*Psychosynthesis Research Foundation*

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April 1, 1969

Dear Colleague:

The last meeting of the 1968/69 series of Psychosynthesis Seminars (held on the third Friday of each month) will take place on Friday, April 18th at 7:30 P.M.

Our speaker will be Dr. El Meligi, N.J. Bureau of Research in Neurology and Psychiatry; his subject: "Experientially Oriented Psychotherapy and its Relation to Psychosynthesis." Following his talk will be the usual group discussion.

We trust it will be possible for you to be with us.

Cordially,

JACK COOPER, M.D.

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| Date & Time of Meeting: | Friday, April 18, 1969 - 7:30 P.M. prompt |
| Place: | "Directors Room", mezzanine floor, Park Sheraton Hotel, 7th Ave. & 55th St., N.Y.C. (There is a public car park across the street from the hotel.) |
| Speaker: | A. Moneim El Meligi, Ph.D. |
| Subject: | "Experientially Oriented Psychotherapy and its Relation to Psychosynthesis." |

PSYCHOSYNTHESIS SEMINARS

1968-69 SERIES

Seventh Meeting: April 18, 1969

Speaker: A. Moneim El-Meligi, Ph.D.
N.J. Bureau of Research in Neurology and Psychiatry
Box 1000
Princeton, N.J. 08540

Subject: Experientially Oriented Psychotherapy and its Relation to Psychosynthesis.

Participants:

Martha Crampton, M.A.
Jack Cooper, M.D.
Rena Cooper
Emily Costa, M.D.
A. Moneim El-Meligi, Ph.D.
Frank Haronian, Ph.D.
Frank Hilton
Hilda Hilton
Norman Klein
Emanuel D. Kotsos, M.D.
John Parks, M.D.
Rev. Ted Smith
William Wolf, M.D.
Shirley Winston, M.A.

Psychosynthesis Research Foundation
Room 314
527 Lexington Avenue
New York, N.Y. 10017

Dr. Cooper: Our speaker tonight is Dr. Moneim El-Meligi of the N.J. Bureau of Research in Neurology and Psychiatry. His subject is "Experientially Oriented Psychotherapy in Relation to Psychosynthesis." Dr. Haronian,would you care to add something about him?

Dr. Haronian: Well, a couple of years ago I was very much interested in knowing what a fully individuated personality would look like at first glance, so I spoke to a Jungian specialist, and he said, "Oh, if you want to know, look at Moneim El-Meligi!"

Dr. A. Moneim El-Meligi has a B.A., M.A. and Diploma of Education from Egyptian Universities. He won his Doctorate in Psychology at the Institute of Psychiatry of London University and received post-graduate clinical training at the Tavistock Institute of Human Relations in London.

After nine years of teaching in Egyptian universities, he came to the U.S.A. as Visiting Professor of Psychology at New York State University. For four years he was Associate Director of Psychology at the New Jersey Neuropsychiatric Institute, Princeton, New Jersey.

He is a Fellow of the International Council of Psychologists and is affiliated with various other scientific organizations in the U.S.A. and elsewhere. He is the author of several books in Arabic and various papers in English.

Dr. El-Meligi: I would like to start with a brief account of my interest in psychosynthesis. I heard about it for the first time about three years ago from Dr. Cooper. I read parts of Assagioli's book and whatever literature I received from your Foundation. I claim no deep knowledge of the foundations of psychosynthesis, nor do I claim any experience with its practices. In spite of my minimal knowledge of psychosynthesis, I was fascinated by its principles. I was confident that its model of man as an experiencing creature is a necessary reaction to the mechanistic models that unfortunately pervade contemporary psychology. Right from the start I felt that its general orientation is conducive to the production of effective psychotherapeutic techniques. It is a coincidence that at the time psychosynthesis was brought to my attention I had embarked on the difficult task of developing the "Experiential World Inventory" together with Humphry Osmond. This task took almost all my time and I was not ready to get involved in psychosynthesis. Therefore,I deliberately resisted my fascination by psychosynthesis until I began recently to realize that the applications of our diagnostic techniques have much relevance to psychosynthesis. Indeed, many of our findings might constitute empirical validation of many assumptions of Assagioli and his followers.

The purpose of this lecture tonight is to explain what our technique amounts to and to point out its implications for psychosynthesis. Let me remind you that the "Experiential World Inventory," better known as the EWI, was intended to be a psychometric instrument to quantify the degree of pathology as reflected in the immediate experiences of psychiatric patients. It focusses on patients' perception of the world about them, of their own bodies, of themselves, and of other people.

The test rationale derives from a phenomenological approach to psychopathology. It recognizes the crucial role of perceptual disturbances in mental illness, especially in schizophrenia. It relates disturbances in thinking, affect, and will (or volition) to changes in spatiality, personal time, lived-movement, body image and I-Word Relations.

The Inventory consists of 400 statements compiled from the accounts given by patients of their own immediate experiences. It consists of eight scales:

The first scale is called Sensory Perception. It covers a wide range of sensory anomalies and alterations: increase or decrease in sensory acuity; changes in appearance of objects; distortions of perspective such as loss of depth perception or such as increased or decreased distances between objects; loss of perceptual constancy; disorientation in space; synesthesia and sensory over-loading. This scale provides an index of perceptual disorganization and reflects the precariousness of one's position in the world.

The second scale, Time Perception, deals with the psychopathology of subjective time, by far the most neglected area in both psychiatric evaluation and psychodiagnostic testing. The experiences covered by this scale include:

1. Changes in the experience of time flow.
2. Experiences of discontinuity in time, e.g., dissociation.
3. Indications of unrealistic engagement in past, present, and future.
4. Failure to relate to one's own age group.

Here are some typical items: "Time has stopped for me." "I am constantly in a hurry for no particular reason." "Time seems to stop altogether; everything is suspended and dead quiet." "Time seems to slow down at night." "I hate free time."

These items, as you probably have guessed, indicate changes in the subjective experience of the flow of time. Some of the items indicate painful experience of dissonance between one's subjective time and objective (or social) time.

Another category deals with the experience of temporal discontinuity ranging from inattentiveness to change to dissociation and from "suffocating boredom" to sudden realization that the seasons have changed. Two examples: "If it were not for cold and snow, I would not realize that it is winter time." "I hardly pay attention to the sequence of day and night."

A third category taps one's differential engagement in the past, the present, and the future. In other words, it detects the degree to which the three categories of time dominate one's life. It also enquires into one's attitudes towards different epochs of one's life, how pleasant or unpleasant is one's perceived past, to what extent is the present a source of dissatisfaction or satisfaction, and how attractive or threatening is the future. Examples: "I wish I had lived in ancient times." "I don't brood over the past." "I do not belong to this century." "It is too late to try to be somebody." "I am afraid of the future."

The third scale is called Body Perception. Essentially, it deals with body image distortions and negative feelings about one's own body. In many ways, distorted body imagery is related to distorted perception of space and to distorted time perception, as I will try to show you if we have time.

The fourth scale is called Self Perception. It deals essentially with problems of personal identity. These experiences include such disturbances as fragmentation of one's personality, dissociation, identity-diffusion, weakening of

ego boundaries, loss of autonomy, depersonalization, self-doubts, self-hatred, etc. The relation of this scale to depression is quite close. It is useful in predicting suicide. It provides the red light or alarm in suicidal patients. Many depressed schizophrenics experience intense hatred of themselves and this is usually reflected in their responses to this scale. A schizophrenic patient seems capable of hating himself as if he were somebody else. He is therefore capable of hurting himself as if he were inflicting pain upon somebody else. Hatred and self-destruction in these patients may be experienced as directed against somebody else. This is a function of the fragmentation or disintegration of the ego.

