**An Investigation into the Ego disintegration of the Chronic Schizophrenic and a suggested Occupational Therapy procedure of re-educating self-awareness**

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**Chapter 1**

**The Problem and Definitions of the terms used.**

Throughout the ages disturbances of personality have been recorded,[[1]](#footnote-1) and due to lack of scientific knowledge, these people remained untreated; being made outcasts by society; the only measures taken being of a more physical than medical nature.[[2]](#footnote-2) With the ever increasing demands of our complex society, statistics have revealed that more people are seeking psychiatric help.[[3]](#footnote-3) The developments and advances made in psychiatric medicine since the end of the 19th century, and the resultant enlightenment of society have possibly been major factors contributing to the fact that many people now seek psychiatric help, and subject themselves willingly to treatment by medical and para-medical professions.

Just as in the field of psychiatric medicine, there have been great advances made in Occupational Therapy, although some professional disciplines within the professions have progressed more rapidly than others. In Occupational Therapy, various schools of thought have expressed the need for a standardised planning and executing treatment.[[4]](#footnote-4)

A method of assessing and grading intensive treatment of psychotics is employed at the Weskoppies Hospital, Pretoria, whereby the patient is assessed as being at one of the following levels:

* Tone
* Self-awareness
* Presentation
* Participation
* Contribution
* Competition[[5]](#footnote-5)

If, however, this method is to be considered a scientific one and one which constitutes a valuable contribution to the profession, the elements of each phase have to be analysed in order that treatment may be accurate and consequential.

**Statement of the Problem**

It was the purpose of this study:

1. To analyse and define self-awareness;
2. To propose a practical assessment scheme involving the basic characteristics of self-awareness;
3. To suggest a graded execution of treatment based on the findings of the investigation into the level of self-awareness.

**Importance of the Study**

Although great advances have been made in psychiatric occupational therapy, little progress has been made in the accurate assessment and grading of the execution of a treatment scheme. This factor is possibly due to the fact that there is virtually no reference matter in this sphere. As a result, the profession has depended entirely upon the therapist’s professional judgement and the verbal response of the patient, and treatment has often been on a trial-and-error basis rather than being based on established and accurately assessed facts. The importance of this study is based on the following facts:

* Firstly: it is absolutely essential for the execution of scientific and valid treatment that the therapist is able to grade accurately the patient through the stages of personality reconstruction.
* Secondly: to provide a basic scheme to serve as a standardised scale and uniform approach.
* Thirdly: although the basic scheme has been applied to only European hospitalised schizophrenics, it can be adapted for various racial groups, cultures, intellectual levels and both sexes. The suggested scheme, therefore, includes the factors essential for the adjustment of man to the demands of most structured societies.
* Fourthly: if the occupational therapist is to be considered one of the essential diagnostic and treatment disciplines, the assessment and the treatment of the psychotic must, of necessity, follow the trend towards scientific formulation.
* Fifthly: if the occupational therapist is to assess accurately that the patient is at the level of self-awareness, the inherent factors of this stage have to be ascertained.

**Limitations of the Study**

The study will be limited:

1. the available literature;
2. South African conditions;
3. chronic female European schizophrenic patients over the age of twenty-five;
4. patients treated by occupational therapists;
5. five patients;
6. patients who have been hospitalised for over fifteen years.

**II. Definitions of the Terms Used**

**Tone**  Mental tone or poise; an emerging awareness in the patient of his existence.[[6]](#footnote-6)

**Self-awareness** The consciousness of oneself as a separate identity in relation to the objects and people in one’s world. It is during this stage that the pathological abstractions have to be separated from the objects and people in the individual’s world.[[7]](#footnote-7)

**Presentation** A tentative presentation of oneself as a separated entity leading to an invitation to be acknowledged by other people.

**Participation** Desire to share in an environment with other human beings.

**Contribution** Things done in aid of a common effort.[[8]](#footnote-8) During this phase, the responsibility of the patient becomes foremost.

**Competition** Phase during which the individual presents himself for competition and judgement by others.

**Personality** Dynamic organisation within the individual of those psychophysical systems that determine his unique adjustment to the environment.[[9]](#footnote-9)

**Id** That part of the personality structure which harbours the unconscious, instinctive desires and strivings of the individual.[[10]](#footnote-10)

**Ego** The individual’s conception of himself.[[11]](#footnote-11)

**Superego** That part of the personality associated with ethics, standards and self-criticism.[[12]](#footnote-12)

**Schizophrenia** A severe emotional disorder of psychotic depth characteristically marked by a retreat from reality with delusion formation.[[13]](#footnote-13)

**Chapter 2**

**Review of the Literature**

Much is available in literature concerning the Ego, its development and its disintegration. However, there is relatively little available information published by occupational therapists in relation to the treatment of the chronic schizophrenic exhibiting severe ego disintegration.

