

about the posterior commissure and the tract of Meynert. In the midbrain, pressor responses were obtained from the substantia grisea centralis, the lateral portion of the reticular formation, and the substantia nigra. In the superior portion of the medulla, responses were produced by stimulation of the medial and lateral reticular formations, the medial lemniscus, the dorsal and ventral nuclei of the brachium conjunctivum, and the lower portion of Deiters' nucleus. Depressor responses were of lower magnitude, less frequently found, and rarely reproducible. Anesthetic and sympathetic-blocking agents modified the response of the brain stem. The responses of the brain stem in dogs having arterial hypertension were quantitatively and qualitatively the same as those in dogs with normal pressure.

DISCUSSION

DR. ROBERT A. GROFF: How does Dr. Walker think this mechanism is initiated?

DR. MICHAEL SCOTT: Was any correlation made with attempts to increase the blood pressure by pressure on the third ventricle?

DR. A. EARL WALKER, Baltimore: Does Dr. Groff mean human responses?

DR. ROBERT A. GROFF: Yes.

DR. A. EARL WALKER, Baltimore: I do not think these changes are due to hormonal influences, for they occur in the absence of the adrenal glands. The rise in blood pressure is due to an increase in the peripheral resistance coming from a discharge from the sympathetic nervous system. This is shown by the opposite method of removing the sympathetic nervous system and getting no rise in the blood pressure. There may be a late rise, which may be due to a second renal factor. The primary factor seems to be neurogenic. We have had no experience with pressure on the third ventricle.

PHILADELPHIA PSYCHIATRIC SOCIETY

Hugo Mella, M.D., *President, in the Chair*

Regular Meeting, Feb. 8, 1952

Preverbal Aspects of Psychotherapy with Schizophrenic Patients. DR. CARL A. WHITAKER, Atlanta, Ga.

The poor integration of the schizophrenic patient results in a poor capacity to use formal symbols. This means that the verbal content of therapy with a schizophrenic patient is relatively unimportant. The problem of communication involves emotional recognition on the part of the therapist that he is being perceived (felt) and an emotional recognition on the part of the patient that he is being perceived (felt). The channels for this deeper communication include the voice characteristics which carry affect, that is, more primitive symbols, and the other methods for communicating meanings, as opposed to information. Once the communication channel is established, there will develop in both the therapist and the patient the capacity to break through these tensions and establish deeper channels, a major problem in this type of therapy. This implies a need for the deepest possible affective involvement of the therapist with the patient. Can the therapist become "crazy" about this patient? If he does, then the quality of his voice, and tensions in his facial muscles and muscles determining body posture will express this. The therapist's perception of the patient as his own child self will be communicated to the patient. The patient and his biological drive to grow is a constant. The inadequacies of the therapist as a person is the problem. These inadequacies include his inadequacy in communication. He is frequently hampered by his use of verbal substitutes for communication of affect. What does the therapist need for adequate communication with a schizophrenic patient? The capacity to use his own biological drive to grow in the framework of this relationship. This is begun by his own psychotherapy, increased by the therapy he gets from patients, and augmented by all the growthful experiences he has with colleagues. However, we must differentiate this type of personal growth from professional experience and technical growth, which is more superficial. Finally, he needs a group of colleagues under similar demands and stress, so that in this little subculture they can dare to breach the cultural barriers which so definitively disapprove of the depth of interpersonal relationship necessary for the cure of schizophrenia.

DISCUSSION

DR. MALCOLM L. HAYWARD: My thoughts are still somewhat chaotic. However, I can contribute most to the discussion by giving some more examples of situations in my experience which I have felt carried a great deal of emotional relationship between patient and therapist, and yet in which there was no actual verbal exchange. A patient was trying to describe what the therapist had done for him at the start of his illness. He said, "Assume that the patient has delusions of being Napoleon." Our analytic training tells us that the patient has killed his father and by incorporating him has become Napoleon himself. One way to deal with this is to explain to the patient, "You have killed your father, etc." When we are faced with a schizophrenic patient, the element of regression makes it difficult to do that. The patient said of his physician that simply by his presence, by his actions and personality, he conveyed to the patient the idea, "No, you are not Napoleon; I am Napoleon." The patient was freed of his guilt; the father was brought to life again, and all of this was apparently accomplished without the therapist himself being aware of it, although it was a very stormy relationship.