The fifth scale is Perception of Others. Using this scale, we were able to unravel a wide range of unusual ways of perceiving people ranging from the perception of people as objects moving in space, as inanimate objects, like robots, to distortions in the physical qualities of people, as when people appear like two-dimensional pictures projected upon a screen. When people appear two-dimensional, they look grotesque, especially when they move. Their movements are bound to acquire a jerky and, consequently, weird quality. We found that many of the fears experienced by schizophrenic patients are caused by distorted perceptions of people of the kind that I have mentioned. Hostility expressed against a therapist can often be explained in terms of perceptual distortions instead of (as many therapists think) in terms of transference or other dynamics.

Interesting relationships were discovered between various experiences. For example, hyperesthesia, that is, heightened sensitivity, was found to be related to vulnerability of ego boundaries, the experience of time coming to a standstill was found to be related to the experience of being dead or inanimate; and the perception of people as two-dimensional facilitates the commission of violent acts against them.

The sixth scale is Ideation. It unravels the patient's experience of his thoughts, the speed or intensity of his associations, the intrusion of bizarre ideas or unpleasant images, the tendency to philosophize or intellectualize, etc...

The seventh scale, Dysphoria, measures the degree of depression.

The eighth scale, Impulse Regulation, focusses on the psychopathology of will. It reflects the patient's problems of volition. This scale has some relevance to psychosynthesis. It revives the concept of will and brings it into the heart of psychopathology. I prefer to call it Impulse Regulation rather than Impulse Control in order to emphasize the fact that even the most seriously disturbed patient is engaged in an attempt to maintain autonomy, to be in command, to preserve his will. In psychopathology, it is very important to find out how certain the patient is about willing his own actions, how secure he feels about being in command of his capacities. It is important to find out if he still experiences himself as capable of synthesizing the stimuli impinging upon his organism from the outside world and from within his body.

We have found that psychopaths and catatonic schizophrenics occupy the two extremes of this scale. The former score very low; the latter score very high. Low scores indicate increased regulation and high scores indicate decreased regulation. All our scales are scored in the pathological direction. In other words, psychopaths (who by definition act out their impulses) do not <u>experience</u> loss of control. Their loss of control, as it appears to us, is not experienced as such by them. Rather, psychopaths experience their actions as acts of will. Catatonics on

the other hand experience a serious loss of will. Events occuring outside or in their bodies happen in spite of their conscious intentions. They experience loss of will much more intensely than any other type of patient. Our findings indicate that impulsive patients who tend to annoy others by their activities are often misclassified by psychiatrists as psychopaths. The insights we gain from our inventory help us to avoid such errors in classification simply because we rely on the patients' experiences rather than their overt behavior. Many so-called psychopaths turned out to experience distortions of perception that justify a diagnosis of schizophrenia in spite of their delinquent behavior. Often violent behavior against people is caused by distorted perception of people. Unless we place a given person's behavior in the context of his experiential world, we will not find out what his behavior means.

Once we completed the standardization of the principal scales, we began to see that other important scales could be derived from the inventory. For instance we found that 24 items deal with the experience of euphoria and that, counter to expectation, its negative correlation with the Dysphoria scale is minimal. This means that a euphoric person need not necessarily score low on Dysphoria (or depression). We found sevèrely depressed patients who also experience euphoria or elation.

We began to consider the balance of scores on the Euphoria and Dysphoria scales. This proved crucial in the prediction of suicide. Apparently, patients who have extremely high scores on Dysphoria do not commit suicide if their scores on Euphoria are not too low. While these patients feel very depressed, they are still capable of utilizing their euphoric resources, as it were. They have not yet lost their potential for happiness. The severity of their depression does not prevent them from deriving pleasure from being with people. Depressed as they are, they still are capable of projecting themselves into the future or they can fall back on the happy memories of the past.

(Wolf: When you referred to "successful suicides" were you referring only to those who actually killed themselves or also to attempted suicides? Also, what about the kinds of suicide, that is, the ways that they committed suicide?) Both; I was referring to two categories: The category of patients who successfully committed suicide and for whom we have records including our test results, and the category of patients whom we tested after they had attempted suicide. So we have test results from both, and we are, therefore, in the position to compare the two categories.

From our clinical experience, it seems that severely depressed patients are typically unable to project themselves into an imagined future. Instead, they tend to be nostalgic, namely, past-oriented. But memories of past experiences, whether pleasant or unpleasant, enhance their depression. If the depressed patient happened to have pleasant experiences, his memory of them gives rise to painful feelings of loss. On the other hand, if they are unhappy, thinking about them generates feelings of the futility of life.

Happy memories of the past can foster happiness only if the person is future-oriented. The happy individual is likely to rejoice that the bad times have gone or to cherish the memory of the happy times that were. In brief, the reference to the present or to the future is the only guarantee against unhappiness as expressed in nostalgia or bereavement.

For this reason, freeing patients from the clutches of the past seems crucial in the treatment of depression. Psychoanalytical psychotherapies do the exact opposite. They force the patient into the dark corners of his past. They force him to relive his past conflicts. What is more serious, however, is that a linear conception of time is inherent in these therapies. Everything that is happening now or will happen in future has been somehow determined by one's reactions to situations during the first five years of one's life.

An inadequate model of man is inherent in the theory of infantile sexuality. To put it in the eloquent words of Gordon Allport (1960):

> "The trouble lies chiefly in the excessive emphasis upon infantile experience. We are asked to believe that an individual's character-structure is, in all essentials, determined by the time his last diaper is changed. Even Suttie, who postulates as the foundation of morality an original and embracing instinct of tenderness, affection and social symbiosis, believes its fate is sealed according to the manner in which the mother handles his affiliative impulse before and after weaning...." (p. 59)

In our technique, we start from the assumption that the future can alter our past as much as the past can influence the future. By this we mean, past events can acquire new meanings as a result of future orientation. How do we do that in practice? Frank Haronian can provide an answer from his experiences with Desoille's technique of directed daydreams. With our previous knowledge of Desoille's technique, I train depressed patients to visualize themselves in the future. Depressed patients find it very hard to do this. Anxious patients are too preoccupied with warding off immediate (present) threats to engage in such luxury. By practice however, patients do begin to stretch their future perspective. They keep sliding back and forth until finally they get used to projecting themselves far ahead. Definite amelioration of mood and outlook takes place. They begin to feel that the world is as spacious as the horizon. They lose the sensation of being "boxed in".

A depressed patient may be so dominated by rage because of past injustices (real or fancied) that he can only see the future as a repetition of the undesirable past. In this case the future has no potential for novelty; it is merely a fearful anticipation of a painful repetition of the past. This experience is far from being new, and newness is a prerequisite for a future-orientation if there is to be an unfolding of possibilities, and an actualization of potentials.

What do we do with an enraged, vengeful patient who holds on tenaciously to a painful past? We help him to recall, through visualization techniques, pleasant events in order to experience a nostalgia, a genuine sadness, a noble sadness from which tenderness is generated.

Those who use guided daydreams are inadvertently opening-up their patients' futures. By increasing the patient's spontaneity in producing images, we seem to free the patient from a compulsive boundedness to the harsh actualities of his life. Through imagery, the patient is helped to transcend both his past and present. However, we have to be careful in applying this technique to schizophrenic patients who are already flooded by imagery. I believe that the EWI can provide a service to those who would like to use Desoille's technique. The inventory can tell us which patient is flooded by imagery and for whom the technique is contraindicated.