1. **The development of the ego.**

One cannot discuss the ego without mentioning Freud. From 1920, Freud developed a theoretical framework for Psychoanalysis which included the division of the personality into the Id, the Ego and the Superego. It is not the intention of the candidate to discuss the Id or the Superego in detail. It would suffice to mention that the Id is described in the newborn child as a “seething mass of impulses and instinctual drives entirely lacking in any directing power or guiding consciousness, and because of its primitive nature, this primitiveness is describes as the Id”.[[14]](#footnote-14)

The Ego, or the “self”, becomes differentiated as the child comes to terms with reality, the prime function being to test reality. The Superego develops out of the need to face society’s moral prohibitions.

It is the Ego the candidate wishes to discuss more fully. There are two important considerations which enable the ego to develop in man:

1. Man’s psychological functioning is able to take on a symbolic level, or a conceptual level, thus enabling him to comprehend reciprocal relationships and to make effective use of the accumulation of diverse symbols and concepts. Man is unique in his ability to use symbols, that is, he is able to form abstractions of his interaction with his environment. Speech, the most important form of symbolic expression, enables man to communicate to others the formulation of concepts regarding himself and others.
2. When man is able to function on a conceptual level, he has to live in a highly ordered world, where interpersonal relationships, society and the products thereof necessitate his adaptation to lawful nature. Without the norms, values and symbols of society, consistent and continuous ego formation in the individual would not be possible.[[15]](#footnote-15)

The newborn is not able to distinguish between himself and his world; boundaries are blurred, stimuli and sensation constitute an undifferentiated field. Objects are merely a prolongation of the child’s activity. It is only later that multidimensional boundaries emerge and the child begins to distinguish between himself and his environment; inside and outside; moving and feeling motion; feeling his own surfaces and those of objects.[[16]](#footnote-16) A complex variety of sensory stimulations related to the whole body, not to any one area, function or structure, is necessary for the delineation of the bodily ego as a reality. Once the bodily structure and functions have reached a greater level of maturation, the stimulations will be reacted to and experienced in a much more specific and differentiated way than those stimulations which were initially experienced and reacted to in a gross and diffuse way. Finally, “all these separately differentiated perceptions of self … become organised into a unified concept as they occur sequentially or concurrently and hence interact”.[[17]](#footnote-17)

The first step in the ego development is thus the delimitation between self and objects and people with which the child was previously fused. The ability of the child to distinguish between his activity and the objects towards which his activity is directed is considered by Piaget to be an ego contribution to the development of object relations and an essential element in the institution of the reality principle. Hartman states that Piaget’s findings coincide well with the findings of analysis, and that metapsychologically speaking, there is from then on a difference between the cathexis of an ego directed eco function and the cathexis of an object representation.[[18]](#footnote-18)

The most acute consciousness of self is said to arise from the delays of gratification of the child’s organic needs, and an anaclitic relationship for the satisfaction of his needs arises. Further development of the self perception takes place by means of the baby’s reaction to the mother, who serves as an anchorage point for the slowly developing self pattern. Volitional crying becomes a method of relieving unpleasant stimuli relating to the self, and the help of the mother, or the help that comes from outside the self, further helps the distinction between self and world.

As speech evolves, the ego becomes consolidated as a concept. The child develops egocentricity accentuating “mine”, so highlighting the distinction between himself and other people. A genuine self-awareness is implied when the child is able to say “I”; the individuality of the child thus being made distinct.

The ego is constituted of attitudes which may be designated as ego attitudes and these are related, from infancy on, as the “I”, “me” or “mine” experiences and aid in defining the person’s relative standing to others and to institutions, and to determine the more or less enduring character of his own personal identity, with the values and norms incorporated in him.

The ego is not a fixed identity, and as the attitudes are subject to change, just so is the ego subject to change. If ego attitudes are relatively stable then one’s psychological sense of status in relation to society should be relatively stable and secure. Attitudes have varying degrees of affective properties and may change or disintegrate. As attitudes are formed during genetic development, so the ego is formed. “Starting with the delimitation of one’s own body from the surrounding objects, ego formation rapidly expands by the learning of attitudes related to it”.[[19]](#footnote-19) This is particularly so after the acquisition of communicable language.

