HYPOTHERMIA & ZN TREATMENT OF SCHIZOPHRENIA

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Central Islip State Hospital
Central Islip, N. Y.

REFERENCES


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Since autopsychic driving is more easily carried out, this import has been based upon that type, with implants set up by means of periods of 10 to 30 minutes' driving—repeated, if necessary, once a week.

Preferably, the communication should deal with one topic only and should not be longer than about 20 seconds. In practice, the material is derived from a psychotherapeutic hour which has been recorded on magnetic tape. It has been found useful to transform these communications to 14-inch records and to reproduce them through a high fidelity phonograph adjusted for continuous playing.

The communication should be derived from a community or action tendencies which are of basic significance to the patient. Moreover, it is most effective if taken from the time of origin of this communication. It may, for instance, be selected as expressive of one of the great formative relationships of the earlier part of the patient's life, as in the following communication, in which the patient is reliving her early relationships with her mother:

"Everything about me was wrong—the way I acted, the way I spoke, the way I dressed... everything I did. Many times she [the patient's mother] would just talk and talk and talk, and... well, I can't go thinking up these things."

Or it may be drawn from a long-continuing climate of rejection, insecurity, or hostility which prevailed during a critical early period in the patient's personality growth:

"Now that I think about it, seems to inc that my parents lin'I me just to even up the family... not because they wanted mi'... because of course their attitude towards me... Gee, I doift remember the boys getting as much hell as I did... or my sister."

The significance of the cue communication must be assessed not only in terms of the therapist's conception, but also in terms of the patient's response. Time two do not necessarily coincide. The second is time more realistic guide.

Time following is an example of the patient's immediate response to the implanting of a cue communication. For time purposes in presentation, a response at the upper level of intensity has been selected. The case is that of a woman suffering from hysterical anxiety and hysteria with many conversion symptoms. The cue communication ran as follows:

"I stayed home all the time when my mother lived. I stayed with her... didn't want to leave her. I was always left staying home and... I didn't have any life like all... the other girls."

On the first implanting on January 4, 1955, the patient, who had come in that day and rather gaily said that she had nothing on her mind and nothing to talk about, was silent. At the end of four minutes she said, "It makes me nervous, you'd better stop it... it makes me feel bad." She was now restless and anxious and very different from the gay person she had been when she came at the beginning of the hour. At eight minutes: "Doctor, doctor. I've had enough, please stop it." Holds head. Nine minutes: "That's enough. It makes me nervous to hear that." Ten minutes: "Why don't you stop it, doctor. I've heard enough. It is always the same."

At the end of 10 minutes, the patient was asked: "What did you think about it?" Answer: "It made me nervous all over again. Everything hurt me all over as it did before. My voice sounds like I am going to die." She then went on to bring out a great deal of new material, saying: "My mother almost might not have had me, I was so quiet as a child." And again: "After my mother died, my father gave up his music and began to drink. I tried to take her place for him. I wanted so badly to please him and I cried every night and I tried to carry on. I tried to carry on. I was always left staying home and... I didn't have any friends by the time my mother died."

If the cue communication evokes too great a response from the patient, it will, in a measure, defeat its own purpose, since defenses will be erected which may take a considerable time to reduce.

The writer would like to state here clearly an answer to a question which he is sure will arise in everybody's mind. In two years of exploration into this new field, covering more than 100 cases, in only one has there been seen a possible persisting trauma resulting from the implant; and even here, current events—such as the breakdown of a love affair and threatened deportation—have corrected the situation. Hysteria, with many conversion tendencies, is not a disease which can be cured by a single injection, but rather by a series of injections given at frequent intervals.
A second procedure is to produce a filtered record: that is, a recording made of the cue communication with the therapist and, since this recording is a filtered record, it may be heard as a filtered record by the patient. The patient's response is at once different. She commented that she felt extremely tired after listening to it, that the voice sounded as though it were inside her head; and she said: "It brought back a lot of memories of my childhood days." A few weeks later, when it was used again, the patient said: "When I listen to that voice now, I feel like screaming and putting on a tantrum. The voice seems to scream at me all the time. It is like the voice of a stranger. I know it is my own. It seems to say, 'I was afraid of being scolded.' It says it over and over again. It makes me think that even with my husband and my father and my father-in-law I have to hide things from them. I always felt as if I would be scolded. It means I must be afraid of being scolded."

