

## Apathy

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**A**PATHY IS COMMON. IT may be normal, as in, “I don’t care about” something, or pathological, a syndrome often present as one of the cardinal features of depression, Alzheimer’s disease, Parkinson’s disease and a host of other disorders. Like most behavioral constructs, it is complex and difficult to understand, and has no objective markers.



Since I care for a large number of people with Parkinson’s disease, apathy is something I deal with every day. It is probably most noticeable to doctors in the form of lack of spontaneous speech. Apathetic PD patients generally keep quiet, even though the appointment with the doctor is for them. It is the spouse or the child who usually does the talking. The patient responds when the doctor says hello, and will answer questions when they are addressed to him, but often only after specifically asked to answer, waiting for the significant other to answer first. There are a few potential explanations for this, but apathy is usually part of the explanation. (I note in passing that there is the occasional patient, although severely dysarthric and almost unintelligible, who is exceedingly loquacious, even when not understood, and the opposite of apathetic.)

I once attended a small conference on

apathy hosted by a drug company interested in developing a drug for the condition. Their interest was focused on schizophrenia, in which apathy plays a major role. Many non-psychiatrists, and certainly the lay public, think of schizophrenia as a disorder in which the afflicted have auditory

hallucinations ordering them to do weird or dangerous things, and delusions, such as thinking their thoughts are controlled by aliens. And while hallucinations and delusions are, in fact, common in schizophrenia, these are part of what are considered the “positive” phenomena of the disorder, whereas the most devastating features are the “negative” symptoms, the reduced motivation, the reduced pleasure, the weak social bonding, the poor insight, and apathy. The positive symptoms are what respond best to antipsychotic drugs. The negative symptoms do not, so that patients are generally only partially improved and often don’t feel better on their psych meds, and so may stop taking them. Apathy is a very central issue in many psychiatric problems, and, I learned at this meeting, for many in the Alzheimer’s world as well.

I learned that they consider apathy a serious problem. I, on the other hand, had developed a belief that apathy in PD isn’t necessarily a bad thing. My

thinking was based on the fact that apathy generally develops hand in hand with dementia in PD, and that, although patients experience reduced enjoyment, they also have a blunted response to their losses. As apathy develops, the patient initially may not want to do the things he used to for entertainment. He may not care much about socializing, going to the movies, entertaining at home. The pleasure no longer offsets the effort. There is a drop in motivation. There is less interest in starting conversations, getting questions answered, or completing projects. The patient loses interest in what he watches on TV. This inexorably progresses to the point where he may not care if the TV is on or off, what is going on around him, or what’s for dinner. In the end, the only thing that provides pleasure is a visit from the grandchildren, and that for only a few minutes before the activity becomes overwhelming and uncomfortable. That is a tragedy. The persona of the patient has slowly been extinguished. The spark that made that person who he was is gone, and only a shell remains. On the other hand, this patient has been spared the suffering that the family is experiencing. The only person not devastated by these changes is the patient himself. He doesn’t care. Yes, he knows that he can’t figure out how to use the TV remote control, that he can’t drive, get to the bathroom on time, and forgets how many grandchildren he has, or their names, but it no longer bothers him. He

doesn't get happy but he doesn't get sad. Emotions are largely gone. The family suffers but the patient does not. He no longer grieves for his losses.

I always point this out to the family, and they seem greatly relieved to hear me tell them that they are probably suffering more than the patient. "He doesn't care but you do." I believe that they often have thought this themselves, but felt guilty to give voice to this insight.

I was surprised, then, when I mentioned to my colleagues, all in the schizophrenia or Alzheimer's disease worlds, that I thought apathy had some positive aspects. They were aghast. I felt that they responded as if I had just suggested reinstating haloperidol as

a "chemical straitjacket" for obstreperous, demented nursing home patients (using drugs like haloperidol to make patients unable to move, and therefore unable to stand and fall, or to attack others). I've thought about this a lot and have not altered my thinking.

Apathy is more than lack of emotion. It encompasses lack of motivation, and therefore overlaps with fatigue, an amotivational syndrome. Fatigue, of course, is a common problem in daily life, and is increased in virtually all disorders, somatic and psychic, particularly depression. The only disorder I've been able to think of without an increase in fatigue is mania.

