

ON TALKING WITH THE DELUDED SCHIZOPHRENIC PATIENT IN SOCIAL THERAPY

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While it is true that many schizophrenic patients talk very sensibly on almost any topic, it is equally true that a great many reveal their delusional systems through speech, all or some of the time. When the non-schizophrenic is presented with this it is difficult to know how to handle the problem. One theory would say that the task is to insist that the schizophrenic adjust to reality and abandon his "crazy talk" (8, 10). Such a theory would argue that the non-schizophrenic (or let us say the therapist) refuse to talk with the schizophrenic unless he talks sense. This notion would further stress that the therapist should enter debate with the schizophrenic by logical means when possible (8, 10). Another approach would urge that the therapist interpret the delusions of the schizophrenic, i.e. by talking to their affective and/or symbolic meanings (16, 24, 27, 30, 35).

It will be argued in this paper that both approaches are correct, depending on the individual patient and the circumstances. A thorough knowledge of the patient should assist the therapist in making the right approach to the subject of verbalized delusions at the right time. Examples will be given which refer to actual patients and which suggest the approach of choice.

The setting in which these data were collected involves group activity with patients who have been the subjects of an intensive and extensive rehabilitation program (8, 10). Frequently the tone of the paper focuses on the individual, yet generally the setting involves the group. Moreover, the therapeutic approaches suggested will, from time to time, be illustrated not alone by citing the relationship between therapist and patient but will also demonstrate ways in which patients have assisted one another.

INSISTING ON STRAIGHT TALK

When some consensuality is present. Insisting on straight talk would seem to be in order, first of all when the patient gives no evidence of structured delusions, but instead talks in tangential terms (32).

For example, one patient known well to me never talked about any systematic delusions, e.g. having iron in the veins, being persecuted by the FBI, receiving messages from the television set, etc. He did, however, talk in a "strange way" about a great many things. This involved using words that were not quite right in the context used, yet were not totally incongruous. Thus, for example, when asked after listening to an impressionistic piece of music, what the composer had in mind, he said, "There is no public." I was left with a tantalized reaction of almost but not quite getting the point. In this person's case a patient restatement, e.g. "I don't understand you. Say this again so I can," generally produced a move toward more definitive speech. In the above example he finally said, "He (the composer) writes about his own feelings."

It would appear in this case and others like it, that the delusional material is ephemeral in the mind of the patient, that he cannot pin it down as a series of concrete concepts, that it floats somewhere between abstraction and concretization, and is expressed as a compromise formation as in poetry. With these cases, in my opinion, the therapist ought to try to assist the patient to move toward consensual clarity, since the speech itself is in some measure consensual to begin with. It would be wrong to try to interpret what the patient is saying or to infer symbolic meaning from his speech because these might push him away from the partially consensual to the autistic and thus destroy the existing base of communication.

In the above case, many weeks were spent urging this patient to speak in a consensual way. Never was he permitted to say anything that was not totally clear to us, no matter how arduous the process of restatement became. Eventually he came to talk consensually all of the time.

When reality of delusions is doubted. Also, one might demand straight talk with a patient who does have structured delusions, if he has given earlier evidence of doubting their reality or his need for them. Frequently a patient will arrive at the conclusion that the voices he hears and things they say are "in my head".¹ When a patient says this, I always agree. But if he should later relapse and the voices and the ideas they express regain their former intensity, then I challenge the patient, calling attention to the fact that he has

¹This seems to be a shift away from a "psychotic" to a "neurotic" frame of reference, in which the patient says essentially, "I know now that these voices aren't real, they're in my head but they still cause me trouble." There is a parallel to neurotic obsessional thinking or compulsive behavior in which the patient recognizes the ideas and the rituals are nonsensical, yet fully accepts their psychological reality by being forced to think and do certain unpleasant or meaningless things (25, p. 377).

earlier had reservations about them. If the therapist does this, he comes to stand for the patient's healthier self and insists on that better self when the patient is moved to abandon it. I would also argue with the patient if necessary and try to offer logical evidence why he should not retreat further into his delusions.

When social reality is denied. There may be one other time when the therapist will talk straight to the patient. This will happen when the patient expresses ideas having the intent of denying the social reality existing between himself and the therapist.