So far, I have talked about the EWI as a diagnostic instrument. Before I discuss its therapeutic application, I would like first to answer this question: "What is distinctive about this inventory?" First, it focusses on patients' experiences rather than on their behavior. It allows the patient to convey to us his innermost experiences. Second, the 400 statements in the inventory all represent authentic experiences of patients. For this reason, it appears to me, the inventory captures the patient's attention and sustains his interest throughout. The wordings are clear, straightforward, and completely free of psychiatric jargon. Third, the EWI is not committed to current psychiatric nosology. We do not classify patients into diagnostic categories. More meaningful than this is the classification of patients on the basis of experiential parameters such as temporal orientation, spatiality, sensory over-loading versus sensory deprivation, depression due to perceptual change versus depression in spite of perceptual stability, etc.

Fourth, this is the only inventory that focusses on the patient's perceptual world. It adheres to the phenomenological premise that the patient's behavior can only be understood in the context of the patient's total experience. To understand behavior, we must find out the meaning that a given patient assigns to it. It is only with the help of the patient that we can gain access to his personal world.

Fifth, in administering the test, we make it clear to the patient that it is simply a means of communication, a bridge between his world and ours. We encourage discussion subsequent to the test. The patient is encouraged to elaborate on certain statements or to contribute experiences that are not included in the inventory. We promise him an account of the test findings and invite his comments. Thus, the patient is not treated as an <u>object</u> of study nor as a <u>subject</u> in an experiment, but rather as a <u>partner</u> in a common enterprise. Somehow, we get this message across to him, and it proves most effective.

That brings us to the part concerned with psychotherapy. Throughout psychotherapy, we are guided by the EWI findings. The EWI is administered repeatedly at significant stages, thus serving to monitor change and to decide which dysfunctions we should attack. Furthermore, the EWI findings serve as a stepping stone towards the perceived world of the patient.

It is important at this point to spell out what I mean by "perception." Perception is an active process of organizing reality. Following Strauss and other phenomenologists, I do not separate "sensing" from "perceiving." To sense or to perceive the world implies consciousness of the world. When I talk about a schizophrenic's disturbances of perception, I mean unfavorable changes in his consciousness of his world. Consciousness of things does not guarantee experiencing things as existing outside our consciousness. We can be conscious of our surroundings and yet they may be just dreams, memories, or hallucinations.

The belief that objects exist outside our consciousness of them presupposes, first, that they are situated beyond the boundaries of our bodies, second, that they exist in relation to other objects, and third, that they exist in relation to our own bodies. All this amounts to saying that perception of the world is but consciousness of being in the world. Counter to the belief of most people, this level of existence is not universal. Schizophrenics may lose the experience of the world as "<u>really existing out there</u>." Let me illustrate what I mean by an account provided by a 30 year old chronic schizophrenic woman:

"I try hard to see the third dimension but I do not succeed. People and objects look like TV pictures. Objects have no substance. There is a quality of hardness and glassiness to people's bodies. They move, but in a jerky manner like in old-fashioned movies. It is hard to hold shapes of things in your mind. Things and people are parts of a horrible vacuum. Things are not real. Lines that make the borders of things are disconnected. Objects are out there but unrelated to each other and unrelated to me....

"What is missing in things is the substance, the weight, the inner tension. Ordinarily you see things as if they were formed from within, but to me they are like shells. I get the feeling that they lost their weight and that they are shells without substance. Therefore everything is dead. There is only a horrible void."

In contrast, a 19 year old schizophrenic, paranoid type, tells me that objects around appear very real to him, and yet he experiences them as projections of his mind. Percepts, instead of being the result of a movement from the world to the mind, are the result of an inverse movement from the mind to the world. To this patient, objects occupy space, they have volume and weight, and they possess all the physical characteristics recognized by most people to exist in <u>real</u> objects.

Therefore, unlike the former patient, the latter experiences the world around him as substantial and real. In fact, he does not need to experience objects outside of himself to establish a sense of reality. Images can be projected at will into the outside space without delay or difficulty. Natural phenomena such as wind comes to his attention as concretely as material objects. He can perceive sudden changes in the speed and direction of the wind. This is usually accompanied by visual and auditory hallucinations. With the increase of the perceived speed of wind or the perceived change in its direction, objects emerge. They are seen to float in the air, crash, fall and even explode.

Both patients carry the same diagnosis, both experience hallucinations, and yet, how far apart their worlds are! In fact, the difference between their worlds is not less than the difference between the world of either and that of normal people. The world of the former is remote, elusive, unreal, and disconnected. Hence, the horrible experience of void. The world of the latter is vibrant, dynamic and interacting. Hence, the experience of involvement and fullness. The former patient feels deprived, if not dead. The latter feels stimulated and excited. The former feels helpless while the latter feels potent, though threatened. The former feels alienated while the latter feels in the midst of events. He even creates events. No wonder he reveals no signs of depressive mood; his score on the Euphoria scale is far above the mean of normal subjects.

It is interesting to note that in both cases, alterations in their phenomenal worlds gave rise to metaphysical thinking. Both patients were confronted with some of the basic philosophical problems that have confronted homo sapiens for millenia. Indeed, the latter patient realized the similarity between his world and Plato's cave. As you recall, Plato in his theory of ideas considers the material world a projection of the mind.

Neither of the two patients showed concern for gratification of instinctual needs. Rather than being concerned with immediate gratification of primitive impulses, they were engaged in cosmic issues. That brings us to Assagioli's concept of the "superconscious." Assagioli (1965) emphasized the importance and validity of

what he calls the superconscious, which encompasses such phenomena as aesthetic, ethical, and religious experiences; intuition, inspiration, and states of mystical consciousness. According to him these phenomena are "factual and real in the pragmatic sense...producing changes both in the inner and the outer world."

My experience with schizophrenic patients fully corroborates Assagioli's contention that the superconscious is a real experience. Schizophrenics are often much more concerned about spiritual achievement than about gratification of primitive needs. Nothing can be farther from the truth than the assumption that the schizophrenic regresses to an earlier phase of development. For example: The schizophrenic woman to whom I referred earlier, after years of disappointment with psychiatrists, found relief in religion. She found refuge in mystical writings and practices. You might recall that for her objects had lost substance and depth, and that the distance between her and objects had diminished. This caused things to appear dead and ugly. In order to restore beauty to the world she began to explore the writings of mystics such as Simone Weil. She wrote:

> "Tonight the empty senseless feeling is very bad. Like being an empty tin, and a kind of unattached guilt and anxiety, maybe for wasted time .... It is one of the few times I have felt worse instead of better after meditation, and this troubles me. Simone Weil says that when the mind ponders movement to and fro it imitates circling movement - which she associates with the heavens. I tried following a line back and forth first with the eyes, then in imagination, and this seemed to help a little, briefly, but I am not sure of what she meant.
>
> "One thing she wrote seems very important - I can only copy it, not yet say much, except that often in my illness I have thought of Tolkien's and Lewis's images of distance, deepness, signifying greater reality."

The patient ends her account by citing quotations from her favorite mystics, quotations that seem to bring tranquility to her agonized soul:

> "The role of beauty is to accomplish the union bridging the distance."
>
> "We have to remain quite still and unite ourselves with what we desire yet do not approach...."
>
> "We unite ourselves to God in this way: We cannot approach him."
>
> "Distance is the soul of beauty."
>
> "The knowledge of distances which are observed by things teaches us obedience, eradicates the arbitrary element in us, which is the cause of all error."

