A CASE STUDY: VINCENT VAN GOGH (1853-1890)

One of my most memorable experiences as a tourist was a visit to the Vincent van Gogh museum in Amsterdam. Of course, the magnificence of his art is breath-taking, but his life is a case study for a personal struggle with poor mental health. But first a little about his disease.

It is most likely that Van Gogh suffered from comorbid illnesses. As a young adult it seems he developed a (probably bipolar) mood disorder in combination with features of borderline personality disorder. [Aside: temporal lobe epilepsy (TLE) has also been mooted as being contributory, but even as a non-psychiatrist I am skeptical of that because at on stage in the recent past, TLE was a fashionable diagnosis. I know, I was erroneously diagnosed with it.] Pharmacological treatment was usually unhelpful and he self-medicated with alcohol, which worsened his situation, as did the ensuing malnutrition. His escalating alcohol abuse and psychosocial tensions precipitated numerous crises (cutting off an ear is the well-known one) with periods of delirium and psychosis. His suffering finally pushed him to suicide. Let's look at his symptoms from a personal perspective, as much as we can anyway.

Social support and relationships

Besides the healthcare workers, Van Gogh received support from his beloved brother, Theo, but even in that relationship there were tensions. Without Theo, however, he would have been much worse off, emotionally and financially. Van Gogh struggled to maintain romantic relationships. All of these symptoms of social isolation highlight how the personal struggle with mental health invades the patient's social life, with devasting consequences. Humans are, by nature, social creatures.

Medications and drugs (prescribed and self-administered) and their side-effects

Van Gogh's alcohol abuse was related to his (subconscious) attempt to self-medicate, something that mental health sufferers often do. Paul-Ferdinand Gachet, the artist's physician almost certainly used digitalis to treat him, and its side-effects are intriguing. Overmedication with digitalis causes patients to see the world with a yellow-green tint. They complain of seeing yellow spots surrounded by coronas, much like those in his painting Starry Night. And, as anyone who has seen his paintings will agree, Van Gogh was drawn to yellow shades in his work.

The depth of suffering but still hope

Mental health percolates into everything and the depth of despair can be catastrophic. Van Gogh died by his own hand, life was simply unbearable. At the same time, and especially today with more advanced treatments, there is always hope, and hope is central to patient management. When I visited the Van Gogh museum someone asked me what my favourite painting was. If I had to choose one, I would choose Wheat Field with Crows (Fig. 1). Besides the obvious beauty, it captures his mental health struggle for me. In the brooding sky we see an ever-present threat. The dead-end path feels like hopelessness. The crows are (unfairly) maligned creatures of darkness and despair. But, let's not forget the vibrant wheat fields: there is always hope.

Figure 1: Wheat Field with Crows

A FINAL NOTE ON GENIUS AND MENTAL HEALTH

Current teaching suggests that there may be a difficult-to-identify relationship between artistic talent and mental health. They do appear to correlate, weakly, but there is no evidence to suggest one causes the other. One should not make that fallacious connection. My tour guide at the museum told me that Van Gogh was brilliant despite his disease and not because of it. And that was Van Gogh's view as well. In one of his last letters, he wrote: "If I could have worked without this accursed disease, what things I might have done."

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MENTAL HEALTH: A PERSPECTIVE

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This article honours the request from a healthcare worker, motivated by the tremendous burden of mental health problems on individuals and their families, for a newsletter on the topic. For educational purposes I will open with the screening tests that are helpful when faced with mental health patients. But an educational newsletter is only part of my aim. This article is different—as much 'perspective' as 'didactic'—in the hope that it sheds light on the individual's burden. I will discuss the value in understanding the sufferer's perspective. I will end with a case study, one that you may be aware of, the remarkable story of Vincent van Gogh and his battle with mental health.

WHICH LABORATORY INVESTIGATIONS ARE HELPFUL FOR SCREENING?

One of the important considerations in mental health is to differentiate physiological disturbances from primary psychiatric conditions and that is typically the reason for requesting a pathology test screen. Here is a list of the most important ones, but there are others depending on the clinical presentation. Box 1 gives an at-a-glance recommendation of pathology tests recommended in psychiatric illness.