One patient constantly referred to himself as "it", "this kid", etc. When coached by me to make proper identification, he would say, "This kid says that you're Dr. East." Following Haley's (17) scheme it was clear that the patient denied the reality of the situation by false identifications. Also, by identifying me with "Dr. East", a real person who was almost the exact physical antithesis of myself and who had long ago left the hospital, he further denied the reality of the social setting. I always felt that little was gained by letting him get away with this, because, as Haley points out, the issue here is control, and if the patient is permitted to deny interpersonal relations, no therapy can take place. The therapist must stay in charge and this he can not do if the patient, through speech, is permitted to "walk away." Here again, I insisted that the patient properly identify himself, myself, and the social setting. I noted that he slowly abandoned his denial tactics when he became convinced that I meant business.

Frequently I have seen that when a patient employs denial tactics in a group, the other patients will call attention publicly to the fact that the first patient is crazy. Often someone will say, "He's crazy, isn't he?" and accompany the statement with a derogatory laugh. In my opinion this technique brings the patient to his "senses" and leads to his abandonment of denial tactics. However, I am not sure that a "sane" therapist could get the same result. Perhaps patients realize the futility of trying to fool each other but will try to fool the therapist until he is able to establish categorically that he will not be fooled, i.e. lose control of the situation.

GETTING AT AFFECTIVE MEANING

On the other hand, there will be times when straight talk is not indicated. This would seem to be true whenever it is clear to the therapist that the patient's delusions are stable and structured and that he, in some sense, believes in their reality. I hesitate to say objective reality because as Bateson (4) points out, the deluded patient is not quite clear himself what his delusions mean. Do they

stand symbolically, or metaphorically, for his feeling states, or are they real in an objective sense? Bateson claims the patient is caught in a dilemma. I would add that such patients have probably not yet come to doubt the reality of their delusions. Rather the problem is in what sense they shall be judged real. Also, although such delusions may obviously be used to deny social reality, they may still have a constant property at all times. Thus, the patient who believes he has iron in his veins, for example, may verbalize this idea to prove his "insanity" and thus avoid close personal relationships, but still may think this when no one else is around.

If the problem is one of meaning, it would follow, as Bateson also states, that to try to talk the patient out of his delusions would have the effect of confirming them. If you say to the patient, "No, you don't have iron in your veins," you, in essence, say, "This is something we can argue about. It must therefore have a factual base because we can argue about concrete matters and what they mean. It can't be a feeling state because if it were we couldn't argue about that. You feel as you feel." Thus, straight talk with these patients has the opposite of the desired effect and confirms them in their delusions. I would suggest, on the other hand, that to say nothing could produce much the same effect since to raise no voice may not argue for the delusion, but neither does it help the patient to clarify its meaning.

There is another problem which may develop if the therapist tries to talk the patient out of well-structured delusions which he accepts as real. Ruesch (31, p. 57) points out that abnormal thought is often characterized by magic thinking which cannot be conceptually validated. A challenge to that magic thinking through a denial of its validity is threatening and produces much anxiety. In "normal" situations, i.e. when a cherished idea which cannot be proved is attacked logically, the result may be anger, panic, or some other emotion suggesting a collapse of normal control. But, the schizophrenic faced with a challenge to his magic thinking is less likely to "loose his head." He may, instead, respond with a stubborn denial of the arguments raised by his speech, or shift to a different delusion which may totally unseat the therapist and thus shift control of the situation away from him. I have had this happen to me frequently and have been left as a result with a feeling of total helplessness and frustration. In this situation the therapist has not only confirmed the patient's acceptance of his delusional thought but has also surrendered control in the therapeutic situation.

Enlisting the group. Not infrequently the only way that my helplessness has been overcome in these situations and control eventually swung back to me, is by my enlisting the help of the group.

One example will suffice to illustrate this. A patient had been ranting in a very delusional way, developing a series of delusions in response to my challenge of his initial delusion. Finally, I asked the group, "What is he talking about?" One very quiet patient said, "Money." I was unable to see how this could be, but the deluded patient immediately stopped talking. I tried to look wise and said, "I see." The group moved on from this point with no further interchange of conversation between myself and the deluded patient, but group equilibrium had been restored. I don't understand what happened in this case and others like it, but I would hypothesize some form of empathetic understanding between patients emerges which convinces the deluded patient that "the jig is up" for right now, and that though the therapist has been fooled, at least one of his fellow patients has not been.

Understanding delusions metaphorically. The therapist must, of course, recognize that delusions are real, but in a metaphorical or affective sense. They may be viewed as standing for the patient's emotional state. The schizophrenic is "flat" because he does not experience his emotions as such, but deals with them metaphorically. As Adler says in speaking of auditory hallucinations—one small concretized (2) step beyond the delusion — "Like dreams, they must be understood as a metaphor" (1, p. 317).

