Brit. J. Psychiat. (1969), 115, 959–60

The Function of Thought Disorder: A Postulate

By R. G. PRIEST

Many neurotic patterns of behaviour are considered to be adaptations to the environment, although often thought of as "maladaptive" in the sense of not being the optimum adaptation, and as reflecting pathological needs and expectations.

Depressive illness can be thought of in the same way, and after a series of losses or disappointments decathexis can be seen as protecting the patients from further trauma (Forrest *et al.*, 1965).

Schizophrenia, too, has been considered as a reaction to the environment, and, in fact, in recent debates about the need for U.S. psychiatrists to conform to a world nomenclature, fears have been expressed that this position might be abandoned (*Psychiatric News*, 1968*a*, *b*).

The schizophrenic reaction is not always thought of in a teleological way as adaptive, however. Disorder of the content of thought (delusions) may be regarded as fulfilling an unconscious need, but disorder of the form of thought (formal thought disorder) tends to be regarded as an enigmatic outcome of the schizophrenic process.

The author has been impressed by the way in which chronic schizophrenics tend to *use* their thought disorder to avoid communication, and it can be seen that it is well suited to this function. While appearing to co-operate, and even to be compliant, the schizophrenic can subtly defeat the attempts of the staff to control him and to communicate with him. In this way, he is able to avoid indicating his distrust and hostility.

There is evidence that the schizophrenic does have high levels of hostility (Foulds, 1965; Caine *et al.*, 1967), and this may be related to the feelings of frustration and irritation frequently experienced by those attempting to deal with such patients.

This argument seemed even more plausible to me when I found that, without much difficulty, thought disorder could be eliminated by making it redundant. In interviews with grossly thought-disordered patients I found that there was almost always some meaning being generated behind the mask of word salad and assyndesis.

If, in psychotherapeutic sessions, communications from the therapist concentrate on this signal rather than on the noise, the patients become more alert, responsive, sad, and often silent. When they do talk, the thought disorder has disappeared: it no longer works. This sadness or depressive affect appears even though the therapist's communications are reflective ("It seems that you feel so-and-so") rather than interpretive; but it is difficult to distinguish from the fact that so often the feelings that are being expressed covertly are in themselves of a depressive nature. (In fact the author, in common with many others, does not make interpretations of unconscious material to schizophrenic patients, for fear that this might provoke more anxiety or depression than they could tolerate.)

I would wish to add that I do not see schizophrenia as purely environmental in aetiology, but regard it as probably resulting from a combination of internal and external causes. I find the concepts described here more useful in chronic schizophrenics than in the acute phase, and I would be cautious about using anything other than a very supportive approach during the acute phase. In the chronic phase the patient's behaviour, including his thought disorder, may be regarded as a way of life. In making his analysis of this situation the therapist has the same responsibility as with any other patient for considering whether it is warrantable to try to get the patient to change that way of life.

Formal thought disorder is one of the defences that the patient can abandon if necessary.

How can one test such an hypothesis? One might use the Hostility and Direction of Hostility Questionnaire (HDHQ, Caine *et al.*, 1967). This not only gives a measure of the general level of hostility, but also of its direction—intropunitive or extrapunitive. It has been shown (Foulds, 1965) that the more severe a depressive illness, the more the hostility is directed intropunitively. One would predict therefore that (a) thought disorder would be associated with high levels of hostility and (b) that removal of thought disorder by psychotherapy (or possibly even by phenothiazines alone) would result in a higher intropunitive score.

Alternatively, to see if depression resulted, a more direct measure of depression could be used, such as the depression scales of the MMPI (Hathaway and McKinley, 1951), the Symptom Sign Inventory

https://doi.org/10.1192/bjp.115.525.959 Published online by Cambridge University Press

(Foulds and Hope, 1968) or the Middlesex Hospital Questionnaire (Crown and Crisp, 1966). This is, *faute de mieux*, to beg the question of the distinction between depression as a mood and depression as an illness.

There are, however, a number of ifs and buts. For instance, may one regard a questionnaire score as valid in the presence of a sign that implies that the patient uses words incorrectly? (Even if it shows concurrent validity may one assume construct validity?) Is one justified in assuming that thought disorder would be associated in any case with manifest hostility if it is an effective defence against revealing the hostility?

One may have to resort to the psychoanalysts' argument that, with the individual patient, correct predictions do inductively justify the hypothesis on which the predictions were made, and that enough swallows do make a summer.

At least there is scope for more research at the observational, if not the hypothesis-testing, level. Are others able to confirm my observations on the results of circumventing formal thought disorder? Do schizophrenics with thought disorder show characteristic scores on hostility questionnaires? Do their scores change in an intropunitive direction on clinical improvement, and do they become demonstrably depressed?

References

Caine, T. M., Foulds, G. A., and Hope, K. (1967). *Manual of the Hostility and Direction of Hostility Questionnaire (HDHQ)*. London: University of London Press.

Crown, S., and Crisp, A. H. (1966). "A short diagnostic self-rating scale for psychoneurotic patients." *Brit. J. Psychiat.*, **112**, 917–23.

Forrest, A. D., Fraser, R. H., and Priest, R. G. (1965). "Environmental factors in depressive illness." *Ibid.*, **111**, 243–53.

Foulds, G. A. (1965). *Personality and Personal Illness*. London: Tavistock.

—— and Hope, K. (1968). *Manual of the Symptom-Sign Inventory (SSI)*. London: University of London Press.

Hathaway, S. R., and McKinley, T. C. (1951). *Minnesota Multiphasic Personality Inventory*. Revised edn. New York: The Psychological Corp.

Psychiatric News, **111**, January, pp. 1 and 24, (1968*a*).

Psychiatric News, **111**, February, p. 2, (1968*b*).

R. G. Priest, M.B., B.S., M.R.C.P.E., D.P.M., *Senior Lecturer in Psychiatry, St. George's Hospital Medical School, London, S.W.1*

(*Received 10 May, 1968*)

https://doi.org/10.1192/bjp.115.525.959 Published online by Cambridge University Press