This patient, and indeed many others, convinced me of the relevance of the spiritual dimension to psychotherapy. Many patients have been driven to the very edge of a psychic cliff, a metaphoric chasm separates them from another ledge. All they need is a push to enable them to leap the chasm and land safely on the other cliff. The other cliff is the spiritual mode of existence. There lies the only salvation for many schizophrenic patients whose long illness has made it impossible for them to endure the complexities of conventional living. We need specific techniques to meet these patients' needs for spiritual growth.

Schizophrenia alters consciousness in various ways. In many patients, the alteration takes the form of acquiring utterly new modes of structuring reality, new visions and fresh insights into the human condition. Patients may recover from their illness and yet remain unable to join the crowd. Techniques geared towards adjustment are not suitable to such patients. Psychosynthesis seems more relevant and more effective. A great deal of work is needed to help patients live creatively and authentically.

In psychotherapy with schizophrenics, our primary task is to destroy the delusions by attacking their sources. We assume that many of these delusions derive from space-time distortions. We try to explain the connections between perceptual distortions and delusions to the patient. Once we have done that successfully, it becomes easy to eliminate the delusions even though the sensory or time anomalies may persist. In most of the cases we handled, by-passing personality dynamics proved to be a good policy.

My experience with the patients whose delusions derive directly from changes in perception leads me to believe that the source of the trouble lies more in the repression of the sensory and temporal antecedents of delusional formations than in the repression of psychosexual conflicts. Jaspers (1963) came close to this notion when he observed that "the fabric of the individual momentary experience is woven from a number of phenomena which we can separately discern by description. For instance, a hallucinatory experience is pervaded by delusional conviction; the perceptual elements gradually disappear, and in a given case we can often be no longer sure whether they ever existed or, if so, in what form." (pp. 59-60)

In order to show how in practice I deal with the sensory basis of paranoid delusions, I will read a portion of a psychotherapy session with a schizophrenic who used to have episodes of panic whenever he was flooded by environmental stimulation.

"Dr. But let's talk about your experience in the store, your immediate experience.

Pt. The only experience I had was in a book store where I was looking for a particular book and I couldn't organize myself to find it.

Dr. All right. You went there. Let's pretend that you are there, and tell me about your experience.

Pt. Well I'm there. (Pause) Dr. What do you see?

Pt. I see all the books, the people. I <u>feel</u> these people; they are <u>annoying</u> me; they are like a <u>threat</u> to me because I am not sure of where I am going.

Dr. Don't talk to me. Remember, you are there,I am not with you. Try to visualize the situation as it occurred then.

Pt. I am not sure of where I am going and I cannot focus on the books; I cannot control the feeling; I cannot focus on these books and it is like it begins to whirl; your perspective, you can't control it. I can't control the whirling in this place and so you keep struggling to control and you can't do it so all the time you are breaking out into perspiration and you are beginning to feel as though you are going to pass out, you see? This is fear, fear of passing out, so what you do is you....

Dr. Do you feel you are there?

Pt. Yes, I'm there. So what you do is you grab yourself and go. You get out. In other words, the desire for what you went there for now, you can't get what you went there for because you can't control yourself and you are aware that you are concerned that if you confront someone about what you want you don't know what to say because you are not organized; you are not in control, you see. All your reinforcements that you would normally have under psychological feelings don't come, they are not there. They are crowded out by this feeling of, oh, this upheaval.

Dr. You mentioned something about people, you said "you feel people."

Pt. Yes, you feel them. In other words they are like threats to you because you cannot organize.

Dr. How about books?

Pt. Well, the books become confused because you can't focus on them.

Dr. Well, what is the difference between the way you experience books and the way you experience people?

Pt. Well, people are moving around, and these movements, because you can't organize them, they constitute a threat. (Patient shrinks back in his seat.)

Dr. Now this movement you made just now, what does it mean?

Pt. It means that there is a threat coming in.

Dr. This "coming in" experience, where exactly do you feel it?

Pt. Well you feel them in your head, your senses in your head. (Pause.)

Dr. Do you feel that they are coming at you? Pt. Yes.

Dr. In what way? It is very difficult for me to put myself in this experience.

Pt. Well, it's just going to come into you and they come into you and they overpower you.

Dr. And the books <u>do</u> overpower you?

Pt. No, the books wouldn't overpower you, but you can't focus on one. And the only thing I can say to that is if you want that experience, just whirl around till you get dizzy.

Dr. I am interested in your gestures because they are also language.

Pt. Yes, I understand that. Dr. Point at the books.

Pt. The books. Now that I am in the store?

Dr. Yes, now you are in the store and I want you to show me where they are.

Pt. They would be like that. (Gesture indicating that they are far away.)

Dr. Now I want you to point at the people.

Pt. They would be like there. (Patient's body moves back a little and his finger points at a closer spot.)

Dr. Which is closer to you, the books or people?

Pt. The closest is the people.

Dr. There is less distance between you and the people. Pt. Yes that is right.

Dr. How about the distance between you and the books?

Pt. There is great distance.

Dr. People appear closer and objects further, people threaten you but objects don't. Any other differences?

Pt. I don't know.

Dr. You yourself told me that objects appear distinct whereas people appear swimming, moving.

Pt. That's right.

Dr. In your immediate experience at the store, the distance between you and people diminishes.
In view of this, I can very well understand your feeling that people become threatening.

Pt. Yes, that is right. This is exactly right and that is the feeling, but there also is the intellectual part that ... now we are talking about a spell, it's a spell. But now intellectually, I see these people just as entities in themselves like the books, you see. But at the time of this confrontation, you don't see it that way.

Dr. No, then what do you fear about people? Pt. I think they are threatening me.

Dr. "They are threatening me." OK what else?

Pt. They are threatening me, I am not able to handle it and I must move away from it.

Dr. But do they <u>really</u> threaten you? Pt. No, no, absolutely not.

Dr. You are <u>threatened</u> by them?

Pt. I <u>am</u> threatened by them. Intellectually I can say that I am not. But feeling-wise, we are talking feeling-wise.

Dr. Your feeling is very real. That is your real and most immediate feeling, but I am also interested in finding out when this experience which is very typical, very emotional, occurs, what do you say about people to yourself at the time?

Pt. At the time, I am liable to generalize and say "God-damn people! Get them the hell away from me!"

Dr. Immediately, your communication with them breaks down. Pt. Yes.

Dr. As a result of this immediate perceptual experience?

Pt. Yes. Now like last night when I had this feeling, I am taking my brother-in-law down from the station. He annoys me - at the time he annoys me. He just does nothing but he just annoys me.

Dr. Did he do nothing - but you felt something?

Pt. Yes, I felt some annoyance. This is another kind of threat.

Dr. Yes. Pt. Do you follow me?

Dr. Well I understand very much that all of a sudden the world around you is spinning, it becomes ambiguous and people appear as if they were swimming around you and the distances are diminishing, they are coming closer to you and you get extremely uncomfortable and frightened.

Pt. That's right; this is the invasion.

Dr. And the invaders are naturally experienced as threatening enemies rather than friendly creatures, so you withdraw.

Pt. Now we hit upon something here. The search is for the friendly person. You follow me?

Dr. OK. Your disturbance in communication is a result of the disturbance in your perception of people. Maybe you should change your perception of people.

