MAGDA B.

Mrs B. was born in Austria in 1900, and came to the United States as a child. Her childhood was free of any serious illnesses, and her academic and athletic progress at high school was exemplary. In 1918–19, while working as a secretary, she contracted a severe somnolent-ophthalmoplegic form of *encephalitis lethargica,* recovered from this after a few months, but started to show Parkinsonism and other sequelae around 1923.

The course of her illness over the following forty-five years was at first known to me only from exiguous hospital notes, for Mrs B. had been quite unable to speak for many years. In addition to the ophthalmoplegia which failed to resolve after her acute encephalitis, Mrs B.'s chief problems were profound akinesia and apathy, and a variety of autonomic disturbances (profuse salivation, sweating, and repeated peptic ulcerations). She had not been prone to oculogyric or other crises. She showed occasional 'flapping' tremor, but virtually no rigidity, dystonia, or resting ('pill-rolling') tremor.

A note dated 1964 remarks on the 'curious absence of anger or frustration in circumstances which would seem to warrant these reactions.' A note written in 1966, when Mrs B. was seri-

ously ill from concurrent illness, commented upon the absence of any anxiety or fear in response to her situation. During 1968, she was repeatedly subjected to verbal and physical abuses by a mad, hostile dement placed next to her in the ward (the latter would insult and curse her, and occasionally struck her): Mrs B. showed neither motor nor emotional reaction to such intolerable goading. Many other notes, which need not be quoted in detail, similarly attested to her abnormal passivity and calmness. On the other hand, there was no suggestion of depressive or paranoid tendencies, and no evidence of eccentric ideation or behaviour: Mrs B. seemed amiable and appreciative of help, but docile, *bland,* and perhaps incapable of emotional reaction.

Before L-DOPA

Mrs B. was seated, motionless, in her wheel chair, when first seen by me: akinesia was so extreme at this time that she would sit without blinking, or change of facial expression, or any hint of bodily movement, for the greater part of the day. She showed a habitual dropped posture of the head, but was able to combat this for brief periods. There was little or no cervical rigidity. She appeared to have a bilateral nuclear and internuclear ophthalmoplegia, with alternating exotropia. Mrs B. was sweating very freely, showed a greasy seborrhoeic skin, and moderately increased lacrimation and salivation. There were rare attacks of spontaneous lid-clonus or closure, but no spontaneous blinking at all. Mrs B. was virtually aphonic – able to produce a faint 'Ah!' with great effort, but not to articulate a single word audibly: she had been speechless for more than ten years, and severely hypophonic for at least fifteen years before this.

She showed profound facial masking – at no time during the initial examinations did any hint of facial expression appear – was scarcely able to open the mouth, to protrude the tongue beyond the lip-margin, or to move it at all within the mouth from side to side. Chewing and swallowing were feeble and slowly performed – the consumption of even a small meal would take more than an hour – but there were no signs of bulbar or pseudo-bulbar palsy.

All voluntary movements were distinguished by extreme slowness and feebleness, with almost no involvement of 'background' musculature, and a tendency to premature arrest of movements in mid-posture. When raised from her chair – for Mrs B. was quite unable even to inaugurate the act of rising by herself – she stood as motionless as a statue, although she was unable to maintain her balance, due to an irresistible tendency to fall backwards. Stepping was not only impossible, but somehow seemed *unthinkable.* If she closed her eyes, while standing or sitting, she at once dropped forward like a wilted flower.

Mrs B. was thus profoundly incapacitated, unable to speak and almost unable to initiate any voluntary motion, and in need of total nursing care. Added to the motor problems were a striking apathy and apparent incapacity for emotional response, and considerable drowsiness and torpor for much of the day. Conventional anti-Parkinsonian drugs had been of very little use to her, and surgery had never been considered. She had been regarded for many years as a 'hopeless' back-ward post-encephalitic, with no capacity for rehabilitation. She was started on L-DOPA on 25 June.

Course on L-DOPA

2 July. After one week of treatment (and on a dose of 2 gm. L-DOPA daily), Mrs B. started *talking* – quite audibly – for the first time in many years, although her vocal force would decay after two or three short sentences, and her new-found voice was low-pitched, monotonous, and uninflected.