Experience shows that the implant can most readily be set up if the driving is carried out during the last 10 minutes of the psychotherapeutic period, the reason for this apparently being that best results are obtained if nothing is done to interrupt the ongoing response of the patient to the fresh implant—as would be the case if one continued therapy afterward. It is sometimes useful, however, to spend some five minutes asking the patient what fresh recollections the implant has brought up. This immediately widens the area of the patient's response and probably tends to stabilize the implant.

A question which must be met at this juncture is: Why is it that statements which the patient has already made, have formulated in their own minds, and have listened to themselves uttering, should be so potentially disturbing when replayed to them—far more so than when they first made them, never more than a week or two before? This question has been explored in some detail and reported earlier. Discussion will be limited to three brief statements: 1. The work involved in listening is far less than the work involved in speaking; hence the patient, when listening, is much freer to respond to what he hears. 2. The law of the summation of subliminal stimuli operates, therefore, to reinforce the patient's original response. 3. The patient is driven to re-experience the entire situation which gave rise to the original response by the implant itself.
seems to be operative: The longer one listens to a statement, the more response it evokes. In all of us, a defense is ... and tissue-conducted sound. The recorder, making use as it does of air-conducted sound only, evades this defense.

A. Findings Relative to Process of Setting Up of Implant

Several factors governing the establishment of an implant have been identified:

1. Intensity of Response. The intensity of the response of the individual to the driving period tends to increase the ... are: the patient's defense, his stress tolerance, and his capacity for desensitization. These will be discussed later.

2. Amount and Repetition of Driving. Repetition of the driving of the cue communication on subsequent days will reinforce the dynamic aspects of the implant. Less clear is what the optimum amount should be, either of the driving on any given day or the repetition of the driving. The repetition of the driving thus far has been limited to a maximum of once a week and a minimum of about once a month.

3. Defenses. The defenses against the setting up of an implant are essentially the defenses against psychic driving. There are: a) the patient's denial of responsibility for the situation; b) the suppression of emotional reaction to the material; c) the denial of, or, when the patient states, "I listen to it as though it were a trance," d) misinterpretation; this is much less frequent, but on occasion patients succeed in completely reversing the sense of a statement, even when repeated 30 or 40 times, by changing it from an affirmative to a negation.

Methods of penetrating the defense which have been most successful are: 1) continued repetition; 2) the use of the earphones; and 3) the use of the filtered record, as indicated earlier in this paper. This last procedure, by its continuous shift in pitch, in volume, in spacing, and by other devices, penetrates the patient's defenses by repeated evoking of what Pavlov has termed in the animal the "orientation reflex." Other methods, such as psychic driving carried out during mild sodium amytal narcosis or during continuous sleep or during the induction phase of nitrous oxide, have not been nearly so successful. In practice, the penetration of defenses has not been found to be a serious problem.

4. Stress Tolerance. Knowledge concerning this is rather limited; but it would appear, from preliminary observations, that patients vary considerably in their ability to hear stress. Those who can tolerate stress well, in general show less tendency to react to psychic driving. Those who can not tolerate stress are more prone to develop defenses. These will be discussed later.

5. Capacity for Desensitization. Concerning this phenomenon, there is still less information. From experience in other fields, it would appear that here, again, patients vary considerably in their ability to desensitize themselves; and those who cannot desensitize readily will show a persistence of the implant.