1. **The disintegration of the ego.**

During the process of schizophrenia, ego disintegration occurs. There is a disintegration of the awareness of self and of relationships between the self and the external world. External and internal worlds become a continuum as with the baby, and it is “only when the outside is experienced ‘alien’ and withdrawn from the ego and body boundaries does it assume a reality value in the experience of the individual”.[[20]](#footnote-20) Each individual experience contributes to the delimitation of the ego and the outside world. “The process of detaching the world from himself becomes to the individual a process of becoming more real to himself”.[[21]](#footnote-21) “The personality appears to be trying to avoid the total disintegration by distorting the perception of reality. The function of proper reality testing or evaluating the environment is sacrificed so that some semblance of internal integration can be maintained … the schizophrenic struggles to provide a new environment to which he can adjust”.[[22]](#footnote-22)

The schizophrenic is unable to assess his external world accurately or realistically due to the loss of a stable reference point. The extent of ego damage is so severe that a new self replaces the old one. This new self no longer regards the regression to a more infantile level of behaviour as degrading, unreal or apart from himself, and now operates within a new personal framework of identity. Ego regression appears to be the primary factor in the loss of reality and the schizophrenic replaces adult reality by reality as it would appear to a child. It implies primitive object relationships and a primitive way of psychic functioning.

The concepts of “ego boundary” and “ego feeling” were developed by Federn who maintains that “ego feeling is the sensation, constantly present, of one’s own person, the ego’s own perception of itself … It is an entity which stands in relation to the continuity of the person in respect of time, space and causality. We possess an enduring feeling and acknowledge that our ego is continuous and persistent … because we feel that processes within us have a persistent origin within us and that our body and psyche belong permanently to our ego”.[[23]](#footnote-23)

The concept of ego boundary constitutes the edge of the “me” or “I” feeling and represents where “I” ends and the rest of the world begins. It is this element, that is, the inability to discriminate between the self and environment that is damaged in chronic schizophrenia. The awareness of self as a separate entity and stable reference point is essential for realistic interrelating with reality.

Confusion between self and the environment calls for satisfying figures in the external world. Identification with such enables him to build or reconstruct his ego and to start functioning on a more realistic basis.

**Chapter 3**

1. In an investigation into the requirements of factors necessary for self-awareness in the chronic schizophrenic patient, the candidate has ascertained that in order to regard oneself as a separate and differentiated entity, the patient has first to be re-educated to be aware of his body boundaries, for it is body boundaries and loss of perspective for their own physical person which manifest in a lack of a stable behavioural reference point. Des Lauriers says of bodily boundaries: “The schizophrenic individual cannot relate to reality because he does not experience himself as real, that is, bounded by finite, separate and differentiated from what is not himself”.[[24]](#footnote-24)

Conditions necessary for the ego to exist as a psychological structure are thus absent in schizophrenia, and “dynamically this appears to be related to a decrease or drastic reduction of narcissistic boundaries, leaving the schizophrenic psychologically undifferentiated and somewhat boundless”.[[25]](#footnote-25) There is an incapability on the part of the patient to form and experience a relationship with an object, and whereas many ego functions, for example, thinking, emotion, etcetera, remain intact, these functions appear to the observer as meaningless, autistic and inappropriate, due to the fact that they have no integrated anchorage point on which to rely.

Without definite body boundaries, the internal and external worlds become a continuum and the self and non-self become confused. The perception of sensations and external impressions are dependent on the growth of the self as a separate entity in relation to external environmental entities.

Well integrated and stable body boundaries act as a receptor for external stimuli. The physical limits of the individual’s body have to be constituted first in order to experience separation and differentiation from reality of the world outside the body. With body boundary disturbances, its objective counterpart, the experience of the world as real, vanishes. The discriminating function of making clear distinctions between external and internal with regard to the perception of sensation was described by Federn as that of “ego boundary”.[[26]](#footnote-26)

The importance of the intact ego is described as follows: “Awareness of the self, the capacity to reflect upon one’s experiences, is dependent upon an intact ego … a realistic appraisal of the environment is dependent upon adequately reflective awareness. Concentration and attention, which are necessary to bring these about, demands that the ego functions remain intact. The state of consciousness correlates with the condition of self-awareness. As self-awareness diminishes, the state of consciousness alters and is no longer adequate for the task of purposive attention and concentration”.[[27]](#footnote-27)

With defective ego functioning, the schizophrenic is unable to form ego relationships. Subject-object relationships are dependent on attitudes.[[28]](#footnote-28)

Attitudes are always related to definite stimuli or to stimulus sensations which may be objects, institutions, people, concepts, values or norms. It is only after contact with these outside stimuli that a relationship can form between the object and the subject. Thus attitudes in object-subject relationships are formed primarily during the perceptual stage, “with the internal factors of the organism and external (objective) factors to the stimulus coming into play”.[[29]](#footnote-29) It is necessary to stress the fact that attitudes may change and disintegrate. In order to have fixed attitudes, the basis for stable object relationships, the individual has to feel that he is a stable, well-integrated reference point, and he must be able to distinguish between stimuli from outside his body and from those within.