8 July. With raising of the dose to 3 gm. L-DOPA daily, Mrs B. became nauseated, and insomniac, and showed striking dilation of the pupils, but no tachycardia, lability of blood-pressure, or akathisia. She now showed considerable spontaneous activity – ability to shift positions in her chair, to turn in bed, etc. She was much more alert, and had ceased to show any drowsiness or 'dullness' in the course of the day. Her voice had acquired further strength, and the beginnings of intonation and inflection: thus one could now realize that this patient had a strong Viennese accent, where a few days previously her voice had been monoto-

nous in timbre, and, as it were, *anonymously* Parkinsonian.

Mrs B. was now able to hold a pencil in her right hand, and to make a first entry in her diary: her name, followed by the comment, 'It is twenty years since I have written. I'm afraid I have almost forgotten how to write my name.'

She also showed emotional reaction – anxiety at her sleeplessness and vomiting – and requested me to reduce the new drug, but by no means to stop it. The dose was reduced to 2 gm. daily.

Reduction of the dose alleviated the nausea, insomnia, and mydriasis, but led to a partial loss of vocal and motor power. A week later (15 July), it was possible to restore the larger (3 gm. daily) dose, without causing any adverse effects whatever, and she was subsequently maintained on this dose. On this, Mrs B. had shown a stable and continued improvement. By the end of July, she was able to rise to her feet and stand unaided for thirty seconds, and to walk twenty steps between parallel bars. She could adjust her position in chair or bed to her own comfort. She had become able to feed herself. Diminishing flexion of the trunk and neck could be observed with each passing week, so that by mid-August a striking normalization of posture had occurred.

Previously indifferent, inattentive, and unresponsive to her surroundings, Mrs B. became, with each week, more alert, more attentive, and more interested in what was taking place around her.

At least as dramatic as the motor improvement, and infinitely moving to observe, was the recovery of emotional responsiveness in this patient who had been so withdrawn and apathetic for so many years. With continued improvement of her voice, Mrs B. became quite talkative, and showed an intelligence, a charm, and a humour, which had been almost totally concealed by her disease. She particularly enjoyed talking of her childhood in Vienna, of her parents and family, of schooldays, of rambles and excursions in the country nearby, and as she did so would often laugh with pleasure at the recollection, or shed nostalgic tears – normal emotional responses which she had not shown in more than twenty years. Little by little Mrs B. emerged as a *person*, and as she did so was able to communicate to us, in vivid and frightening terms, what an *unperson* she had felt before receiving L-DOPA.

She described her feelings of impotent anger and mounting depression in the early years of her illness, and the succeeding of these feelings by apathy and indifference: 'I ceased to have any moods,' she said. 'I ceased to care about anything. Nothing *moved* me – not even the death of my parents. I forgot what it felt like to be happy or unhappy. Was it good or bad? It was neither. It was nothing.'[50]

1969–71

Mrs B.'s course on L-DOPA, by and large, was the smoothest and most satisfactory I have seen in *any* patient.[51] Throughout her two years on the drug, she maintained an altogether admirable degree of activity, sanity, and general fullness of living. There was, it is true, some small dropping-off in her level of energy and motility towards the end of the second year, and there were brief outcroppings of morbid activity: these latter will be described in the context they occurred in.

Much of this was associated with her renewal of emotional contact with, and obvious delight in, her daughters and sons-in-law, her grandchildren, and the many other relatives who came to her now she was well, and, so to speak, restored to reality. She remembered every birthday and anniversary, and never forgot to mark them with a letter; she showed herself agreeable and eager to be taken out on car-rides, to restaurants, to theatres, and above all, to the homes of her family, without ever becoming demanding or importunate. She renewed contact with the rabbi and other orthodox patients in the hospital, went to all the religious services, and loved nothing so much as lighting the Shabbas candles. In short, she donned again her former identity, as a 'frum' Viennese lady of good family and strong character. More remarkably, she assumed, with apparent ease, the mantle of old age and

[50] 'Thus when God forsakes us, Satan also leaves us' – Sir Thomas Browne.

[51] It is curious that the *only* two patients I have ever seen who showed an almost unqualified excellence of response for the entire two years they were taking L-DOPA (Magda B. and Nathan G.) were not, as might be thought, minimally involved patients with Parkinson's disease, but two of the most profoundly involved post-encephalitics I have ever seen.