Pt. Well, I try. Dr. Look at them.

Pt. I do this.

Dr. Now you don't feel that they are threatening?

Pt. No; intellectually I can see that they are not.

Dr. You know they are not threatening you, because you know the distance between you and them is under your control?

Pt. That's right.

Dr. If I come closer to you, you would just back up.

Pt. That's right. Dr. Or push me?

Pt. That's right.

Dr. If I violate your boundaries you can defend them.

Pt. Yes. You see, I now intellectually realize and for 80% of the time, feel that people are just other people.

Dr. Well, give this a thought: the relationship between changes in your experience of distance between you and other people ... because this has something to do with "invasion."

Pt. Yes, but I don't know why they are there.

Dr. Well, let us give it some thought later.

Pt. I just, for the life of me - that's what I said earlier - I don't know when they will be there. I have no preparation for them and the first thing you know, what will happen is that they come on me but I wouldn't want to be involved or committed to any procedure at the time of this. I must have the freedom of withdrawal.

Dr. Freedom? What does it mean in this context? That you control the distance?

Pt. Yes. Dr. You regulate it.

Pt. That's right.

Dr. If you have the confidence that you can regulate the distance, you will never experience people as invading you.

Pt. No, but what happens is you lose the confidence. For some unknown, unaware thing, you lose the confidence, at least 20% of the time."

This is the end of the dialogue.

While I do not claim to have cured completely any schizophrenic by discovering the sensory bases of their delusions, I can say with confidence that paranoid delusions can be dissolved if we demonstrate to the patient that the delusion is a faulty way of explaining his sensory and time peculiarities to himself. My earliest successful experience was with a paranoid schizophrenic with well-systematized delusions of persecution. I wish I had time to show how his delusions disappeared overnight subsequent to the discovery of the connections between his delusions and various sensory and temporal oddities. He continued to suffer from all sorts of perceptual distortions but he did not need paranoid explanations any more. He now has better explanations. Neither his wife nor his boss nor FBI nor the Communists any longer have anything to do with the changes occurring in his phenomenal world.

We have now reached the point at which we can relate a given delusion to specific changes in the perceived world. I hope to give you examples during the discussion.

Thank you for listening.

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DISCUSSION

Smith: I would like to know if you have found the same thing that you found in schizophrenics in people who had drug-induced experiences.

El-Meligi: At the beginning we could not differentiate on the basis of raw scores between drug-induced psychosis and shizophrenia. Recently, however, we have been able to make the differentiation on the basis of configurations of scores. In drug-induced psychosis, you find discrete distortions of both time and space, but usually, temporal distortions are more prominent. In schizophrenia, especially if it is chronic, disturbances cut across most personality functions. Perceptual and temporal disturbances may be less discrete. It seems that in schizophrenia, the length of the illness allows sufficient time for personality traits to be affected by sensory and temporal peculiarities.

Also, most of those who break down under the influence of hallucinogens score high on Euphoria scale. The euphoria seems to be due to heightened spiritual awareness. LSD-induced psychosis is not as morbid as schizophrenia except in those who were already schizophrenic. Those patients get extremely confused, disoriented, and even destructive because they cannot stabilize the world around them. Does this answer your question?

Smith: Yes; it is just that I was in a discussion on the kinds of perceptual distortions found in schizophrenics and LSD users, and I wondered if there was some distinction that you could draw between them.

El-Meligi: Yes; until you explore what I call the natural history of the symptoms; then you begin to find that every change in perception under LSD is paralleled by similar changes in schizophrenia, if you can go back or if you meet the patient in his earlier phases. I was amazed; I used to say that I would challenge any schizophrenic to produce a distortion like that under an LSD trip. Now I am finding that it depends on knowing the whole range of phenomena. So that when you enquire carefully you can get everything in schizophrenia that you get under LSD. The only exception seems to have something to do with time.

Cooper: The duration of the illness is an important factor in creating a difference between schizophrenic and drug-induced psychosis. And then, you get LSD effects in eight hours, a full experience in 9 hours, instant schizophrenia, as it were. And there is no puzzlement in LSD; you go into it with your eyes open. Instead, there is anticipation.

El-Meligi: Also, there is an element of repression in schizophrenia (I call it "repression" as a facetious reference to the psychoanalytic literature). The most serious repression in schizophrenia is the repression of the connections between sensory disturbances or time distortions and the delusions; not the repression of psycho-sexual conflicts. And the experience I have evoked in almost every session in the past year is, "Oh my God, I discovered it!"

Cooper: It must be a tremendous relief to the schizophrenic to know this.

Wolf: I wonder if you could discuss a little about the hippie mind in relation to what you have just said: the prolonged thing not being like an acute LSD experience; those who have been almost brought up into that kind of value judgment that you mentioned; and then comparing that to the schizophrenic type of thinking.

El-Meligi: It seems to me that the authentic hippie is hungry for superconscious experiences. His problem lies in his need for a new value system; and for this reason the hippie may be similar to the schizophrenic in remission. He can now move about in space, can control his imagery, and can restore the consonance between the time systems within his body. A 52-year-old schizophrenic in remission kept telling me again and again: "Do you see what happened to me?" (meaning the trauma of recovery). I couldn't see what he was trying to point out to me until he said: "People are just people! They are so uninteresting." Before they were frightening figures, like giants. They were imposing. The whole world had a strong impact on him, people in particular. Now that he is free of distortions, people have become less imposing, less significant, and consequently, boring. I think something like that happens to those who become hippies. The world was colorless and dull, and they sought a more colorful, more exciting and more authentic world.

Wolf: How about the schizophrenic? He had no time to establish a value system.

El-Meligi: The schizophrenic first has to stabilize the physical world, to settle down in his body, to achieve an integration of his body and his identity. During the turmoil of the illness, values are sort of luxury. When the world is in turmoil, survival becomes more important than other values.

Winston: (Undecipherable question having to do with auditory hallucinations. Ed.)

El-Meligi: Let me remind you of the two schizophrenic patients. They had similar delusions about people, but you miss the difference until you place the hallucinations within the context of the worlds in which they live. Hallucinations never occur discretely; hallucinations are organized and integrated into the spatial-temporal relationships, Let us remember this. You cannot say that a given delusion necessarily means such and such; you can only try to understand the delusion within the context of the patient's world. And you can differentiate between worlds but not between delusions. Two similar delusions may belong to two entirely different experiences. A delusion of persecution in one patient may derive from the fact that he experiences himself as the center of the cosmos or the Creator. In another, it may derive from the fact that he feels helpless.

Klein: .....It strikes me there are certain differences. The hippie lives in a world of shared experiences in which his "delusion" is collective. It is: "I and a great concrete environment." And this environment has its own ritual. Next, as I see it, you define the schizophrenic delusion as a protest against some condition, which is true also of the hippie, but in the latter case the protest begins as a conscious protest; it is collective, ideological. I have spoken to many student protestors and I didn't get that feeling from very many of them; that is, a conscious awareness of protesting. Now could it be that you are postulating a protest where in effect it might not be present?

El-Meligi: You have a very strong point there, namely the possibility of shared experiences among the hippies, and I fully agree. I only have one amendment to add, and that is that there are many of them in shared worlds. And I also agree with you that there isn't a culture among schizophrenics. As I pointed out with these two patients, their worlds are far apart. You cannot have "Schizophrenics Anonymous" like "Alcoholics Anonymous." There are attempts, but they have to be guided by a leader to bring members together. But there is protest among schizophrenics too, I have found in my experience. It is not collective protest but individual protest. I would like to add that the hippies remind me more of what you might call pre-literate societies....