In the discussion on ego development, we have seen that when a child is born, he is not able to differentiate between sensations produced outside his body and those produced from within his body. As such, there is psychologically no possibility of an object-relationship. After the child’s first perception of emotional and instinctual significance, whereby the mother or mother-figure is recognised as the one who produces gratification, a dependent anaclitic relationship develops with a seemingly sharp awareness of the gratifying mother figure and an apparent lack of awareness of self in contrast thereto.

Fidler and Fidler maintain that such a relationship also characterises some adult psychotic personalities.[[30]](#footnote-30)

From the anaclitic love-object relationship, one of narcissistic object relationship, one of narcissistic object relationships develops whereby instinctual gratification is derived from one’s own body. When speech evolves and develops and one is able to form abstract concepts, the individual searches for objects to gratify instinctual needs and to reduce tension. More mature object relationships are formed and a more mature body image and self identity develop concomitantly. “Mature object relationships depend on an ability to distinguish the object in question from other objects and on a well organised personality having a good self concept as well as object concept”.[[31]](#footnote-31)

In schizophrenia, object relationships have been found to be of a primitive kind with identification being made crudely so that one object is exchanged for another. Affect related to object relationships may be grossly impaired or inappropriate.

1. The candidate wishes to discuss the basic approach and technique of the method devised to re-educate self-awareness.

**Communication**

Lorentz presented the hypothesis that communication is essentially “the process of transforming the inner private subjective experience and thoughts into external public form, accessible to recognition at large, where it can the acquire validity in the shared real world”.[[32]](#footnote-32) It is through communicative activity that we may exist as people and not as objects.

Communication with the chronic schizophrenic patient poses a problem for staff working with the patient. The schizophrenic has been found to communicate on an essentially physical basis, one which is concrete and direct, and Ruesch maintains that it needs no interpretation inasmuch as its only value is to put the schizophrenic physically in contact with his environment.[[33]](#footnote-33)

It appears that the ego damaged person has difficulty in understanding what is being addressed to him; he has difficulty in giving and receiving messages. With the schizophrenic, the need for verbalisation should therefore be minimal and when verbalisation is necessary, the instructions should be simple and direct. In attempting to re-educate self-awareness in the patient, the therapist must always include the patient’s name and title in the instruction.

It is advisable that ambiguities be avoided. Facial expressions and gestures should be minimal as gestures seldom have universal meaning and differ from culture to culture. The patient is more likely to interpret a gesture incorrectly or in a way entirely divorced from the original meaning. It is far more appropriate to say: “I am pleased” or: “I am not pleased” than to show pleasure by smiling or displeasure by scowling. In this way, the therapist reduces the possibility of incorrect and subjective interpretation on the part of the patient. Statements should never be modified or weakened by contradictory action, and all directions should be clear, precise and direct.

In attempting to re-educate self-awareness in the patient, the therapist should use a maximum amount of physical handling and verbalise simultaneously. As many types of stimuli as possible should be applied to the surface of the patient’s body, but perhaps the most suitable of all is sustained and firm manual pressure on the body area the therapist is emphasising at that particular moment. The therapist can, for example, hold the patient’s hand firmly and say: “This is your hand”. Then the therapist should ask the patient to show his hand to her. A system of reward can be used in the initial stages of treatment. The therapist must be persistent and adopt an attitude of purposeful intervention into the consciousness of the patient. The pace should be regulated to that of the patient. Other types of stimuli may also be applied, for example, thermal stimuli wet and dry, and pain, which may take the form of gently pulling of the patient’s hair.

It is essential that the same therapist treat the patient during the re-education of body boundary awareness, the sense of separateness and the differentiation of self from non-self. “The sense of identity is acquired by long term contact with one and the same person so that the diversity of external conditions can be elaborated with this person and fused into a whole”.[[34]](#footnote-34)

Consistency of stimuli, therapeutic approach and pace is basic in the early stages of the re-education of self-awareness.

**The Physical Environment**

The physical setting is also of value inasmuch as it is able to provide cues for orientation for place and time, as well as for person.

The environment in the treatment of the regressed schizophrenic is of primary importance. When setting up a treatment area, the following factors should be borne in mind.