If he accepts this idea, the therapist can understand the basic affects for which particular delusions stand. To begin with, delusions are either of persecution or of grandeur. If the patient says something that implies he is the victim of something, he is persecuted. If he expresses his delusions in terms of his own power, he implies grandeur. It is only a question of affective emphasis, since at the base all schizophrenics experience delusions of grandeur (1, 36, 37). As Adler says of the goals of schizophrenics, "We can find in all goals one common factor — a striving to be Godlike" (1, p. 314).

Yet the distinction between persecutory and grandiose verbal expression can be made, and once the therapist has clarified the temper of expression, he can assist the patient to understand the affective sense in which his delusions are real. Here the therapist's own experiences may be useful. Though he may never have experienced true delusions, he will probably have had transitory mental states where he felt "the whole world was against" him or when he "could lick the world." Thus, the therapist can suggest that the

patient may be feeling emotions of loneliness, grief, rejection, etc. (persecution); or of anger, hostility, jealousy, etc. (grandeur).

I have tried this approach many times. At first patients deny my suggestions, but sometime later many will confirm them. There is here the problem of suggestion. If the patient only confirmed the therapist's suggestion by a bald statement, e.g. "I do feel lonely," we could suspect that he merely said what an authority figure suggested he should say. But, patients who respond to this approach give good evidence that suggestion alone does not motivate them.

For example, one patient informed me that she was "one hundred years old" (actually about fifty) had been born in France (actually Vermont) that her father was Louis XIV King of France (actually a Vermont farmer) and that she herself was, for ten years, Queen of England, and for many more years an outstanding Hollywood actress. I suggested that she must be very angry and disillusioned to find it necessary to feel this way. She quite definitely denied my statement, but a few moments later said, "I was terribly angry at my husband." Her case record reveals that she, in fact, did threaten him before her admission to the hospital.

One of the beneficial side effects of this sort of interchange between therapist and patient is that another patient in the group may be moved to begin quite suddenly a recital of past difficulties and hurts. Some of the most poignant data has suddenly emerged from a second patient, following a dialogue of the above type.

Guessing hesitantly. In this approach one actually ignores the symbolic content of the speech and fastens on the affective meaning that it stands for. It seems wise in using this method that the therapist suggest a wide range of affects that seem to him consistent with the tone of the delusion expressed. It seems unwise that the therapist would tell the patient what he is feeling. An approach to this material somewhat as follows seems to be in order. "I don't know, but it seems to me that maybe you feel lonely, hurt, grief-stricken, or something like that. Could this be so?" It is important not to inform the patient straight out how he feels because there is a good chance that the therapist may be correct in his surmise and the patient may thus have the feeling that his mind is being read. As Laing (20) points out, schizophrenics feel that their every thought is known by others. Thus, they cannot tell a lie. It is important for them to learn that they can have feelings which no one else knows about. Thus, the therapist should show understanding by making it very clear that he is guessing at the patient's mental state. If correctly done, the patient may have the feeling of being understood in human terms without any suggestion of mind reading.

Also, a rather hesitant guessing approach will help to show the patient that the therapist's mental mood is not the same as the patient's. Schizophrenics have some tendency to feel that their ideas and emotions are experienced in the same way by others (31). I recall vividly many conversations with schizophrenics in which it was perfectly clear that they assumed that I knew and felt what they knew and felt, as though there was no difference between their minds and mine. Thus, to guess, but in a rather fumbling way, at the patient's mood, and to make it clear that you really don't know what that mood is, may help the patient to a greater sense of his own ego boundaries (14).

Moreover, the patient will doubtless think of the therapist as an authority figure, even though the therapist may go out of his way to be permissive (39). Thus, for the therapist to be too blunt about stating to the patient what he's feeling, and to be too "oracular" about this, could enhance the patient's overdependency toward authority which may be a very large part of his problem anyway (21). Guessing about mental mood gives the patient the chance to affirm or deny what the therapist says, and also a greater chance to feel understood in less pathological terms.

Uniqueness and commonality of feelings. If the patient confirms the therapist's guess about his mental mood with some recalls from the past, the therapist should *not* say, "We all feel this way from time to time," or make similar statements. Effective work can be undermined by the therapist's denial to the patient of the validity and uniqueness of his experiences and emotions after he has worked so hard to make them clear. It is important that the patient be permitted to appreciate the reality of his own feelings. Only as this is done will he be able to recognize their meaning in his life.