Klein: ...In the hippie society, for instance, if you take what you call the scaffolding, in the schizophrenic this is a completely individual (rest of question undecipherable)? Is there some similarity to Jay Haley's view of the schizophrenic as refusing to define his relationship with other people or with certain objects?

El-Meligi: No, I don't really think that the schizophrenic chooses his way of life like the hippie does.

Klein: It may be at some level.

El-Meligi: The choice occurs only in remission. The schizophrenic begins to protest and to choose when in remission. It is then, not before, that he begins to say "All right, what kind of a world do you want me to live in?" This is not because of the schizophrenia; it is rather because of the recovery from perceptual change.

Cooper: And they do recover, spontaneously.

Klein: Yes, but do you then regard schizophrenia as an affliction rather than as some kind of meaningful decision.

El-Meligi: I am afraid I consider it an affliction. But considering it an affliction does not necessarily mean that it can only be treated biochemically. But then again, this is a matter of faith. It is not "science" to say that spiritual techniques might be able to alter biochemistry. But that is a matter of faith; it is something that stems from my experience rather than from a scientific proof.

Mrs.Hilton: You mentioned that the schizophrenic has not had the option of choice, as a hippie does, of this illusion or delusion. Is there any way of implementing or strengthening the will and thereby giving them choice - either by living with it as your man has done for three years, or ....

El-Meligi: In the initial stage of the illness, I don't think the patient chooses or decides the genesis of the illness. He simply feels ill. However, he gives the illness its shape. By this I mean that the symptoms are but the end-products of the patient's struggle to restore a balance. So "will" is involved, right from the very beginning. Patients' accounts of their illness indicate that they develop all sorts of rituals which help them maintain control. I would therefore say that "will" is aroused by the illness, but the illness itself is not an act of "will".

Mrs.Hilton: Would that be one of these techniques that you use?

El-Meligi: The first step in my psychotherapy with, say, a schizophrenic patient is to get him to realize that he is sick. Many schizophrenics do not need me to show them they are sick. They know it long before they come to me. Well, one schizophrenic says "I am a schizophrenic," I pose the question, "What do you mean by am?" Here I employ the psychosynthetic technique of disidentification. I help the patient see that the illness, severe as it might well be, should not be allowed to define who he is. In other words, I help him recognize his efforts to ward off the illness. I then show him that what we call symptoms are partly created by him. I may tell him, "True, you are sick, but you don't have to have paranoid delusions. The delusions are often intellectual attempts to explain

strange happenings." By getting the patient to recognize the illness and to be conscious of his efforts to combat it, we make him aware of his own "will". We hope that early in psychotherapy, the patient will tell himself something like this: "I have schizophrenia, but schizophrenia is not me. I am a person fully engaged in a battle against an illness." When he can do this, the patient becomes assertive. There is a difference between "will" and stubbornness.

Cooper: It is to be willing.

El-Meligi: Right. Then I say to the patient, "You cannot make it alone; you need help. There are certain things you can do to help yourself. First, take your medicine regularly. Second, make the best out of psychotherapy sessions. Third, you will be required to do homework which will consist of certain exercises and meditations about your innermost experiences. You will let me know whatever discoveries you make about the kind of world in which you live." With regard to the patient's personal (or experiential) world, I work like an anthropologist. To me the patient is a native of a world that is alien to me. I call upon him to be my guide. I know what dimensions I should explore. He provides me with bits of information. I have the schema which puts these bits together into a meaningful whole. The EWI is based on a schema that organizes the data provided by the patient. This is explained to him. That is how we work together.

I am far from having a complete psychotherapy. I have the framework which I am trying to fill with specific techniques. I have a few techniques which are still rudimentary and are geared toward orienting the patient to his own world. These are the techniques that are directly derived from the EWI findings. They constitute what I call "perceptual analysis," that is, the description of the patient's modes of perception and the exploration of the sensory and temporal bases of delusions and mood disturbances. I make use of imagery to alter the patient's self concept and also to free him from the clutches of both the past and the present. I train patients to develop future-perspective by having them close their eyes, relax, and visualize themselves already in the future.

Klein: I am not a psychologist but I remember a patient at Bellevue.... The woman had hallucinations, but a very clear perception of time. After we had been talking (and she couldn't see my watch) she said , "Shouldn't this interview be over? An hour and a quarter have gone by." And I looked at my watch and an hour and 18 minutes had gone by! I had been interested in what she had been saying, and it seemed to me to be very much less time. (Rest of question undecipherable. Ed.)

El-Meligi: Remember the lady I referred to earlier? When she touched something like this ashtray, she'd feel that it had no substance and that her body had no substance. Her body felt like a shell; sometimes she said it felt like cotton. Her finger felt like it was one mile away, if you can imagine that. She has no feeling. She had heard me speaking at Fordham University on the role of hyperesthesia (over-sensitivity) in schizophrenia. She said, "I heard you speak about that and I came hoping you would make me over-stimulated like other schizophrenics. It would be a blessing if I can acquire this condition." She was longing for this lively and vivid impact of the world. We began doing all sorts of exercises together to correct her tactile abnormalities and to minimize the distortions in perception of distance arising from them. One exercise required the patient to close her eyes, to reach out toward objects, to touch them, to lift them, and to weigh them so as to maximize her feelings of all the muscles involved. She was urged to invent similar exercises at home. She found it very helpful to balance plates on her palms with her arms outstretched while moving her body around.

She began to discover the relationship between her body and the space that it occupies. Remember that one of her most painful experiences was the loss of distance between herself and objects. People would appear without the third dimension. The exercises helped her to delineate body boundaries more effectively. As she began to explore the space around her, I suggested that she join a class in ceramics in order to maximize her feelings of her fine muscles and to increase her tactile discrimination, not to mention the rewards deriving from moulding things.

Smith: I was thinking about your differentiation between depression and the inability to enjoy, and the relation of this to suicide. Could you say a little more about this?

El-Meligi: The EWI has a Dysphoria scale which assesses the degree of depression and an Euphoria scale which assesses the degree of happiness or joy. The presence of depression does not completely rule out the capacity to enjoy life. A severely depressed person might sometimes tell himself: "One day my depression may subside; things are not going to continue to be this awful." Or he might recall happy memories of the past. Being able to make use of this store of joyful experiences, the depressed patient will not experience depression as devastatingly as it would have been had his euphoric resources been nil. This insight gave us the idea of using the ratio of both scales instead of relying on either of them. Therefore, high Dysphoria with low Euphoria indicated that suicide is a risk.

Smith: How do you register the ability to enjoy?

El-Meligi: The items in the scale - this is in terms of another number of questions.

Smith: Could you give us examples of some of the questions?

El-Meligi: Yes. "The last few years have passed very quickly," means that there wasn't an element of boredom or immobilization. "I have many things to be proud of," "People like me," "I trust myself," "I sometimes enjoy rowing in the moonlight." I think another question is "I like my image in the mirror." So the items in the euphoria scale point to the presence of a positive self image, and indicate that basic trust is not lacking. A person who goes along with the statement "I look forward to every new day" will certainly be more tolerant of present disappointments than a person who can only entertain negative expectations. The former can derive compensation from his future-perspective. In maniacal patients you find a paradoxical coexistence of severe depression and excessive elation. Hypomanic patients often score much higher than normals on the Euphoria scale. This is understandable because for a well-balanced individual, life does not really seem that rosy. It is stupid to see the world as all beauty. There is so much ugliness in the world.