The physical surroundings provide the cues for the patient and should these be ambiguous, they lend to disrupted ego feeling, disorientation and anxiety. Parsons states: “The messages of the environment are clear sanctions on the patient to act appropriately to it, to be violent, or slovenly, or antisocial”.[[35]](#footnote-35)

Physical surroundings can either help or hinder the patient’s recovery and the occupational therapist should, therefore, pay particular attention to the physical surroundings in the treatment area. Cumming and Cumming maintain that furniture in many mental hospitals is arranged in such a way that no interaction between patients is possible.[[36]](#footnote-36) Chairs should be comfortable and arranged in a circle if it is the aim to bring about an awareness of other people. As far as possible, the physical environment must facilitate the treatment of the patient.

For those patients who are disorientated, all cupboards and doors in the department should be marked, and those areas that are for staff only should be clearly marked as such in order to reduce uncertainty.

Chairs should be of general but sensible design, similar to furniture found elsewhere. Smaller types of furniture should be used, as these can be rearranged as the need arises. However, if one is attempting to re-educate ego-identity and self-awareness, a feeling of continuity and stability must be derived from the physical setting, so that the therapist should be extremely careful to see that all the furniture is in exactly the same place for each treatment session.

**Temporal Orientation**

Without the awareness of the patient that he is a stable reference point, temporal orientation is extremely difficult. He appears not to be able to regard himself as a fixed entity in relation to the past, the present and the future.

Many cues for temporal orientation can be provided for the patient by the environment. Asking the patient the date is hardly an adequate way of testing to see if he is orientated in time. Many normal people have difficulty in both dates and days of the week. All cues as to the date are usually absent in a hospital. The department should, therefore, have large calendars prominently displayed with the present date underlined or marked in some fashion. Calendars which are of the type that have a separate day for each day should be avoided because the passage of time cannot be seen. Current newspapers should be displayed which, apart from stressing the date, keep the patient abreast of current trends and affairs.

It is important for the therapist to stress the passage of time for the patient in order to promote continuity of ego feeling. This can be done in the following way: “You came with me yesterday at two o’clock in the afternoon, and I have come to meet you again. Tomorrow I shall also come.” It is essential to be punctual if one arranges a time with the patient.

**Clothing of Therapist**

The clothes of the therapist should remain the same throughout the treatment of the patient. Some people argue that informal clothes have a more desired effect on a relationship with the patient, the candidate is of the opinion that in treating chronic regressed schizophrenics, the therapist should wear a uniform, as a uniform usually creates the awareness in the patient that the person wearing it is a member of the hospital staff, and it also helps to reinforce differentiation between two people in the treatment situation. Large name tags should be worn, as well as the therapist’s professional title.

**Use of Mirrors**

Full-length mirrors should be placed in the treatment area to promote self-awareness and identification, as well as body image, thus giving the patient ample access to his own appearance. The candidate is of the opinion that small mirrors, in which only a certain amount of the body is visible, should be avoided initially until the patient has reaffirmed the concept of the continuity of his body, and that it forms an integrated whole.

**Assessment Form**

In order for the therapist to be able to assess the extent of self-awareness in the patient, the included assessment form was drawn up by the candidate. This assessment form may also serve as a guide to treatment.

**The Method and Conditions for Assessment**

In view of the fact that the schizophrenic has difficulty in receiving messages from the environment, the therapist should remember to speak slowly, having a relatively long time lapse between each demand in order to prevent the patient from becoming confused. The therapist should remain in full view of the patient, and as many disturbing stimuli as possible should be eliminated from the testing area, for example, telephone calls, people walking through the area, music, and similar interruptions.

It is important to note the type of response made by the patient. It may be verbal, a nonverbal one where the patient may merely point in the direction of the body area, or else there may be no response whatsoever on the part of the patient. With chronic patients it may not be possible to assess the awareness of all the body parts during one session due to the distractibility of the patient and the decreased concentration span. The anxiety which accompanies all new situations should also be taken into account.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **TABLE 1**  **SELF-AWARENESS ASSESSMENT FORM** | | | | |
| **BODY PART** | **AWARE** | **NOT AWARE** | **TYPE OF RESPONSE** | **\*LATERALITY** |
| HEAD |  |  |  |  |
| HAIR |  |  |  |  |
| FOREHEAD |  |  |  |  |
| \*EYES |  |  |  |  |
| NOSE |  |  |  |  |
| \*CHEEKS |  |  |  |  |
| MOUTH |  |  |  |  |
| TONGUE |  |  |  |  |
| TEETH |  |  |  |  |
| CHIN |  |  |  |  |
| \*EARS |  |  |  |  |
| NECK |  |  |  |  |
| \*SHOULDERS |  |  |  |  |
| \*ARMS |  |  |  |  |
| \*ELBOWS |  |  |  |  |
| \*HANDS |  |  |  |  |
| \*THUMBS |  |  |  |  |
| FINGERS |  |  |  |  |
| FINGERNAILS |  |  |  |  |
| CHEST |  |  |  |  |
| \*BREASTS |  |  |  |  |
| WAIST |  |  |  |  |
| STOMACH |  |  |  |  |
| BUTTOCKS |  |  |  |  |
| GENITALS |  |  |  |  |
| \*HIPS |  |  |  |  |
| \*LEGS |  |  |  |  |
| \*THIGHS |  |  |  |  |
| \*KNEES |  |  |  |  |
| \*CALVES |  |  |  |  |
| \*FEET |  |  |  |  |
| TOES |  |  |  |  |
| TOENAILS |  |  |  |  |