I think it is probably correct to regard lack of motivation and fatigue as major

problems in all disorders, but I think it is equally correct to consider apathy a problem only when it is, in fact, a problem, not simply because it's there. Some clouds do have silver linings. ❖

#### Author

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## Blue eyes, bleeding heart

ANANYA ANAND, ScB, MSc

**H**E STARED UNWAVERINGLY AT ME. I touched his head, covered with fine reddish-brown hair, when I felt it – the “boggy” subgaleal hematoma I was mentally anticipating but thoroughly unequipped to handle emotionally.

Three weeks into my pediatric rotation with three more weeks and one more rotation to go before the culmination of an intense third year of medical school, I thought nothing could faze me anymore. Ten months of rotating through the core specialties had tested my resilience, and I thought I had made it to the other side relatively unscathed. Dealing with a patient whose abdominal sutures burst open, exposing all of his intestines. Handled. Giving a previously healthy patient a new diagnosis of ALS. Handled, but with a lot of tears. Each emotionally exhaustive experience felt like a cut into my very essence that healed with a scar – tougher tissue yet still obviously deformed, a constant reminder.

Pediatrics thus far had been relatively straightforward and highly rewarding. I had spent time in urgent care diagnosing the flu and upper respiratory infections. For one week, I was at a small regional hospital on the maternity ward, doing newborn exams on healthy babies – this came with the fringe benefit of that warm feeling that spreads through every pore when one sees pure, unadulterated innocence. I was now on an inpatient pediatric ward where the children were more acutely sick.

Midway through the week, my resident asked me to accompany him to see a patient that would be transferred from the NICU to our floor. Baby J was a two-month-old who was brought to his PCP by his parents because of bilateral subconjunctival hemorrhages believed to be secondary to straining with bowel movements. At the visit, the PCP noticed

that J’s head was swollen and he had a bruise to his left cheek. The parents were told to take J to the ER where a CT scan showed that he had three calvarial skull fractures and signs of a frontal lobe hemorrhagic contusion. In non-medical speak – J had been violently abused. There was evidence that not only had he been shaken, he had impact injuries, ultimately receiving a diagnosis of “Non-accidental trauma” (NAT).

When I heard J’s history, I was livid. When I walked into his room, stared into his eyes and placed my hand upon his head, tactually perceiving what had been radiographically described, I began seething. It was unfathomable to me how anyone could brutalize a defenseless baby, let alone their own. As I checked J’s reflexes and performed his physical exam, he reached for my index finger. The second his tiny hand gripped my finger I experienced what felt like the entire gamut of human emotion. Anger, sadness, pity, love, tenderness, confusion – each emotion hit me like waves of a raging ocean slapping down a helpless swimmer. I picked J up and held him close to me and began to sob.

That night, my emotions still running rampant, I called my mother who has been the sounding board for every exhaustive experience I have had in medical school. The tears flowed as I recounted J’s story, and the frustration surrounding one particular point was evident – what could possibly make J’s parents hurt him this way and even when they did, what possessed them to bring him to a physician?

As I spoke to residents and attendings, trying to make some sense of this story, I learned about the psychological nuances of NAT. In many cases, parents become frustrated or overwhelmed and, in moments of exasperation, hurt their

children. The subsequent guilt, particularly when a child begins to display visible symptoms or signs of injury, often drives parents to bring the child to see a physician. These violent abuses are inexcusable acts, but I couldn’t help but feel some pity for those parents as well. Not only do they do something terrible, which they often regret, but also they risk losing their child forever into an unforgiving system.

Over the next few days, I would visit J, play with him, hold him in my arms and rock him to sleep. NAT babies need a tremendous amount of love, and I wanted to do anything in my power to share some of my love with J. Just as soon as he entered my life, he left and was sent into the foster care system – yet, he persisted in my thoughts. I still wonder how his trauma will affect the trajectory of his life. Will he have long-lasting neurological side effects from his abuse? Will being in foster care affect his mental and physical development? What about his prospects for school, college, and socioeconomic advancement? Will his attachment to caregivers become destabilized if he is bounced from home to home?