Wolf: Have you had any experience working with schizophrenics using what you might call spiritual techniques?

El-Meligi: Unfortunately, I do not have specific spiritual techniques. I have been focussing on means to alter mood and behavior through perceptual analysis and perceptual modification. I think I have made headway in coping with paranoid delusions by unravelling their sensory basis. In the meantime, I gave much attention to altering time orientation. Specific techniques dealing with temporality are beginning to shape up.

With regard to spiritual growth, all I have been able to do so far is to help patients deal with value conflicts and to sensitize them to their own spiritual needs. I also encourage patients to pursue their religious interests and explorations.

In addition, my emphasis on imagery and visualization seems to expand the patients' spiritual horizons. After all, imagery opens up many possibilities that free the person from the here and now and, consequently, frees him from egotism and self-centeredness.

Crampton: Would you take a depressed patient and have him project himself into the future in a positive way?

El-Meligi: Typically, depressed patients escape to the past and resist early in the therapy any attempt to project them into the future. Would you like me to read to you excerpts from a session during which this phenomenon was dealt with? The patient is a 52-year-old chronic schizophrenic in remission. This patient used to have episodes of panic during which he would experience decay in his body and indeed in everything around him. In walls, he would literally see holes, rust, rotten wood, and deterioration. Sometimes his perceptions were reality-based but greatly exaggerated. Deterioration extended to society. He became an authority on the economics of depreciation. In his agitated phase, he would pester people around him by his efforts to alert them to imminent disaster. He saw the world on a precipice. His anguish was compounded by the fact that people would not pay heed to his warnings. People were felt to be insensitive; he felt as if he was talking a foreign language.

In one of our sessions, we established the connection between hyperesthesia (that is, heightened sensory awareness) and sensory distortions, between hyperesthesia and distortions of body image. Later, we found that these distortions were also related to distorted temporality; the patient was suffering from a breakdown in temporal integration. Instead of experiencing time as a unified and regular flow, he was experiencing two dissonant time systems. On the ideational level, time was racing; he felt that his thoughts were almost rushing out of his head. But at the physical level, he felt his body lagging behind. On one occasion, the patient came to my office literally dragging his feet and drooping completely. He was only one step short of catatonic immobilization. He had lost the feeling of being in unison with himself.

Furthermore, time passing seemed like "the end of life, no future, only nothing." It was at this time that a delusion developed. One day, he left his house to go to the village in which he spent all of his life. He found that it had been taken over by strange people belonging to another generation. This delusion seemed to have been triggered by the death of two elderly people in the community. The patient always gravitated towards such figures. To him they were like"landmarks in the map of my life." The patient would cry like a child (let us recall that he was then 52 years old) at the thought that his mother (then about 80 years old) was going to die, which would be followed by his sisters' deaths, and that consequently, he would be abandoned and helpless.

Had it not been for my earlier clinical observations of temporal disintegration, I would have tackled his anxiety by focussing on personality dynamics or on the symbolism of decay. Had I done that, I would, in fact, have anchored him more in the past. He was already too strongly anchored there and had absolutely no future-perspective. He was actually reliving a past epoch. His

adult personality was not available, to use Berne's terminology. Intuitively, I commented on his dread of the imminent death of his relatives: "Who told you that they will die before you? Do you realize that you are 52 years old and that at this age, you may very well die before your sisters?" This remark, cruel as it sounded to me at the time, had the impact of a shock. There was an interval of silence, followed by lucidity and serenity up to the end of the session. A rediscovery of his own age had taken place, to a degree. My remark gave him a violent push forward in time and placed him in the proper epoch along the dimension of time. He came in touch with adulthood.

Later sessions dealt with the patient's tendency to cling to a youthful attitude. I tried to show him the advantages of accepting his place among his contemporaries.

The next phase was to establish a continuous and progressive view of his life. In this way I tried to get him to see the past as a stage in his life, and to stop regressing to earlier phases of his life and reliving them. Once this had been achieved, it became possible for the patient to avoid reverting to the past. The past was reduced to memories.

The next phase was to help the patient to project himself into the future. In order to show how this actually took place, I will read a dialogue that took place between the patient and myself almost one year after the session referred to previously. This dialogue marks the very end of the session.

Patient: "I feel better than I have felt at any time in my life. I do not look at years as I used to, so many months in a year, so many days in a month. I look at time rather as cycles. I do not think of myself as 54 years. If I start to relate to myself in years, I would begin to mark things. I do not look at my life anymore as made of marks. I look at it as involvement, as cycles like the cycles of trees." He is referring to the rhythmic quality of nature. The patient adds:

"I have a different feeling about time. I took away the markings, the signs. When I did that before, I used to panic. Now my life is a life cycle. I am aware of life that can be free of all conventions. I am freer in my balance. You really can live beyond all that you see."

Here we can detect the beginnings of a future perspective, experiencing the beyond. We can also detect signs of transcending both past and present. The patient goes on:

"I feel like I were in a closed stuffy place and all of a sudden the doors opened up and fresh air rushed in; a very invigorating air."

At this point, I decided to use his imagery as a vehicle to launch him into the future. I said: "Look through the doors and tell me what you see." He paused for a while and then said: "You see nothing but space, vast enormous space." "What kind of space?" I asked. "You can go into it, you free yourself from the chains." "Which chains?" I asked. "The past." I said: "The past is your chains; the space is your future." He said: "The future opens up all sorts of possibilities." (Pause, laughter). He goes on: "It is funny, I understand now what you were trying to tell me long ago. I could not even smell a future. It was horrible." I said: "What you are experiencing now is youth. Youth is to have an open future." He nodded: "That's right."

Haronian: How long was the course of treatment?

El-Meligi: This patient I saw when I was a dumb, insensitive psychologist using the usual battery of tests for about a year with absolutely no progress. Then during the next year I began to use the new techniques inspired by the EWI. Then change began to occur.

Haronian: You commented about the characteristics of the scale for people who are prospects for suicide: lack of euphoria, the lack of a sense of the future, the lack of the feeling of control over their destinies.

El-Meligi: Not all of that; some have control; some depressive patients choose to die. There seem to be two types of suicidal individuals: those who have no other choice but to die and those whose suicide implies self-assertion. The latter try to prove something by their suicide; they are cynical intellectualizers whose suicide appears to be an act of will.

Haronian: The question I wanted to ask you was if there are implications in this for emergency intervention and suicide prevention?

El-Meligi: Yes, I believe it is as effective as electric shock to force the patient to see something in the future even though it might be something very unfortunate; to see a disaster occurring - let us say one year hence, and to get him anxious about it.

Haronian: You conceive of the anticipation of a disaster in the future as prophylactic?

El-Meligi: I would say it is good tactically, it is very good tactics.

Cooper: Yes, then clean it up as you would using ISP.

Crampton: Has any of this been published?

El-Meligi: No, but it will be soon. One has to be sure about this off-beat kind of work, you know. But it will be published, and the test is being used in Canada and in this country with some arrangement.

Cooper: They might get around to using it in Boston! (Laughter).

El-Meligi: It has actually been used by Dr. Dussik, a psychiatrist who pioneered insulin chemotherapy. He wrote "Ways Out of Psychosis." Unfortunately, he died before he could give me his insights. One of his collaborators is using it in Boston.