At the same time these emotions should not unduly isolate them. The therapist can help by pointing out that his feelings, although his own, are similar to those of other people. The therapist, once he has helped the patient to be more "authentic" (22), can then use experiences of his own (if he feels secure enough to do this) which can help the patient to link himself affectively with the human community.

The following illustration suggests this: A patient in a group setting began to talk vaguely, but dramatically, about feelings of humiliation and shame. In the past, he felt himself the "butt of things." The therapist listened, and a memory of his own came to mind. He felt as though he should recite it to the group.

The therapist said: "I remember once when I was in high school, I played

right field on the baseball team, and we made a road trip and I was scheduled to start. My girl made the trip and I got permission to have her sit on the bench. I was anxious to make a big impression. Well, before the game the coach was hitting flies to the outfield. I could see my girl sitting on the bench out of the corner of my eye. Pretty soon the coach hit a fly my way. I went back for it knowing that if I caught it, it would be a good over-the-shoulder catch. I made the catch alright. But just then my feet went out from under me and I went out of sight into a muddy ditch which was right in front of the fence and which I hadn't seen. When I came up, I was covered with mud from head to foot. The coach was laughing so hard he had fallen down. My girl was doubled up with laughter. Everybody was laughing. Well, I had to walk right in front of the bench to get to the locker room. She was laughing herself to death. Well, I took a shower and came back to the bench in a fresh uniform. The game had started and my replacement in right field got a three-base hit with the bases loaded. I never played anymore except to pinch hit once or twice."

The therapist laughed at the story, and pointed out that it was just one thing in his life, and nothing as great as what the patient was talking about. The group also laughed, and the patient went on seemingly in a more relaxed and confident way to tell about humiliating experiences. After a time, one or two other patients joined in.

ENTERING INTO SYMBOLIC MEANING

However, is there a place for talking with the patient in his own language, i.e. utilizing his symbolic modes of speech? In my opinion the answer is "yes," but with some qualification, involving the therapist's intuitive sense. Talking with the patient in his own language to me involves an intuitive sense of schizophrenia as an artistic creation in which the therapist feels the language of the patient in terms of "poetic license" (39). In my experience, if the intuitive sense is present, the therapist can communicate successfully in "schizophrenese" (39). On the other hand, without an empathic feel for the patient's poetic speech this would be impossible. To put it another way, talking the patient's language from a scientific orientation, or with a view to relating his talk to certain psychic mechanisms or stages, is most likely doomed to failure since successful communication involves parties talking at the same level (31). Unless the therapist can communicate with the patient on the latter's terms, he cannot talk the patient's language. He would be better off using the affective approach discussed earlier which is based more on logical deductions rather than a more vague intuitive feel.

However, there may be rare moments when any therapist will suddenly have the feeling that he understands the symbolic utterances of the patient, in the sense that he captures, if not the actual

meaning of the words, the uncanny essence (15, 37) which seeps through and permeates the message. One could call this, I suppose, a meeting of unconscious (15). The therapist may perhaps unwittingly, find himself caught in the spirit of the patient's message and language and thus talk with him in his own terms. Thereby he may enter the patient's world, if not to understand it objectively, at least to experience a deep psychological reality. I have had this experience very rarely, and when it has come my way it has been thrust upon me. At all other times I would avoid trying deliberately to do this, because of a feeling that I do not possess ordinarily this much native artistic ability. There are those, of course, who do possess this ability and as a matter of course try always to meet the patient at his level of communication (16, 24, 27, 30, 35).

To explain further the rather obtuse nature of this point, I am reminded of the short stories of Franz Kafka (19). I have read these many times. If my mood is fairly bland, I have the feeling that these are rather odd stories which have an uncanny touch to them, realizing this character at an intellectual level. However, on one occasion I read many of these stories while feeling a mixture of anxiety and depression. While still not clear as to what precisely Kafka was trying to say, I felt the psychological reality of his message and had a most uncanny reaction, feeling that I had been introduced into an artistic world of almost incredible horror.

I sense that those who develop therapeutic techniques based on the therapist moving into the world of the patient and grappling therein with his symbolic utterances, experience this sense of the uncanny as a constant part of their therapy. One would imagine that much could be successfully done with the patient through this means, since it represents for him a profound understanding of his reality. Yet most of us are perhaps better able, through either scientific orientation or personality bent, to beckon the patient to our world, rather than to enter his, although on rare occasions we must unavoidably meet him where he really lives.

