

MAINTAINING CONTINUITY OF EXPERIENCE IN ORGANIC DEFICIT

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One of the significant themes in the understanding of the behavior of brain-damaged persons has been that a portion of this behavior is related to the patient's efforts to adapt to his condition. Goldstein was the first to suggest that the person with organic damage presents symptoms not only of limitation and disordered function, but reactions to what he called an impending "catastrophic condition," defined as the "subjective experience of being in danger of losing existence" (1). While this concept appears to capture a phenomenal aspect of the brain-damaged person's experience, the actual danger that he faces is not clear.

Mayman and Gardner (3) developed an additional explanatory step in terms of signal anxiety aroused as an organically damaged person approaches difficulties in functioning. Such anxiety is assumed to arouse defensive maneuvers to avoid the development of catastrophic anxiety. These concepts are important considerations in comprehending some facets of the behavior of brain-damaged persons, notably: constriction of the world with which they have to deal, systematizing efforts that aid in simplifying their world, and a dominant concrete orientation.

According to Hebb (2) the complex processes most affected in brain damage are: organization, coordination of subprocesses, guidance and unification of mental functioning, which permit the organism to behave as an integral personality spanning time. The danger the patient faces is that of confusion and loss of continuity. The organized pattern of mental functioning, the basis for a sense of control over one's experience and for an experience of identity or self, are threatened. The concept of loss of continuity of experience appears to capture that aspect of events to which the person is most directly reactive.

A portion of what the organic patient manifests in his behavior can be interpreted as his efforts to maintain continuity of experience via channels that remain available to him. The theoretical premise is offered that concretistic or more peripheral patterns of functioning

to be described, provide such alternative bases. Such functioning is resorted to because (a) the organic patient is indeed limited as higher coordinating processes fail to function, (b) efforts beyond concreteness raise dangers of discontinuity, and (c) concreteness permits him to remain close to peripheral physical events as means of maintaining continuity.

Where the danger of inner discontinuity becomes imminent, the organically impaired individual invokes defensive measures that are observed as organic symptoms but consist of mechanisms that serve to maintain continuity of experience.

The reader may be puzzled by the almost synonymous usage here of concreteness, and sensory events or peripheral experience. Many organic patients evidence concreteness in the sense of utilizing conceptions that focus on past experiential learning rather than immediate sensory events. A test response such as this to the Wechsler Similarities Test, "A bicycle you pedal; a wagon you hook a team of mules to it," shows concreteness when the patient tells what is done with each item instead of describing the similarity between them, but the response hardly appears to be charged with immediate peripheral experience. The clarification of this point comes by way of perceiving a continuum from focus on sensory events as the extreme in concreteness, to a middle ground of past experience orientation, to a level of inner, reflective integration as the abstractive end of the continuum. This middle ground has been the subject of a paper by Scheerer in which the concept of "spheres of meaning" is presented. This notion appears closely related to Hebb's (2) and Piaget's (4) ideas of early concepts developing via action contexts, although Scheerer presumes even prior schematic configurations that are given inherently. Scheerer points out: "Spheres of meaning differ from actual concept formation. They do not stem from deliberate reflective ordering and abstraction. They are anchored in and derived from situational experiences. They are intermediate cognitive stages between schematic and logical groupings through concepts . . . the sphere can be transformed into a concept only when it becomes the object of abstractive thinking" (5, p. 56).

The sphere of meaning as an "intermediate cognitive stage" becomes a crucial construct to help understand how the organic person can operate in the limited manner that he demonstrates, yet not be entirely a creature of sensory input, or on the other hand, not lose his bearings entirely. This is an intermediate stage that utilizes what

may be conceived of colloquially as "well worn pathways" and in another sense as not requiring the "deliberate reflective ordering and abstraction" which is so difficult, and so dangerous, for the organically damaged individual.

