A Psychofeedback Approach to Schizophrenia

by Anna Marsh

Abstract

Annitto (1981) has criticized my work on the nature of hallucinations (Marsh 1979). One of his points—the need to take the patient's affective state into account—is valid. His other criticisms—that I propose to use my outline of hallucination types for diagnostic purposes and that I have blamed the patient—are serious misconstructions of my work. A number of psychological techniques used for alleviating hallucinations in an acute schizophrenic patient are described. A psychofeedback approach, based on the biofeedback model used in psychosomatic medicine, is proposed as a modifying treatment for some schizophrenic patients.

Annitto (1981) has criticized my article (Marsh 1979) on three counts: One criticism is valid. The other two result from a misinterpretation of my work.

• The criticism that I have neglected the affective tone of the hallucinator is valid. In fact, I had already recognized this failing of my previous work. New data have now been collected, which examine ratings on five emotions experienced by drug users during hallucinations. I plan to continue exploring the variable of emotion in my research on hallucinations.

• Annitto states that I use "the varying forms of visual hallucinations as one of the major criteria for diagnosis." This is false. I have not done so for three important reasons. First, the limitations of a one-subject study are so obvious that only a naive researcher would generalize from such findings as mine, without further test. This was made clear in the original article. Second, diagnostic classification of a patient is not reliably made from the existence of one symptom alone, but from the existence of a cluster of symptoms. Therefore, diagnostic accuracy does not depend upon the use of, or the failure to use, any one criterion, but on the judgment of the diagnostian that the several criteria used form a coherent diagnostic profile. Third, differential diagnosis on the basis of hallucination type was not the objective of my study, nor did I state in my article that this was the case. My purpose, rather, was to provide a description of a very small segment of the experience of a girl who had taken drugs and had subsequently been diagnosed schizophrenic, so that the reader could better understand the nature of that experience.

• Annitto's third criticism is his most serious misrepresentation of my work. It is his statement that I have blamed the patient for choosing to hallucinate. In his argument for this thesis, he has used my words out of context, and has inferred from them a meaning which is not evident in the words themselves. In my article, I described two scenarios which might occur if a person were to experience spatial and depth distortions. The first scenario was that the person would attribute the hallucination to a drug or to fatigue, and would therefore maintain the ability to test reality, accepting the hallucination as part of his imagi-
nation. The second scenario is that the person would accommodate himself to the hallucination. This would entail developing a new philosophy about the nature of reality, including a belief in the existence of the hallucination, apart from the self. Such a belief would seriously impede the hallucinator's ability to test reality.

Another way of looking at the reality testing function is as the presence or absence of delusion. The person who believes in the existence of hallucination has a delusion which is attached to the hallucination. The person who sees the hallucination only as part of the imagination, by contrast, has no such delusion.

In the 1979 article, my description of the types of hallucinations was facilitated by a description of reality testing. Here, I have replaced the term ‘‘reality testing’’ with the concept of delusion—its negative counterpart. If Annitto is to maintain his argument that I am blaming the patient, he would have to think that I am blaming a person who is suffering from delusions for acting in a way which is congruent with the delusional system. Annitto’s assertion therefore is reduced to a logical absurdity. How else can a deluded person act, but in congruence with his delusions? If he were to act in any other way, he would no longer be deluded.

Review of the Case

To clarify the case study in question, I shall review some facts, and enumerate the treatment techniques which the patient used in order to control her symptoms. First, the patient was acutely schizophrenic. It is therefore important not to generalize from her case to that of chronic or other types of schizophrenia. Second, the patient was not treated with drugs. Yet, she enjoyed a full recovery. This fact is difficult to reconcile with the view that schizophrenia is a medical illness that can only be treated with direct physiological intervention.

The treatment was at a psychological level, and involved the following techniques for alleviating symptoms:

- At the height of her psychosis, the patient was confronted by the staff with facts of reality that contradicted her hallucinations.
- The patient was encouraged to attend to her internal emotional states when she noticed hallucinations occurring. A diary was kept for this purpose.
- The staff helped the patient to feel less odd about hallucinating by explaining to her that everyone has some experiences in which they think they have heard or seen something other people have not. An example is the argument which can ensue after a volleyball lands close to a boundary.
- The voices the patient heard were explained to her as possibly being a facet of her own thoughts which she was afraid to accept, as opposed to being externally controlled.
- Finally, if the patient still heard voices talking to her, she learned to talk back to them, in her imagination. This technique helped to alleviate her anxiety about the voices, and seemed to contribute to their eventual disappearance.

A Psychofeedback Approach

The feud between medicine and psychology is prolonged and continued. Instead of continuing it, it may be useful to consider an integrative approach which has revolutionized the field of psychosomatic medicine—the biofeedback model, as described by Schwartz (1978). Consistent with this model is the view that hallucinations are psychobiological processes that can be influenced by psychosocial or pharmacological means.

Schwartz has distinguished two functions which a medicine may have. These are modulation and modification. Modulating medicines lose their effects when they leave the system. Modifying medicines, by contrast, modify the system in such a way as to make their effects lasting, even after the medicine has been removed. Those medicines which are used to treat schizophrenia, and the cessation of phenomena which results in a recurrence of symptoms, are modulators. It is desirable, instead of maintaining a patient on modulating medicine, to seek a means of modification.

In biofeedback therapy, the patient effects modification by attending to psychophysiological phenomena, and by learning to control the undesirable symptoms. Similarly, the hallucinating patient in question learned to attend to phenomena at the psychological level, and appeared to develop some control over her symptoms. This is not to say that her symptoms were not triggered by the release of a specific chemical. However, the discovery of a biological

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1 I am indebted to Rafael Diaz, of Yale University, for this idea.
substrate to schizophrenia does not preclude the utility of intervention at the psychological level. By training some schizophrenic patients to attend to their psychological processes, we may enable them to modify the chemicals which contribute to their illness. In this way, it may be possible for some patients who were once schizophrenic to look back on their experience, not with shame, but with an awareness of their possible capacity to alleviate such pain in the future.

References


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An Invitation to Readers

Providing a forum for a lively exchange of ideas ranks high among the Schizophrenia Bulletin's objectives. In the section At Issue, readers are asked to comment on specific controversial subjects that merit wide discussion. But remarks need not be confined to the issues we have identified. At Issue is open to any schizophrenia-related topic that needs airing. It is a place for readers to discuss articles that appear in the Bulletin or elsewhere in the professional literature, to report informally on experiences in the clinic, laboratory, or community, and to share ideas—including those that might seem to be radical notions. We welcome all comments.—The Editors.

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