A PSYCHOTHERAPEUTIC APPROACH IN SCHIZOPHRENIA.*

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I AM presenting to you in this paper my own views and experience in a practical psychotherapeutic approach to psychotics. I am aware—acutely aware—that I am speaking, with only two or three years' experience behind me, to distinguished psychiatrists. I cannot bring myself to apologize for having definite views on so short an experience; they are views that struck me before I had been employed in a mental hospital for a week, and I have had no occasion to change them since. I am not even sufficiently well up in the subject to know if they are peculiar to me.

The first point that I want to make is, that of all the patients in a mental hospital, those who seem to me to be the most accessible to psychotherapeutic approach are the advanced schizophrenics. Not the borderline cases, nor the so-called fleeting schizophrenias who, however acute and severe their symptoms, still give one the impression that they will eventually find their feet again. Both the above types are very tempting to the psychotherapist because one feels that psychotherapy ought to be able to do something to tip the mental balance in the right direction for them, but nevertheless, I feel that, as a psychotherapist, certainly as an analytic psychotherapist, I should keep my hands off those cases. The advanced case is a different matter—I mean the patient who has set a psychotic course and kept to it five, ten, twenty years, with little change except progressive dementia. It is this approach to such cases that I find encouraging.

The second point concerns this dementia. It is constant in the advanced schizophrenic, but I am convinced that it is more apparent than real. The obvious evidence of this is the occurrence, described in all textbooks, of spontaneous remissions in old-standing cases, and the temporary remissions under the influence of severe illness that are often observed. However short the remission, the patient's real personality emerges on these occasions—they are not just improvements in behaviour. So the personality cannot be disintegrated; it must be *there*. I am more interested in the psychotherapeutic evidence of this point, and my best story here concerns a patient who presented the perefect picture of dementia. She was completely withdrawn—chattered

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unintelligibly, was dirty and helpless, and just played with her fingers all day, and had done it for about twenty years. I made contact with her on my own lines, and after about a month decided, on what evidence I cannot remember, that there was opportunity to make her take a step out into reality. I conveyed this to her and the immediate result was very striking. She stopped playing and chattering, and looked terrified, then showed all the signs of a severe mental struggle: she sweated, went pale, and her breath came in gasps and she did not speak a word. I have never seen such a severe mental struggle, and complete with physical signs, and she kept it up for an hour and a half while I just watched and put in an occasional word of encouragement. At the end she lay back and looked me full in the face and said, "I can't; I shall lose too much," and went back to her psychotic behaviour as if she had clicked a switch. To be able to face a problem dead square like that in a way that I have never known even an intelligent neurotic to do, that, to my mind, is inconsistent with true dementia.

The Approach.

The difficulty in speaking intelligently about this approach lies in its simplicity. When I have done more work on it I might be able to complicate it sufficiently to make it acceptable to the intellectual mind, but that has not been achieved up to date. For the sake of clarity I want to outline the principle of the method as a whole before attempting any details of technique.

Please think of the schizophrenic as if it were a child at an age when a child creates definite fears for itself which then hold sway over it for a period. Fears of the kind I mean are fairly general at a certain stage. I mean that stage in one's childhood when one knows that, at a certain turn on the stairs or bush in the garden, something will jump out on one. Or that when the bedroom door is shut at night, a man will jump out of the cupboard. It is not a generalized fearfulness—the fear is definite and remains the same with perhaps embellishments for days or even weeks. If you know anything about the sort of fear I mean, you will know that one does not talk about it; one wouldn't—couldn't—except perhaps impersonally to frighten other children, and that is not the same as telling one's fear. You will know too the characteristic intensity of the fear—one lies and sweats with it. I often wonder how much night-sweats in children, attributed to rickets, etc., really come under this heading; I think quite a lot. Usually the child ultimately deals satisfactorily with these fears and they disappear. But suppose the fear gains in intensity so as to become really intolerable; the child will then, as a last resort, and against its intuitive judgment, make a desperate effort to tell someone about it. Suppose everything is in its favour and mother is the most understanding person in the world, she will still probably rely on reassurance and proof that there *is* no man in the cupboard. The child is now in a really

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desperate plight. For the first time she is utterly alone with her fear. Mother doesn't know about the man in the cupboard—the child *can't* make her know. The fear was intolerable before; now, shut up alone with it and made aware that she lacks the ability to convey it to the outside world, i.e. mother, the situation is sufficiently hideous to warrant the most drastic measures being taken by the child to bring itself relief. For instance, a plunge into wild unlimited fantasy or the cutting of all ability to feel down to *nil* may be justified.