I can only hope and pray that he will be treated with the unconditional love, kindness and understanding that we all deserve. But one thing is certain – his blue eyes had pierced into my very being and left an indelible mark. ❖

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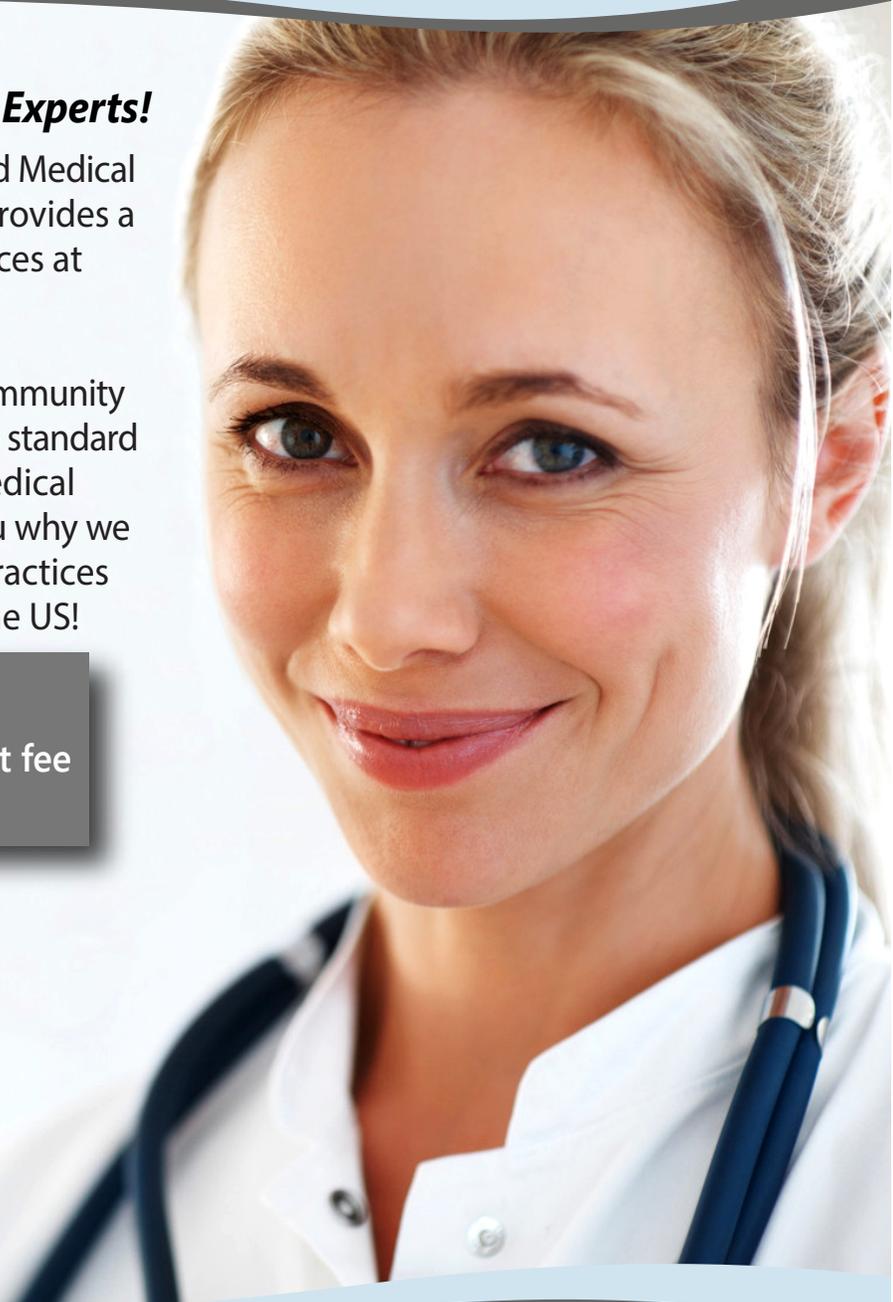
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