BOX 1: SCREENING TESTS IN PSYCHIATRIC ILLNESS

Recommended tests
(unless clinically inappropriate)

FBC, U&E, TFTs, LFTs, s-calcium (and Vitamin D in most cases), s-magnesium and phosphate, s-cortisol, CRP, ESR, recreational drug screen, urine dipstix and microscopy and culture

Additional tests, if clinically appropriate
porphyria screen, drug level, specific metabolites

1. Electrolyte disturbance
Disturbances in electrolytes cause symptoms that can be mistaken for a primary psychiatric illness e.g., confusion, fragmented thoughts, psychosis. It is essential to exclude disruptions in sodium, potassium, chloride, calcium (a vit D level is often also recommended), magnesium, acid-base, and carbon dioxide etc. before diagnosing a primary psychiatric illness.

2. Thyroid disease
A full TFT screen is recommended and it is important to interpret TSH with fT4 and fT3 - bearing in mind their different half-lives.

3. Other endocrine disorders
Disorders of the hypothalamic-pituitary axis cause multiple disorders many of which lead to secondary mental health symptoms. At least a cortisol level is recommended although more may be warranted depending on clinical suspicion.

4. Haematological disorders
A FBC is helpful as marker of many primary haematological and secondary conditions. Haematological emergences that may overlap with psychiatric symptoms include TTP (thrombotic thromocytopaenia purpura), AML (acute myeloid leukaemia) and cerebral malaria.

5. Infections
A CRP and ESR are recommended. In the elderly renal infections should always be excluded. Common diseases like intracranial parasites, tuberculosis, meningitis etc should be considered if clinically appropriate.

6. Drug screening
Drugs are both a cause of mental health disorders and a symptom (used for self-medication).

7. Pharmacological side-effects
Drug levels may be important based on the medical history. Some drugs used for malaria prophylaxis are a cause of confusion and psychosis, but there are many others.

8. Metabolic conditions
As a baseline a full liver function analysis is usually recommended because there are numerous inherited and acquired metabolic disturbances cause psychiatric symptoms. One that should always be considered in South Africa is variegate porphyria, which has both cutaneous and neurological symptoms. Urine and blood porphyrin levels as well as plasma fluorescence scanning are indicated if porphyria is suspected.

THE EXPERIENCE OF MENTAL HEALTH SUFFERERS

Of course, all the statistics relating to mental health are important for policy makers, research, etc. But when it comes to the individual case, most of this loses relevance and it becomes a question of providing optimal support for that individual. It always seems so contrary to management of the disease when I read articles like: "Quantifying the global burden of mental disorders and their economic value" (2022) Arias, Daniel et al. eClinicalMedicine. Of course, there is value in knowing this, but for those at the coalface correlating the economic loss with a mental health issue feels so disconnected from the immediate reality, which is why I wish to provide a perspective. At the same time, each individual's experience is unique, and I cannot speak for every person, but I think there are some aspects that are common enough to worth mentioning. Aspects that I can comment upon based on my own experiences, and my interactions with patients and colleagues.

Mental states are the most human of all human qualities. And a disturbed mental state infiltrates every part of the human experience. One cannot over-emphasize this aspect, because every part of the patient's existence is coloured by their emotional and mental states. Sufferers of depression and anxiety say that the disease manifestation is always there, it's just sometimes worse than other times. And management needs to take this into account. Pharmacological management goes without saying, but the psychosocial support is so important. The individual wants, or needs, to engage with life in a meaningful way and to do that, support is required. I remember the head of department of psychiatry and dean at Wits medical school, the inimitable Prof Hart, telling us we can never overestimate the depths of despair and darkness that envelops the sufferer with mental health problems. Yes, I know, I hear those working with patients with personality and conduct disorders adding that we should never underestimate manipulative behaviours. But Prof Hart was referring to bona fide mood, anxiety, and psychotic disorders.

How do the psychosocial elements play out?