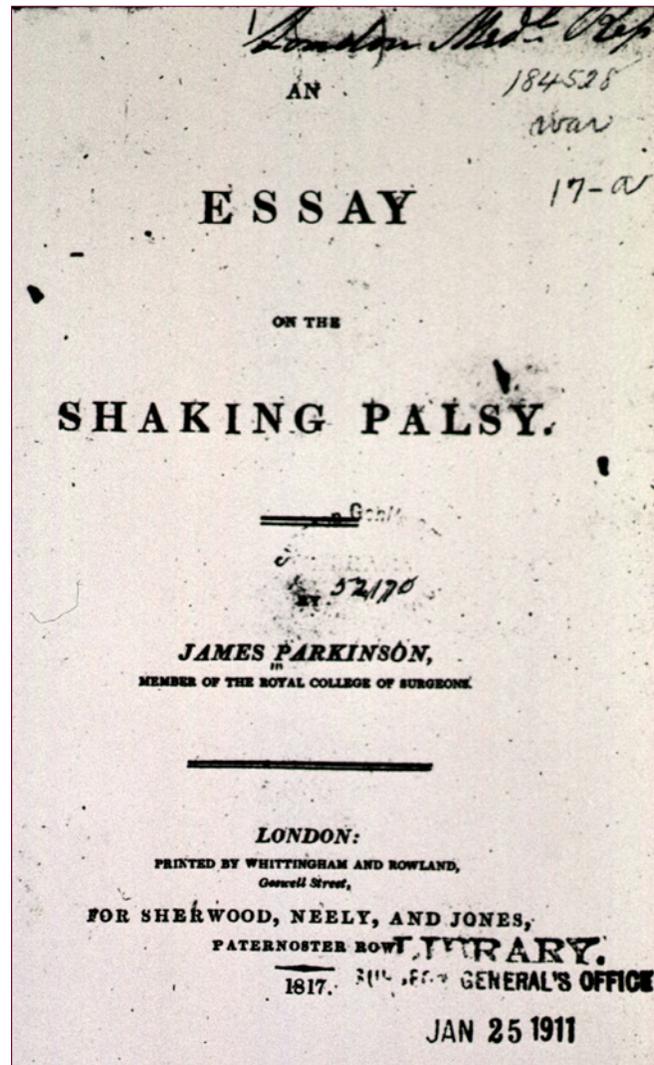
Children with Sydenham's chorea, adults with Huntington's disease and Parkinson's disease patients with L-Dopa-induced dyskinesias, similarly under-perceive the movements.

is not true. Children with Sydenham's chorea, adults with Huntington's disease and Parkinson's disease patients with L-Dopa-induced dyskinesias, similarly under-perceive the movements. When mild, they deny having the movements; when moderate they think them mild and when severe, they think them moderate. A common observation by the Parkinson patient is to say, "I always thought my dyskinesias were very mild, but then I saw the videotape that was made at my nephew's wedding. I was really surprised how bad they are."

Until recently I've assumed that there is something special about chorea and related disorders, to make them

under-perceived. And, to be honest, I think that's true and intend to do a small study to confirm this. But I started thinking about other "under-perceptions." As you know, the "official name" of Parkinson's disease (ICD 9, 10) is "Paralysis Agitans," and James Parkinson called the disease, The Shaking Palsy. Agitans was the old British term for tremor. Both names encompass tremor and weakness. In an interesting aside, Parkinson, and many later, great and famous neurologists also thought the illness caused weakness as well as tremor, but this turns out not to be true. PD patients are not weak. However, they often feel weak, generally in the legs, sometimes all over. In fact, in Rhode Island, about 40% of PD patients perceive themselves as weak although they actually are not. PD patients sometimes have difficulty perceiving "up" and may lean to one side, or backwards, without concern. They may look terribly uncomfortable, but are not. And recently I've been asking my hypo-phonic patients if their speech seems normal or soft. They often report that while others frequently ask them to repeat what they've said, their speech sounds normal to them. Speech therapy aims to teach them to speak louder than they think is necessary.

I assume that everyone who has observed the phenomenon of under-perception of a physiological or observable event thinks either that the patient is suppressing or denying the experience, perhaps for psychological reasons, to preserve their self-perception of normality. However, those of us in the movement disorders field see this so frequently that we have come to believe these impaired perceptions are part of the physiology. When the brain perceives limbs moving



Title page of an essay on the shaking palsy, published by James Parkinson (1755–1824) in London in 1817.

in an abnormal fashion, under impaired control, it registers a feeling of "weakness." When the tongue, fingers, or feet are writhing, it may not perceive anything amiss. Yet, patients with tremors or tics almost always register these as abnormal and describe each tic and each tremor. And, to make life even more challenging, there are patients who have sensations of movements, even without the movements, like patients who have lost a limb but perceive an abnormal, uncomfortable movement in that limb, or patients who sense tremors which are not present.