I also remember a woman aged 25 who for three months had been combative, cold, and distant and who suddenly, at the end of one interview, ran over to me and buried her head on my chest. The emotional impact of this was terrific. I said, "I certainly hope we can help you solve your problems." She answered angrily, "I am much too busy helping a lost lamb to find its mother that."

Another hint I got from a patient when she passed me in the hall and said out of the corner of her mouth, "Man and woman are the same: one mother," and went on her way.

In regard to the confusion made of the terms "verbal" and "extraverbal," a patient once said to me, "I never listened to your words. I watched your expression and tone of voice to see if it all added up to show love." I cannot help feeling that this is the source of a great deal of confusion in the literature. We all tend to go into considerable detail about what we said and when we said it, but what is important is how we said it and what we said besides the words.

DR. EDWARD TAYLOR: What Dr. Whitaker has said this evening is something we have all known and thought about from time to time, namely, that the treatment of a schizophrenic patient is largely a problem of the therapist. It is the therapist who always determines whether the patient is going to make progress or not. That has been my experience in my work with schizophrenic patients. When I am able to go forward myself, I find I am usually able to bring some improvement to the patient.

Aggression is one of the major problems in the treatment of schizophrenia. I should like to mention a personal problem I had in regard to a patient with an obsessive-compulsive compulsion. I had a pretty good idea that he had a fantasy that he wanted to murder me. When I came to a point where I was not worried about what he was going to do to me, but what I was going to do to the patient, we had no problem, and we made progress.

DR. JOHN P. KOCHIS: I was getting a little panicky as the time came for me to get up and say something. Then I began to ask myself, "Why am I so confused about all this?" It goes back to something Dr. Whitaker said. I have gotten no information, but I have gotten a lot of meaning. One intense relationship with a schizophrenic patient will bring to life all that Dr. Whitaker meant. The idea that words mean nothing in such a relationship I have felt to be true many times. With the proper tone of voice and a feeling relationship with that patient, you could say, "A, B, C," and make progress with the patient. I should like to show some motion pictures we had taken of a patient at Philadelphia General Hospital. (Beginning of film shows patient getting willingly into crib type of bed.) This is a 33-year-old schizophrenic woman. The patient entered the hospital in a completely regressed state. She took intuitively to the setup we put her in. (Film continues with therapist offering a nursing bottle to the patient, now recumbent and scratching aimlessly at her head with her left thumb. She finally accepts the bottle and drinks from it while the therapist holds it.) This film was taken several months ago. By now she has somewhat lost her taste for bottle feeding. (Film continues with patient on floor displaying interest in toys shown to her by the therapist, followed by a sequence showing the patient playing with a small child and feeding him with what appears to be an apple.)

This has been an experience completely on a preverbal level. This woman had spent the previous 18 years in a psychiatric hospital. Therapy here consisted of feeling, not words. When verbal expression came into the relationship, it consisted mostly of the therapist's telling her "This is your bottle; you may have it for as long as you want, whenever you want it," and of the patient's telling what the bottle had meant to her and what the therapist had meant to her. Feeling, not words, is the most important thing we have. It is through feeling that we have given her her first 18 months out of a state hospital.

DR. KEITH FISCHER: I have had little experience with psychotic patients. Those I have seen have been in an open ward. My colleagues and I may use methods a little different, but we are interested in the same things.