In a recent number of the *Journal of Mental Science*, Sawle Thomas quotes Skottowe on schizophrenia, and it reads to this effect, that Skottowe considers the hall-mark of true schizophrenia to be a symptom which he calls dys-symbole, and defines as "a state of mind which manifests itself by the inability of the patient to formulate his conceptual thoughts upon personal topics or to discriminate the gradations of his emotions in language which is intelligible to others." I differ only from Skottowe in that I consider dys-symbole to be not only the hall-mark, but the basis of schizophrenia, and this I have tried to convey in the above picture. I do not wish to convey that I think schizophrenia has a purely psychological basis; I believe it *has* a physical basis, but it is the psychological disturbance irrespective of the nature of its physical basis that I am concerned with in this paper.

To return to the picture of the schizophrenic that I drew, and thinking still in terms of the child, there is only one way in which it occurs to me to approach the situation. I *watch* the child, behaving to her in the meantime as an ordinary friendly person, and avoiding interference with the line of conduct she has taken up. I avoid questioning her or any attitude of "trying to find out" about her, but I watch, and there will be straws to show which way the wind blows. I shall notice, for instance, that the fear is directed towards the cupboard, and with Freud behind me shall realize that it is probably a man that she is afraid of, and shall wait for evidence confirming this, and so on until I have mapped out the fear as much as I think I am going to be able to. I then play the first active move by saying simply as I tuck the child up in bed at night, "I'll just see to the man in the cupboard before I go." "So she knows about the man in the cupboard!"—there is a sharp response—fear and then relief that is unmistakable to the psychotherapist.

I now keep out of the patient's way for about a fortnight—and this is important. I see her in passing and do meet her a good deal, but not on the footing of her fear situation. You see, if I put the child to bed the next night, I shall have, in order to be consistent, to deal with the man in the cupboard again—and repetition of this will fix him as a reality, and this I have no intention of doing. So an assistant who knows what is required of her who can take over at this point is a necessity.

Towards the end of the fortnight, maybe longer, the relief of tension associated with this first move begins to wear off and the fear itself predominates.

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The next move must come from the child, and I wait for it; it will probably be some plan on her part for escaping from or mastering the fear produced to me in such terms as: "I was silly; I thought there was a man, etc." The child is just being disloyal to herself; the fear is as potent as ever, and she is attempting intellectually to gain mastery over it by deprecating it, and she seeks my support in this. My answer—a dead serious "I know" is a refusal to give this support and conveys—"I'm not going to pretend that it is silly; you can do as you like about it." A patient here played this move a week or two ago, saying "I'm going off my head. I had a baby last night." I answered, "I understand about that." She turned almost fiercely on me and said, "Yes, I know you do—I can't make you out." That, incidentally, is a patient who has been ill nine years and was mute. A period of antagonism to me probably follows this second move, but the patient *is* better, and in due course this phase passes and she goes on to *her* first active move—which will be in this case an open interest in essentially feminine things in relation to herself—very tentative, but with quick response to encouragement. She is now on solid ground for the first time, and although obviously mentally ill, has a normality about her, something quiet and sure, that is very satisfactory. My assistant now takes over again and I just see the patient in passing though she can always see me if she asks for an interview. These periods when the psychotherapist gets out of the patient's way and yet remains available to her are important. The patient is encouraged in feminine activity. Also a piece of slow satisfactory constructive work is started—tapestry or weaving—the sort of work that grows so slowly that the end is scarcely in sight so that the doing of it is the whole point, not the finishing, and from this point the process is just one of building up. From the time that the first active move is played by me I put the patient on suicide caution observation and keep it up well into the last constructive phase. A strong positive transference to me is usual; it runs a full course and dies a natural death. It is important that the Staff should understand the handling of a patient showing a strong transference.

The outward and visible signs, as these stages are passed, are quite definite. When the first corner is turned, i.e. response to the active move, the patient gives me a good working contact with her and this lasts. Coincidentally with this, and presumably because the fact that she can communicate with me gives her some faith in her ability to communicate with the outside world, she responds to her relatives in a way that they never fail to notice even if they do not know she is under treatment; and thirdly there is a marked improvement in her appearance, not only in health, but in looks generally; the rather revolting facial changes largely disappear.

On turning the second corner there is an awakening of interest, but the internal problem still occupies most of the mental energy, and the patient cannot concentrate sufficiently to be occupiable. Here, at the moment, I have got two patients round the first corner and one round the second.