This theoretical analysis suggests that the organic individual has some capacities that may be used in a compensatory manner to avoid dangers of discontinuity in experience. The shift to peripheral rather than central functions, and to associational pathways that avoid abstract, central complex functions, are toward mechanisms that would appear amenable to adaptation by the impaired person. The development of these mechanisms appears to be a learning and adjustive process since one frequently observes that individuals with recent damage typically manifest symptoms akin to Goldstein's "catastrophic reaction" with heightened anxiety and severe efforts at constriction. However, individuals with damage dating over a longer period of time evidence rather more stable functioning. The following adaptive patterns serve as illustrations of these mechanisms.

PREOCCUPATION WITH PHYSICAL SYMPTOMS

One illustration of the manner in which an organically damaged person may attempt to cope with threatened discontinuity of experience is through preoccupation with physical symptoms. The physical symptoms in such cases are characterized by marked physical discomfort, that is, the feeling aspects are most predominant. The patient appears chronically concerned with the distracting sensations of his symptom, and the symptom is often one that is difficult to isolate and treat. Attention to the symptom usually fluctuates. When attention is diverted elsewhere, as toward test material, there is little apparent concern with the symptom. When attention is not diverted, the valance of the symptom is enhanced.

This pattern is comprehensible within the framework described here since physical complaints focus on the most concrete of experiences—bodily feelings. Body sensations, especially if sharp, localized, and continuous are capable of providing the easiest of all avenues of continuity of experience. In normal persons, continuity of experience may be accomplished through various internal as well as external foci—ongoing thought, awareness of shifting patterns of stimulation and reflection. We suspect that in some damaged persons, the burden of keeping the stream of continuity flowing and the concomitant danger of gaps and lapses, provide the impetus for focusing on some

stable anchoring point such as localized pain. This pain, in turn, must be invested with concrete, meaningful associations so that the symptom provides a constant wellspring capable of being a continual focus of attention.

OPERATING AT A "GALLOP"

Another pattern which demonstrates the effort of the organic patient to fill gaps in his experience and maintain some experiential continuity may be described as operating at a "gallop." Such patients produce a stream or chain of responses so that literally there are no gaps. The rapid-fire sequence may appear as a tumbling of concrete associations so that something is always being produced. A 38-year old male epileptic produced this answer to the Wechsler question, "What is a thermometer?"

Action with the sky temperature equalizing; underneath part to make it raise, with humidity to carry temperature; two equalizing temperatures; collect from warm; either from damp day temperature; either is high elevation above sea level would be the dry climate to where it would have dry frost to winds. In sort of lighter oxygen air, so it would go ahead and wouldn't be so hard on people; for the difference of the heavy frost to keep from killing plants or animals, all during the winter that-a-way

Once this stream was touched off by the initial question the patient associated in chain-like fashion, never able to grasp the totality, and only able to focus microscopically on one small direct phenomenon at a time. Continuity is apparently so endangered that the patient cannot cease producing or he will face a void in experience. While this case presents an extreme, we frequently observe organic patients who respond rapidly, and quickly complete their answers to questions as if hesitation will result in losing the thread of what they are doing.

SELF-DIRECTED FEEDBACK SYSTEM

While the chain-like pattern described above often appears to carry itself on with little directional quality, a variation occurs which may be called a self-directed feedback system. The impaired individual overtly tries out ideas or responses and then reacts to his own overt expressions with correction or elaboration. What apparently occurs here is that inner processes that would normally carry out the covert functions of screening, checking, and correction cannot proceed at such length. Immediate associations or reactions are expressed, and at this point the individual can proceed to react to his own sensory-motor products. What has been an internal process can

now be pursued, haphazardly perhaps, through external, concrete operations. As an illustration, one patient responded, "South Carolina" to the question, "Where is Brazil?" On hearing himself give this answer there was an immediate correction to "South America."