The seemingly "hard-wired" nature of these impaired physical insights makes me suspect that much of what makes

for the variations we encounter in social insight, to be similarly hard wired, more nature than nurture, and, perhaps less amenable to modification than we'd like to think. ❖

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The Road from Bethlehem to Bedlam to Compassion

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BETHLEHEM – THE MIDDLE East home of the tribe of Benjamin, Rachel’s tomb, the city of David and the birthplace of Jesus – had undergone much upheaval in its lengthy history. In 1244, the Kwarezmian armies overran Judah and deliberately destroyed Bethlehem, its buildings, shrines and churches. The Kwarezmians were a Sunni-Moslem sect from Afghanistan and eastern Persia, their capitol, Samarkand.



European Christians considered Bethlehem a holy site; and even kingdoms as remote as England regularly collected alms and endowments to sustain Bethlehem’s churches and monasteries. And so, in 1247, a small shelter in the London parish of St. Botolph, called The New Order of St. Mary of Bethlehem, collected funds to rebuild the holy places in Bethlehem; and none considered it amiss if itinerant pilgrims also found shelter there.

By the 14th Century the Papacy had moved to Avignon, France; and the periodic wars between Britain and France then discouraged any resolve to gather further alms for Bethlehem. The name of the London hostel persisted, however, although now shortened to Bethlem. And as its spiritual ties to the original Bethlehem withered, its mission was broadened, now to be known as a retreat for pilgrims and other poor

migrants particularly those “whose sense of reason had departed.”

In the succeeding centuries, Bethlem moved its site to Moorfields in the 17th Century, to London’s Southwark in the 19th Century, and to Croydon by 1930. Its management ceased to be a royal prerogative and was supervised, and often shamefully exploited, by various boards of overseers and governors. The original sanctuary for pilgrims became an enlarged shelter for the ailing poor and thus, also, a hospital.

The Bethlem Hospital, now pronounced Bedlam, survived England’s dissolution of its monasteries. It became increasingly secular, altering its mission as a shelter for the homeless, the wandering beggars and “... as a place where many men that be fallen out of their wit.” The registry of Bethlem’s tangibles now listed

manacles, neck braces, and chains; and its inmates were referred to variously as the witless poor, the morally insane or, in some documents, just prisoners. The care of the inmates had deteriorated so drastically that its common name, Bedlam, became a synonym for chaos. Treatments were “injurious and unnecessarily violent” and the buildings “loathsomely filthy, uninhabitable and wanting in humanity.”

The early 17th Century saw Bethlem Hospital as an institution for lunatics and “criminals bereft of sanity.” A name



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Public Architecture South-West View of Bethlem Hospital and London Wall/ Drawn and etched by J. T. Smith.

was appended to the typical inmate: he was called Tom O'Bedlam; and an anonymous poem by that name was widely read, and even referred to in Shakespeare's *King Lear*. A fragment of the poem:

*The moon's my constant mistress,
And the lowly owl my marrow;
The flaming drake and the night
crow make
Me music to my sorrow.*

By 1676 the institution was enlarged to contain 136 cells arranged in linear fashion, with a long corridor for viewing each room in a design more suitable for prisons or zoos. Bethlem Hospital was then high on a list of places of holiday amusement which included the Tower of London, Bartholomew Fair, the Zoo and the Royal Gardens at Kew. An admissions charge of one penny was exacted from each of the many thousands who came to be entertained by

"the raving lunatickes of Bedlam." Bethlem Hospital, of course, was not the only public institution that offered an entertaining spectacle for its visitors; there also was the Magdalen Hospital for Penitent Prostitutes to fill one's holiday afternoon.

It was presumed that one who "lost his wit" also relinquished his humanity; and such insane souls were treated aggressively with debilitating purges, blood-letting, painful blistering, manacles and a diet fit solely for feral beasts. "Babylon," said Scrope Davies (1783–1852), "in all its desolation, is a sight not so awful as that of a human mind in ruins."

The early 19th Century saw the emergence of an enlightened form of therapy for the mentally disturbed. Under the guidance of William Tuke, a Yorkshire Quaker, a safe home was established for those emotionally ill-equipped to survive in the turmoil of 19th Century

Britain. It was called the York Retreat and it emphasized such therapies as occupational retraining, tranquil surroundings and personal counseling.

And Bethlem Hospital? It too underwent radical changes, dispensing completely with its ancient madhouse regimen of punishment, shame and abuse. It is now the Bethlem Royal Hospital in South London, in academic partnership with King's College Institute of Psychiatry and at the forefront of humane institutions striving to understand and treat the mentally stressed. ❖

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The author has no financial interests to disclose.

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CONTRIBUTIONS

Contributions report on an issue of interest to clinicians in Rhode Island. Topics include original research, treatment options, literature reviews, collaborative studies and case reports. Maximum length: 2000 words and 20 references.

JPEGs (300 ppi) of photographs, charts and figures may accompany the case, and must be submitted in a separate document from the text. Color images preferred.

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Authors submit an interesting image or series of images (up to 4), with an explanation of no more than 500 words, not including legends for the images.

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