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The detailed technique amounts just to the *language* in which these conversations are held. I find that once one has accepted dys-symbole as *absolute* for the schizophrenic and has put ordinary language right away as a means of communication, one is free to discover what forms of expression are in actual use by any one patient. I find the schizophrenic range of language surprisingly wide, even for a katatonic stupor, so that one can select out of the range at least one method of expression in which one has scope for replying—because it is a *conversation* and both must speak the same language. I find, too, that once patients realize that one is listening to *their* language, they often vary it and elaborate it until they have made one understand. It is the listening more than the accurate understanding that is important. In fact, one can answer a patient's question without grasping more than just the gist of it. For instance, there is a gesture that I frankly do not understand, and yet every patient I have treated has handed it to me in exactly the same way and at the same point, i.e. somewhere in relation to the second move in the approach—I have never got a patient round that second corner, whether they have been hebephrenic or katatonic, without receiving this gesture—the patient out of the blue asks to be allowed to wash her clothes. Now what does she mean? Washings are certainly prominent in age-old rites, and this gesture is probably rooted deep in the archaic levels of the mind. But I am concerned with the immediate meaning. Observing the patient I know that that gesture is one of "finishing with something satisfactorily." I have noticed, too, that patients tend to shrink from completing the washing—it is as if this act of "putting paid to something" is courageously undertaken, but they "get cold feet about"—and I always stand by and help them to see it through. But I still do not understand it.

The schizophrenic language of expression includes:

1. *Drawing.*—Volumes have been written on the interpretation of schizophrenic drawings, and I have nothing to add except that I myself do not value interpretations made on the drawings alone by some fixed code of symbols, but find it necessary to be with the patient and observe her while the drawing is being "spoken."

2. *Posture.*—Katatonics seem to rely a great deal on posture for their expression. Literature is very limited on this subject, and one knows very little about its meaning. One patient here managed to convey meaning to me by posturing because it happened that I had seen exactly the same posturing in two cases before. She always held herself rigid, yet the rigidity was mixed with extreme flaccidity; it is difficult to describe—the limbs are at once stiff and yet flail-like. This, together with her insistence on maintaining the erect posture so that one had a struggle to make her sit down, obviously had a definite meaning for her; anyhow she abandoned it after I had conveyed to her what I felt to be the answer.

3. *Creative ability.*—Working with earth and growth is one avenue here.

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Clay modelling is another, and an extremely instructive one. Apart from the symbolic value of the models created, it gives one the opportunity of watching patients construct and destroy—of seeing what they preserve and discard—what they handle tenderly and what cruelly. I have watched a patient model a breast and stroke it tenderly and love it—the wet surface of clay makes it a very satisfactory medium for love play of any sort—and go on loving it more and more until, in an ecstasy of loving, the breast was completely destroyed, and then the patient mourned the loss of it in utter depression. Watching this, one may be able to see the patient enact the complete phantasy that lies behind the characteristic schizophrenic mouth movements—and handed to one in that form, one can deal with it.

4. *Behaviour associated with taking of food, defaecation, urination.*—This form of expression is so full as to need a paper to itself. It is common knowledge that urination is frequently associated with phallic phantasies, and defaecation with ideas of pregnancy. An infantile love desire to give out of itself can be expressed here too. It suffices to say that observation of patient's habits rarely fails to give some clue as to what the patient is trying to say.

5. *Lastly, there is communication in words.*—It is necessary to differentiate sharply between utterances that matter to the patient and what I call "mental froth." This is not as difficult as it sounds, but does need experience. I first hit on it by something in the timing of the answer. I must emphasize that the patient is dys-symbolic so that the meaning of the utterance will not be what the words appear to convey. If I say "I am cold," I mean that the temperature of my environment is low. If the schizophrenic says "I am cold," you can take it that she does *not* mean that—she may mean "something that matters to me is cold, deathly, and still, inside me," or alternatively, something like "I am utterly alone." The background here reads like this: "At my birth when separate and alone for the first time, I also experienced first the sensation of cold." You will reject the latter if you do not believe in analysis of birth separation—it does not matter. I just happen to believe in it and deal with that remark by cuddling the patient up close to me to convey that, although she could not have the intra-uterine warmth back, she could have close physical contact, which, as life goes on, more than replaces the loss. If I felt that the first meaning was the true one, I should make the patient strike matches and light a fire, adding a verbal promise to keep the fire in, backed up by a demonstration on succeeding days that the fire was still alight. I do believe that schizophrenic utterances always concern the big, deep, simple things of life—birth, death, life, love, hate, destruction—and that the meaning has to be looked for on this level.

In spite of the fact that I have tried to explain it intelligently, in practice, one's intellectual reasoning power has no part in this therapy. I believe it is possible to ask one's intellect to stand aside and not interfere, and one can then speak the schizophrenic language fluently because one is thinking in

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that language. I say this because I believe that the schizophrenic's difficulty is not so much her inability to express to the *outside world* concepts and emotions that matter to her, but that, primarily, within herself, an inability exists on the part of the simpler instinctive levels of the mind to communicate with and obtain the co-operation of the higher intellectual levels. At this point, of course, I am back to the old conception of a schizophrenic split.

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