B. Findings Relative to the Effects of the Dynamic Implant

1. Mobilization of Action Tendencies and Progressive Problem Identification. The dynamic implant, especially when reinforced by repeated driving, tends to mobilize more and more of the components of the community of action tendencies from which it was taken. These components tend to appear in the patient's awareness. This fact, in turn, facilitates problem identification by the patient.
one communication are, can without exception, set up in the patient and the therapist, this progress may be assessed in the following ways: the extent to which the patient feels that the therapy has helped him. The first two methods of assessment are obvious and scientifically satisfying. Illustrative of the progressive problem identification brought about by the dynamic implant, is the case of a girl who had feelings of inadequacy, marked dependency and a highly ambivalent attitude toward the male figure. The cue statement was:

"...and there's... ulm... there's still that tendency to idolize or despise... that tendency still exists... I hate you..."

She gave up, she said, the whole idea of a "king": she had now fallen in love with a man of her own age. Asked how this came about,

- I can't get a 'king,' I would give myself a chance to like John.
- I don't put PeiJl'l' on a pedestal like I used to; I don't feel the same way I used to about the boss. I used to have a bitter grudge against my father for my troubles: now I see him as a weak person I don't admire."

2. Durability of Implant. The writer's experience has shown that the implant, if not reinforced, declines in its activity fairly rapidly after two weeks: although, on occasion, it can be found operative as long as two or three months after the first implant. As indicated earlier in this paper, the intensity of the implant can actually be progressively increased by a suitable reinforcement at rates of once a week to once a month.

3. Shifting Attitudes Toward Communication. The writer has frequently encountered the interesting phenomenon of the according of negative values to the pattern of behavior represented in the cue communication: "I hate my whining voice"; or: "I don't have to please people all the time; I'm not like that any more." This imparting of negative values is particularly likely to occur either after repeated implanting or with the progress of psychotherapy in general. A working premise concerning it is that, since the patient comes more clearly to identify the neurotic components in the cue communication and to organize the neurotic defenses in the cue communication, he learns to resist the neurotic tendencies with a growing gradation of more effective defense mechanisms. Therefore the patient comes more clearly to identify the neurotic components with the same gradation. The writer has frequently encountered this phenomenon in his clinical work and has found it to be of particular importance in the case of a girl who had feelings of inadequacy, marked dependency and a highly ambivalent attitude toward the male figure. The cue statement was:

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And these beliefs, I should add, are held with an enthusiasm that is strongly associated with the implant.

4. Mobilization of Action Tendencies. An interesting question which arises is whether an implant can mobilize action tendencies laid down before the event embodied in the implant. Experience indicates that, while this does occur, it is much less usual than the mobilization of action tendencies laid down subsequent to the implant and derived from the basic situation outlined in the cue communication used in implanting.

I will now turn to some of the results that have been obtained in my work with patients. The first two methods of assessment are obvious and scientifically satisfying. Illustrative of the progressive problem identification brought about by the dynamic implant, is the case of a girl who had feelings of inadequacy, marked dependency and a highly ambivalent attitude toward the male figure. The cue statement was:

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FETISHISM: A REVIEW AND A CASE STUDY

Fetishism is a phenomenon that involves a non-erotic, non-functional attachment to an object or part of the body. This attachment often serves as a substitute for the primary object of desire. The term "fetish" originally referred to a worshiping, adoring, or loving something that serves as a substitute for the original object.

The psychoanalytic approach to fetishism, as developed by Sigmund Freud, views the phenomenon as a defense mechanism. Fetishism is considered a reaction formation, in which an individual's repressed homosexual or masochistic impulses are displaced onto an object. This displacement allows the individual to avoid confronting their own psychological conflicts.

The term "fetish" was coined by the French anthropologist Charles de Brosses in 1760, who described the worship of fetish gods. Fetishism may be defined as the "worshipping, adoring, or loving something that serves as a substitute for the original object." In normal sexual life, there usually exists a mute or less pronounced preference for a particular portion of the body of the opposite sex. For the fetishist,

The major continuing effects of the dynamic implant are:
1. A progressive problem identification
2. Resulting reorganization of behavior patterns
3. Negative evaluation of the neurotic patterns present in the cue communication used in driving.

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