But, more prosaic things can also be said which only indirectly relate to symbolic understanding in the almost mystical sense in which we have so far discussed it. The alert therapist can understand the garbled speech of the patient better if he understands the culture from which the patient comes and the particular idioms common to it. (18, 39). This, of course, gets into the area of class differences and similarities which have been richly discussed in the literature (18).

Also, the therapist can talk better with the patient under any circumstances if he will adjust his speech rate and amount to the patient. Simply stated this means the use of a few words at a time, slowly, and distinctly stated, with preference given to simple words over complex ones, couched in the same terms as the expected response. Many therapists fail to understand what patients are talking about because they "snow them under" with excessively complicated messages which the patient cannot understand (11). This in itself may be sufficient to force the patient to be more delusional than he really has to be, out of sheer self-defense.

THE MODEL IN THE MIND

Good communication with the schizophrenic patient should minimize differences between patient and therapist even as good communication always brings people closer together (9). This goal may be furthered if the therapist adopts a model of schizophrenia which stresses the universal humanity of the patient (23). Almost any one, whether consciously or not, will adopt a model of schizophrenia by which he defines and thinks of this kind of illness (3, 5, 28, 29, 40). Stress on the humanity of the patient becomes a broad and humane view of schizophrenia, but other more specific models are possible, as for example, Searles' (34, p. 281) concept of the schizophrenic as one having an abnormal fear of death which prevents him from truly living, or as a chosen life style applicable in intolerable social conditions. Indeed, if the model places stress on the patient's "choosing" of his symptoms, room is given for decision making on the patient's part, and he is seen as something other than an utterly hapless victim of circumstance (6, 7, 13, 22).

Selection of a model is based not on its demonstrable proof, but rather on its usefulness as a tool for understanding (8). Certain models change schizophrenia from a psychological series of "oddities" to a philosophy involving the full range of the patient's life with its major and minor themes (6, pp. 206 & 209), as is often seen in the existential approach (22).

Textbook definitions of schizophrenia are often lifeless, and obscure the rich variety of types frequently seen. Moreover, they do not often suggest meaningful therapy in the sense of how to talk to the deluded patient.

On the other hand, one may conceptualize schizophrenia as too closely allied to normalcy. There is general agreement that schizo-

phrenia varies from normalcy in degree rather than kind (37). But, though this be true psychodynamically, a model too close to the therapist's particular view of normalcy may not be useful. Thus, a patient refusing to work may be seen simply as exaggeratedly lazy; or the unkempt, as merely especially dirty. Since most therapists come from the middle class they may tend to view the schizophrenic through the eyes of middle-class bias (18).

The therapist must develop a model, it seems which does not reduce the patient to a series of fragmented mechanisms or dynamics on the one side, nor produce undue expectations of normal response on the other. As Adler says, "It is the greatest mistake to expect an insane person to act as a normal person" (1, p. 316). The model should also suggest a therapeutic approach which provides the broadest base for communication with the patient.

CONCLUDING STATEMENTS

This paper has dealt with talking with the deluded schizophrenic patient. Although not discussed here, it is recognized that non-verbal communication may be as important, if not more so, than verbal communication (33, 38). Its omission should thus not be construed as ignoring or underestimating its place.

Further, we contend that there is little point in trying to force patients to talk about their delusions if they do not choose to do so. Many schizophrenics are known to be deluded, because on specific occasions they make this perfectly clear; yet they may not so express themselves most of the time. It is reasonable to suppose that these patients will be moved to speak of their delusions less and less if they are treated normally and encouraged to engage in consensual speech. The fact that patients are deluded is not always crucial, as those advocating social recovery point out (12, 26). If the patient can ignore his delusions some times, the therapist is under obligation to encourage this. Talking with the patient about his delusions must serve some end for him and never be done to satisfy the therapist's need to play God.

Lastly, let it be said that the methodological approaches suggested in this paper are but suggestions. The therapist may, in fact, if he knows patients very well and has a sensible and practical model of schizophrenia in his mind, commit all the mistakes mentioned in this paper and more, without doing much if any harm to the patient. In the last analysis, it is feeling for the patient which really counts.

Technique is always subordinated to the human situation. Adler sums up my opinion in this regard.

Insanity is the highest degree of isolation; it represents a greater distance from fellow men than any other expression except, perhaps, suicide. But even insanity is not incurable if the interest in others can be aroused. It is an art to cure such cases, and a very difficult art. We must win the patient back to cooperation; and we can do it only by patience and the kindest and friendliest manner (1, p. 316).

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