LEAPING TO RESPONSES

Still another form of bridging threatened gaps in continuity can be observed in some few instances where the patient demonstrates a rather reckless leaping to responses or solutions. He seems to grasp or seize upon some idea or concept not by a reflective or worked-through ideational process but, even in complex situations, by what looks like a wild guess or leap to a possible avenue of appropriate reaction. Strangely, the patient comes close to or hits the mark, or at least surprisingly shows some conceptual capacity of a relevant nature, although at other times there is more obviously "wild" guessing when a response appears grossly inappropriate. Such "leaping across the gap" to immediate associations can be interpreted as a by-passing or short-circuiting of more complex perceptual, cognitive, and evaluative processes.

Since such processes are weakened in the organic person and so are vulnerable to disruption, the immediate association pattern is likely to be safer. The analogy would be of a person who feels the ground giving way and leaps or clutches whatever is at hand. The "whatever is at hand" is most likely to be an element available via uncomplicated, direct association, primarily from previous experience, and this may often roughly approximate an appropriate reaction. This would illustrate the concept introduced by Scheerer, cited above, of spheres of meaning. In less impaired thinking, intermediary associations along spheres-of-meaning channels are subject to further ego processes that scrutinize, check, covertly anticipate the appropriateness of such a response, and modify the developing response before every expression.

"GARDEN VARIETY" SYMPTOMS

There is a grouping of central or diffuse organic symptoms that might be called garden-variety symptoms. These occur in various combinations and accompany a range of severity of organic conditions. Frequently it is through these symptoms, observed through psychological tests, that the organicity is initially or even exclusively detected. Neurological examination may fail to yield positive findings

and there may or may not be some apparent historical event that could be causally related. Among these symptoms would be a noticeable clinging to sensory data, restriction in the range of stimuli that are included in appraisal, constricted associational reactivity to input data, responsiveness along concretistic lines, and rigidity in mode of operating.

These characteristics describe the variety of functioning that Mayman and Gardner (3) term the organic patient's "accommodation of the span of attention to some more manageable range." The "more manageable range" is a descriptive term for what can be seen as functioning to (a) avoid anxiety associated with impending "catastrophic reaction," (b) retain a sense of adequacy, and (c) avoid the possibility of disruption of the experience of continuity. These possibilities are not mutually exclusive but are supplementary theoretical constructs explaining the individual's behavior at different levels.

DISCUSSION

Even though some adaptation can occur, a product of organically impaired functioning is that the person so afflicted is much more a creature of reaction than one of initiative. The normal maintenance of inner continuity via central ego functions is crucial for providing an inner experience of self. Thus, in the unimpaired individual inner continuity of mental life gives direction and consistency to his interactions with environmental stimuli. The organically damaged individual, like the young child, is relatively "stimulus bound." His responses are much more geared to sensory events than to ongoing inner experiences. In varying degrees he has lost a crucial element of his human quality, that of reacting in the context of his ongoing wishes, goals, and strivings. These may be called forth in various situations but more in terms of reactivation than in terms of pre-existence and guiding of continuity. In this context the organic patient frequently has the feeling of change or loss that colors his emotional outlook.

The brain-damaged person's ability to assess himself is impaired precisely because self-assessment is a relatively abstract function. It involves the ability to gain an overview, make comparisons over time, and check out various possibilities. Also, the organically impaired person's difficulty is in lack or limitation of function—precisely of the intangible, non-concrete form of impairment which results in a void involving the absence of specific identifying eventfulness that

makes the impairment so difficult for him to conceptualize. He is left with only transitory experiences of something not quite as it had once been experienced. To expect an overall appreciation of what the malfunction consists of is to expect him to use just those capacities that are impaired.

SUMMARY

Although brain damage symptoms derive from a complex of the pre-existing intellectual and personality structure as well as specific kind and location of damage, the fact of damage is seen as producing general difficulties which endanger a crucial aspect of personality, that of continuity of experience. The damaged individual reacts to this danger in many ways that can be specified and understood as mechanisms of coping with threatened loss of continuity. A number of symptom patterns that function in this adaptive manner illustrate the concept.

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