Once the assessment of the body part awareness has been completed, the following should be assessed:

1. Does the patient know where in front of him is?
2. Does the patient know where behind him is?
3. Does the patient know where next to him is?
4. Does the patient know where below him is?
5. Does the patient know where above him is?

In order to assess i to iii, the therapist can stand in front, behind and next to the patient and ask the patient where the therapist is in relation to him. It is advisable for the therapist to make as much use as possible of her physical self, in this way stimulating an initial awareness of object relationships.

To reinforce differentiation, the therapist can make use of herself in a similar way. If the patient is able to localise his own body parts, the therapist should then ask the patient to localise the therapist’s body parts, asking the patient to touch the area simultaneously. With very regressed patients, the candidate found that there was little response from the patients during this assessment. If this is the case, the therapist can take the patient’s hands in her own, saying: “This is your hair”, putting the patient’s hands on his own hair, and then: “This is my hair”, putting the patient’s hands on the therapist’s hair. One can also introduce colour differences to reinforce differentiation. Later, differentiation should progress to inanimate objects, firstly in relation to the patient and then to each other. Differentiation can be stressed in size, temperature, mobility, colour and function.

**The use of Clothes and Makeup**

By utilising objects that afford the patient narcissistic gratification, the therapist can emphasise body part awareness. An example of this is the therapist cleaning the patient’s face with face cream, and as such facial area is firmly cleansed, the therapist can verbalise and stress the area: “I am cleaning your forehead” and so on. Similarly, lipstick can be used to emphasise the patient’s lips, eye shadow the eyelids, and mascara the eyelashes.

Clothes, including belts, necklaces, earrings, hats, stockings and shoes may be used to give narcissistic gratification to the patient as well, at the same time reinforcing sex identification.

**Object Relationships**

In order to establish the patient’s awareness of objects in the environment, he should be exposed to a battery of objects. Not only should the patient’s awareness of the objects be noted, but also his reaction to the objects and the manner in which the patient utilises the objects. Objects to which he should be exposed should include:

1. Objects which supply the patient with oral gratification:

* Sweets
* Cakes
* Biscuits and cookies
* Aromatic foods such as hot meat, fresh cakes, etc.

1. Objects supplying the patient with anal gratification:

* Clay
* Plasticine
* Thick poster paint
* Mud

1. Objects supplying the patient with narcissistic gratification:

* Makeup of all types, including combs, brushes, nail polish, etc.
* Clothing including hats, shoes, beads, etc.

1. General objects:

* Balls
* Paper and pencils
* Wood
* Hammer and nails
* Cooking pots, etc.

**Summary**

The candidate ascertained that self-awareness consists of being aware of oneself as a separate, finite and differentiated entity in relation to other people and the objects in the environment. The occupational therapist should, therefore, assess the awareness the patient has of his own body boundaries and body parts. Also to be considered is the patient’s awareness of differentiation between himself, others and the objects around him and the manner in which he utilises the objects of which he is aware. The concept of re-educating awareness is based on the narcissistic gratification the patient derives from his body. The need for physical handling by the therapist was stressed and simultaneous verbalisation in order to emphasise the body area.

**Chapter 4**

**Case Study of One Patient**

The candidate was dependent on the psychiatrist’s professional opinion as to which patient would be suitable for the treatment.[[37]](#footnote-37) Five patients were selected, all severely regressed and not sufficiently integrated to be subjected to tests by a psychologist.

The fundamental characteristics manifested by these patients were little reaction to outside stimuli, for example, response to someone addressing them; they showed an inability to care for themselves in the form of dressing and personal toilet; and the average stay in the hospital was thirty-six years. The personal files of the patients stated that they were poorly orientated to time, place and self.