I prefer the term "extraverbal" to "preverbal," which applies to something a child learns before he has learned to talk. Fromm (*Forgotten Language*, New York, Rinehart, Rinehart & Company, 1951) says it is a shame that there is not a language which is common to everyone; but one really does not have to look so far or create something new. There is a symbolic language. But there is one difficulty. Dr. Fromm says, "Dreams in all countries are the same." By the mere fact that we ask a person to relate a dream to us and translate it into words, we are asking him to make it verbal. This has limitations and difficulties. In our hospital we say to a patient, "If you don't want to describe the dream, go into the art room and draw about it." Very frequently, after that the patient describes it for the therapist. When, as is usual in the course of therapy, we ask the patient to tell us a dream, we are hereby asking him to take something extraverbal and translate it into something verbal.

Then, there is the acting out. The acting out that a patient does is easier to see and understand when different people are watching.

There is a language of body symptoms. It is difficult to understand and talk about. Another form of extraverbal communication comes under the heading of sublimation.

I question the idea that in therapy the patient and the therapist must have a symbiotic psychosis. We consistently refuse to have such a relationship to the patient. I should have to ask Dr. Whitaker, "Can the therapist understand the patient in his extraverbal language only by using extraverbal perceptions? And, in planning treatment, does the therapist have to have this symbiotic relationship to the patient, or is it possible that the therapist can maintain his reality functioning and, at the same time, understand the extraverbal part?"

DR. LE ROY MAEDER: It is difficult to discuss this type of presentation because some of us are working so consciously, at a conscious ego level. Psychoanalysis is an approach by analysis to psychoses from a structural and dynamic angle. We think in terms of personality, ego, superego and unconscious, but we also approach the problem from a dynamic point of view, thinking in terms of instinct, emotions, libido, fear, and the distribution of these energies in different parts of the personality and mechanisms of defense. In therapy the analyst is trying to do several things at once. He is trying to establish rapport, or empathy. He is trying to establish contact with the patient both on a feeling and on an intellectual level. He tries to find out not only the verbal, but also the affective, content. He is trying to get the patient to cooperate with him and get well.

Various people have worked on the psychoses. Freud wrote several papers on the subject. In his work with Bleuler and Jung, he was trying to adapt the libido theory to a solution of psychosis. His later work with Harry Sullivan was an effort to identify the psychotic person on all levels. I believe that the work of Freda von Reichmann is of value in an effort to understand a person on an emotional and intellectual basis. John Rosen acts things out with the patient. In this type of work, Dr. Whitaker and his associates work very much on an affective and instinctual level in the unconscious.

DR. CARL A. WHITAKER: I should like to discuss several points which have come up in the discussion. First, a word about the bottle. In the course of a year my colleagues and I have used it with 300 or 400 patients. We have used it with physicians, psychiatrists, students, and nurses. In every case we got the same type of picture.

One of the things that came out of this discussion is reflected in something that one patient told me, when I had done all I could do for her and I felt that she was getting worse and worse;

I finally said to her, "I just can't stand this any more. I have done my damndest, had another therapist in, and we have fought it out and cried it out. To see you any more will make it worse. I shall never see you again as a patient." She came back the next week, and I told her I would not see her again. She said, "Let me tell you something. I know you have loved me, and nothing you can say or do will ever change that." That told me something: You can't fall out of love. Rejection is denial of the patient in the beginning, but one cannot reject a patient once one has accepted him.

Dr. Fischer asked, "Can you learn the body language?" One of our internists always comes out of an interview with some body symptom, and it is always a symptom relating to the problem the patient has.

Someone said we act like schizophrenogenic mothers. This is perhaps true, but with one exception: We offer the patient a chance to fight free of us.

Can the therapist understand his extraverbal expression only through extraverbal means? Can one retain a sense of reality and still understand the patient? I can in those areas where I am sure and comfortable. Sometimes a patient or a medical student comes in tense and with a problem, and he can go down deep and I can retain my feeling of reality, but not with a schizophrenic patient.

We believe that when a patient regresses he is trying to satisfy a residual need at that level, and if we can free him from the need of being mothered or fathered, he will go on from there, and that his maturity is a spontaneous result of the satisfaction of the need of that moment.