Hilton: Towards the close of your talk, you said you might later give us a point-by-point comparison of delusions and distortions in perception.

El-Meligi: In the last few years, I have identified a category of schizophrenics who may be mistaken for hypomanics or psychopaths. They share the following personality traits: They are all young, in their twenties. They are vigorous, excessively ambitious and intelligent. They are hard workers; they are persistent, they value achievement. They all worked themselves into sickness, as it were. They all have delusions of grandeur and are preoccupied with great goals. Their time orientation is quite peculiar. Subjective time is speeded up tremendously. Things have to be done immeditately; the slightest delay infuriates them.

People around them are experienced as too slow, and may even appear so. The discrepancy between subjective time and social time in these patients makes social adjustments impossible. They often see people as stupid and inefficient. These patients tend to be ultra-conservative in their political leanings. There is a Nazi quality to their political thinking. At a more advanced stage in their illness, their bodies begin to lag behind their mental speed. They begin to experience painful dissonance between the accelerated thinking and the slowed down body. They end by having two time systems with their organisms. It is at this stage that they can no longer tolerate the frustration, and they begin to develop delusions of persecution, delusions of being deliberately "held back." They become very violent and collapse.

Here you see a definite relationship between disturbed temporality and delusions within an entire syndrome. It is interesting that some of these patients discovered their confusion about time on their own. The rest talked about it with relief as soon as the subject was brought up by me.

One of them was reading Einstein. He was a carpenter who had never completed high school. I exclaimed "Einstein?!" I thought his interest was a part of his delusions or that he thought he was a genius. He said "Don't you know about Einstein? He talked about the relativity of time!" That was the reason that he was reading Einstein - for therapeutic purposes!

Mrs. Hilton: You mentioned an inventory of various exercises and techniques; something like a yoga manual. But won't these apply differently for each patient?

El-Meligi: Yes, they will apply differently in each case and with the same individual at different stages of the therapeutic process. What I have in mind is to prepare a "cookbook" to which a therapist can refer in order to derive recipes. By "inventory" I do not mean questions; I mean a compilation of procedures.

Cooper: Do you mean that if a patient suffers from a particular kind of time distortion, you will prescribe a specific therapeutic technique? Do you think of schizophrenia or psychosis as the mind's attempt to heal itself? We understand very little about the disease itself. In any event it is the process of healing that we are really interested in. We generally cannot do much about the cause of the disease, but we do know that it has exacerbations and remissions so that in the schizophrenic experience, if the patient says that standing on his head will relieve or correct a twisted sense of time or a distorted perception, then we use that bit of knowledge to relieve other patients too.

Wolf: I'm wondering about how much you have to allow for a "self-fulfilling prophecy." In other words, if with a certain kind of time distortion, you have to stand on your head to relieve it you say, "I am going to stand on my head and as a result, I am going to get this change," how much of that will be a self-fulfilling prophecy? And I am wondering how that can be avoided. You know what I mean by self-fulfilling prophecy: "The book says so, therefore it is going to happen." (Haronian: Suggestion!) Yes; that is what a self-fulfilling prophecy is. And this is true of many of these "cookbooks." When the cookbook says "Do this and you will get a marvelous sauce," you get it! (Laughter)

Cooper: This is the pragmatic attitude; if it works, it is fine. This is what we are interested in; the pragmatic attitude. (Wolf: It depends on how much you believe the book.) Right.

Haronian: Do I understand you to say that if a schizophrenic patient shows spontaneous interest in mysticism, you encourage this?

El-Meligi: With reservations. I have to make sure that his mystic leanings are not incorporated in a delusional system. That is the first point. I encourage going back to the past, but as a movement of the will. The patient must not be engulfed by the past, like patients who are in a constant state of resentment, for instance. So also with spirituality. If the patient is spontaneously striving toward a spiritual orientation he must give it the form that most suits him. I am very much aware that I belong to a faith that is different from the patient's, so I try not to impose my own beliefs, and I try to let the patient decide how to express his spiritual needs.

Haronian: You want to be sure that they do not use it to strengthen their delusions.

El-Meligi: Right; and I also want to be certain that the spiritual leanings are not based on interpersonal delusions or distortions of perception like "To hell with my family and their religion; I am going to go in the opposite direction. But my mystic girl patient was seriously searching.

Haronian: You started out by saying that you disagree quite strongly with Kraeplin's notion that distortion of thinking is central in schizophrenia. And yet, you seem to be saying that you, too, believe that schizophrenia involves a distortion in thinking, but of an entirely different sort. You seem to be saying that the thought distortion is manifested in the manner in which the schizophrenic seeks to explain to himself his particular perceptual distortion of space, or of time, or of what not. But again, that is a distortion of thinking, is it not?

El-Meligi: No, it is not a distortion in thinking. In the context of the patient's experiences it makes sense.

Haronian: You consider the patient's experiences, his delusional explanations of them and then you give him a different explanation as to how they arise, do you not?

El-Meligi: We explore together the natural history of his delusion. I show the patient that his delusional thinking is not the result of what you might call an imaginative leap or creative leap. It is simply "sick."

Cooper: It happens one, two, three in a consecutive order.

Haronian: Certainly, but you give the patient another sequence, a different explanation. (El-Meligi: No.)

Cooper: Once they see what happens and put the various links in the chain, together then they are apparently able to move forward.

El-Meligi: An example just came to my mind. A woman, about 55 years of age, had amnesia from a brain syndrome. Her daughter, 25 years old, came to visit her, and she accused this daughter of hiding her husband. We know that her husband.... (Haronian: The mother accused the daughter of hiding her father?) Yes, but she never said "father", and that was a discovery. I was very happy about that discovery. The daughter said to me "My mother thinks that I am hiding my father from her!" I said, "Has she ever mentioned 'father'?" I said, "What did she actually say?" She said, quoting her mother "My husband!" I said, "Who told you

that she sees you as her daughter?" It became apparent that the patient had the delusion that her daughter and her daughter's husband and everybody else were hiding her husband from her; and yet we know that her husband had died 15 years back. She was planning to surprise her husband with a picture of her daughter as a five-year-old. She was planning to ask her husband "Isn't she cute? She is coming to see me." When the patient told me that her daughter was going to visit her, I asked, "When?" She answered, "Today." But, I told her, "Your daughter is coming tomorrow." Then she said, "Tomorrow! No! She is coming today!" You see, she was talking about someone else, the five-year-old daughter of her memories. I asked the patient, "How old are you?" She gave her own age as it was when her daughter was five years old. She made a similar mistake when I asked for the age of her husband; she even revived the entire sequence of events of that time. Phenomenologically speaking, she was there. And that was the loss of connection between her memory of her daughter as a five-year-old and her perception of the 25-year-old woman that her daughter had since become.

Cooper: The observer made the mistake, not the person having the experience.

Haronian: It is not the logic that is faulty; it is the perception of the situation.

El-Meligi: Yes, that's right.

Haronian: That fits in with the results of a dissertation of a friend of mine. He studied paranoid delusions in schizophrenics, and he found that the logic was all right but the premises on which it was based were wrong.

Klein: Have you ever tried using two metronomes for the perception of time - one metronome for getting the patient to register what is "out there" and a second metronome for what he experiences inside of himself, both working simultaneously, at two different speeds?

El-Meligi: That is a beautiful idea.

Klein: The reason I ask this is that most people have a very hard time hearing two metronomes working at once, but a patient might not. I am curious to know what he would experience.

El-Meligi: It's a beautiful idea; I don't think any one has tried it.

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