On assessment by the candidate, following the suggested scheme in Chapter 3, on page 12, three of the patients were more integrated than the remaining two, inasmuch as they were able to localise body parts and areas, although exhibiting a relative disturbance of body image, for example, one patient pointed out that she had corns on her feet and then added that although the feet belonged to her, the corns belonged to another patient in the ward “who had bewitched her”.

Intensive treatment was given to the remaining two patients and the candidate wishes to give a report on the treatment of the most severely regressed patient in the group.

**Treatment Report of Miss X**

Name: Miss X

Born: 1912

Admission: 5th April 1931

Diagnosis: Schizophrenic Reaction. Catatonic (Stupor) Type.

Clinical case history: No personal details were available. On admission, the following was noted: Psychomotor retardation; vacant appearance; restless behaviour; dulled consciousness; poor attention span; disorientation to time and place; no insight; persecutory delusions.

The patient was diagnosed as Dementia Praecox Catatonia.

From the fifteenth of the third month 1949 to the eighteenth of the third month 1949, the patient received four Electro Convulsive Therapy Treatments but otherwise received no intensive psychiatric treatment apart from medication.

During the course of her stay in the hospital, the patient was found to be mute, negativistic, inaccessible and withdrawn. The patient’s habits were found to be faulty and lacking in bowel and bladder control. In his report of the third of the fourth month 1968, the psychiatrist reported the following: The patient was mute although indicating awareness of his presence. The patient had to be dressed and was wet and dirty in her habits.

N.B. From 1932 the patient was reported to be mute.

Drugs: Stelazine.

**First Session**

The candidate arranged with the nursing staff in the ward to fetch the patient at 9.30 every morning and again at 2 o’clock each afternoon.

When the candidate arrived at the ward, the patient was pacing in an agitated fashion in the yard behind the duty room. There was no apparent response by the patient to her name being called. When the candidate approached her, she turned in the opposite direction. The candidate then once again approached the patient, placed her hands on the patient’s shoulders and said: “Miss X, I’d like you to come with me.” The candidate then held the patient’s hand, saying: “I’m holding your hand in mine.” Pressure as in a handshake was exerted on the patient’s hand. The patient did not respond.

On arrival at the testing area, occupational therapy department, the patient appeared to be anxious in that she began adopting her manneristic posture by crossing her arms across her chest and making unintelligible noises. She sat only when led to the chair. The other patients were already in the department when the patient arrived, however, the patient paid no attention to them. The rest of the patients were assessed by the candidate for body part awareness and Miss X was the last to be assessed. There was no response at all by the patient in the assessment of body part awareness. She appeared to become even more anxious. Consequently the patient did not respond to the spatial relationship test. The patient demonstrated no response to the exposure to various objects which included clay and clothes. The candidate then picked up a sweet in her hand and said to the patient: “I have a sweet in my hand. Take it with your hand and put it into your mouth.” In this way the candidate was attempting to stimulate:

1. object awareness
2. differentiation
3. body part awareness

The patient took the sweet and ate it, this being her first response. At no time during the treatment did the patient make any spontaneous movement towards any object to which she was exposed without prompting by the therapist. If the therapist’s interpreted the situation for the patient and acted as a mediator between her and the object, there would be a response, such as with the sweet. The candidate then praised the patient by saying: “I am pleased with you.” The session was then terminated. The candidate returned the patient to the ward, repeating the procedure followed when the patient was met. The patient was told that the candidate would fetch her at two o’clock that afternoon.

**Second Session**

In the afternoon the patient was fetched by the candidate. The same procedure of the morning was followed; the candidate using the assessment sheet, excepting that the candidate would touch the body part mentioned when asking the patient to respond. It was only when the hands were mentioned that the patient made any response. A slight movement of the hands occurred in the lap of the patient. This was the first time the patient demonstrated any body awareness. The candidate said she was pleased with the patient and held a bowl of sweets in front of the patient. There was no response and the same patternas adopted in the morning followed and was successful.

The candidate was of the opinion that the patient had established one body area, namely the hands. After this positive response, the demands were framed as follows: “Miss X, put your hands on your hair.” “Miss X, put your hands on your face.” Other body parts, such as chest, legs and neck were incorporated in the same way. The patient did not respond and the candidate took the patient’s hands in her own and placed them on her hair, saying: “Miss X, your hands are on your hair. Feel your hair with your hands.” Had the patient responded, the candidate would have attempted reinforcing differentiation which would have taken the form of the candidate asking the patient to feel the former’s hair, face and other body parts, but this would have been premature at the time as the patient had not yet established her own body boundary or identity. The patient became restless and adopted her manneristic posture. She was returned to the ward. The patient was told that she would be fetched the next day.