'Grannie-hood,' 'bubishkeit,' despite having dropped, as through a vacuum, from her mid-twenties to her late sixties.[52]

She had not, apparently become bitter or virulent in the decades of her illness, and this, perhaps, was connected with her apathy: 'I often felt,' said one of her daughters, 'that Mother *felt* nothing, although she seemed to notice and remember everything. I used to feel terribly sad at her state, without getting too angry – after all, how can you blame or get mad at a *ghost?*'

Mrs B. did develop two brief psychotic reactions while on L-DOPA. The first of these was in relation to her husband, who failed to visit her with the rest of the family. 'Where is he?' she would ask her daughters. 'Why doesn't he come to see me?' Her daughters temporized, explaining he was ill, indisposed, out of town, on a trip, etc. (He had in fact died some five years before.) These many discrepancies alarmed Mrs B., and precipitated a brief delusional episode. During this time, she heard her husband's voice in the corridors, saw his name in the papers, and 'understood' he was having innumerable *affaires.* Seeing what was happening, I asked her daughters to tell her the truth. Mrs B.'s response to this was: 'Ach! you sillies, why didn't you tell me?' followed by a period of mourning, and complete dissipation of her psychotic ideas.

Her other psychosis had reference to a rapidly advancing deterioration of eyesight, which had been 'accepted' with indifference before the L-DOPA. This was especially severe in her

[52] It is of much interest and significance that Magda B. seemed to have little or no difficulty in accommodating to the immense time-lapse, the immense 'loss' of time, entailed by her illness. This is in absolute contrast to the following patient (Rose R.), who on 'awakening' after forty-three years, found herself faced with 'a time-gap beyond comprehension or bearing,' 'an intolerable and insoluble anachronism' to which accommodation was completely impossible (see p. 87). Why such a difference? I think this reflects the absolute contrast (discussed in the Prologue) between 'negative' and 'positive' disorders of being. Magda B., engulfed in non-activity, non-being, nothingness, situationlessness, was not, I think, frustrated or tormented like Rose R.; she was becalmed, asleep, on the ocean of life. When Being and activity were given to her, she accepted it as a pure gift, with gratitude and joy; but their absence, prior to her 'awakening,' was *also* accepted, with a placid indifference (and so too, conceivably, might have been a return to inactivity and inexistence, had the L-DOPA lost its effect). However, it is possible that Magda B., once re-awakened to life and hope, could not have borne its loss again.

second year on the drug, when the faces of her children, the face of the *world,* were rapidly becoming dim and ungraspable. Mrs B. rebelled against the diagnosis of 'senile macular degeneration, progressive and incurable,' the more so as this was delivered to her by a specialist she had never seen before, with a curt finality and a marked lack of sympathy, and for some weeks implored us pitifully to restore her sight, and experienced dreams and hallucinations of seeing again perfectly. During this painful period, Mrs B. developed a curious 'touching tic,' continually touching the rails, the furniture, and – above all – various people as they passed in the corridor. I once asked her about this: 'Can you blame me?' she cried. 'I can hardly see anything. If I touch and keep touching, it is to keep me in touch!' As Mrs B. adjusted to her increasing blindness, and as she started to learn Braille (an enterprise *she* had thought of and insisted upon), her anguish grew less, her dreams and demands and hallucinations ceased, and her compulsive touching grew less marked, and *much* less importunate.[53] It should be stressed, perhaps, that the dosage of L-DOPA was not altered in these psychoses, for it was clear that they were reflections of an alterable reality.

In July 1971, Mrs B., who was in good general health and not given to 'hunches,' had a sudden premonition of death, so clear and peremptory she phoned up her daughters. 'Come and see me today,' she said. 'There'll be no tomorrow . . . No, I feel quite well . . . Nothing is bothering me, but I *know* I shall die in my sleep tonight.'

Her tone was quite sober and factual, wholly unexcited, and it carried such conviction that *we* started wondering, and obtained blood-counts, cardiograms, etc., etc. (which were all quite normal). In the evening Mrs B. went round the ward, with a laughter-silencing dignity, shaking hands and saying 'Good-bye' to everyone there.

She went to bed and she died in the night.

---

[53] I am not suggesting that this touching tic was entirely 'psychogenic' or *created* by circumstance. I have seen somewhat similar touching tics in impulse-ridden post-encephalitic patients who were not in Mrs B.'s position. But I do think that a mild, or latent, propensity to tic was 'brought out' by her excitement, and given shape by her circumstances, so that it *became* a reflection or expression of her feelings.