**Third Session**

The patient was walking back and forth in the area behind the duty room. There was no response when her name was called, but when the candidate approached and asked the patient to place her hand in that of the therapist, the patient did so.

On arrival at the testing area, the patient appeared to be anxious, in the same way as previously mentioned. The therapist led her to the chair and asked her to sit down. The patient proceeded to bow her head and place her arms across her chest. After calling to her by her name several times, the patient responded to her name by looking at the therapist. The candidate proceeded to reinforce body parts, by simultaneous mentioning of the part concerned and touching the area firmly as had previously been done. The patient’s hands were placed on the area concerned by the therapist.

The candidate decided to afford the patient narcissistic gratification from her hands, as this was the first area recognised by the patient. This was done in the following way: the hands were placed into those of the candidate and hand cream was rubbed firmly into them. In this way, sensory stimulation of the hands was increased. The candidate then expressed her approval of the patient’s hands. A bottle of nail polish was held in front of the patient. There was no response from the patient. The candidate then proceeded to unscrew the bottle top and hold the brush out to the patient. The patient made no response to this gesture either. The candidate asked the patient to place her hands in those of the therapist. The patient responded by doing so. The cuticle on each nail was pushed back firmly, the candidate saying simultaneously: “These are your nails.” Then each nail was painted and the candidate said once again: “These are your nails.” The candidate used the same phrases as frequently as possible. The patient appeared unconcerned but as soon as the therapist had finished, she placed her hands over her face. She became agitated, adopting her habitual posture and was taken back to the ward.

**Fourth Session**

The patient was fetched from the ward. She did not respond to her name being called but placed her hand in that of the therapist when requested to do so.

On arrival of the patient at the department, Miss X went to her chair and sat down without being led to the chair. The therapist adopted the usual procedure, stimulating awareness of body parts. There was no marked change, however, the patient extended her hands towards the candidate when her hands were mentioned.

The candidate decided to try and reinforce awareness of body parts by another method during this session. A comb and a tube of lipstick were placed before the patient. The patient made no movement towards the objects at all. The candidate then placed the comb in the patient’s hand and said: “This is a comb. Comb your hair with it.” The patient then proceeded to attempt to comb her hair. Pleasure was verbally expressed by the candidate. A tube of lipstick was then placed in the patient’s hands. The candidate then said: “You have lipstick in your hand, put some on your lips.” The patient attempted to do so.

N.B. It appeared that the patient could localise body areas if she were given an object normally related to it. This was also noted in one of the other patients.

The patient became restless and began pacing up and down in the testing area. She was returned to the ward.

**Fifth Session**

The patient was fetched from the ward. She responded in manner noted the previous day.

The candidate continued with the same procedure. The patient’s only response being an extension of her hands towards the therapist’s when asked to localise her hands.

The candidate placed the patient in front of a full-length mirror to see if the patient could identify herself. The candidate stood next to the patient. The patient became extremely anxious. She began to groan and adopt her habitual posture. She then walked away from the mirror and out of the room, which had a door leading into the garden. She could not be restrained and was subsequently taken back to the ward.

**Sixth Session**

The patient was fetched from the ward. She responded to the candidate calling her name, and waited for the candidate to approach her. On request, she placed her hand in the candidate’s hand. The patient was taken to a boutique operated by the occupational therapy department in the hospital. It was the therapist’s intention to attempt to stimulate body part awareness by affording the patient narcissistic gratification by utilising clothing and also to attempt to ascertain that, if showing the patient objects normally relating to body parts, the patient would be able to localise the concerned parts more easily. This method was coupled with one adopted earlier, that is, simultaneous mentioning and touching of body parts and placing the patient’s hands on the mentioned area.

The patient appeared agitated in her new environment. She adopted her habitual posture, already mentioned. The candidate led her to a chair and asked her to sit. Shoes were placed in front of the patient. Only one pair was presented to reduce tension and anxiety in the patient by having to make a decision. The patient was asked to remove her shoes. There was no response. The candidate subsequently removed the patient’s shoes and said: “Miss X, these are your feet” and simultaneously touched them. “Show me your feet.” The patient did not respond. The candidate held out the new shoes to the patient and said: “Where are your feet?” The patient moved her feet slightly towards the shoes. The candidate then placed the shoes on the patient’s feet and told the patient to stand up in her new shoes. The patient did so, and the candidate expressed admiration by stating: “Your feet look pretty in your new shoes.” A hat was then chosen for Miss X and given to her. The patient made no response and the candidate placed the hat on the patient’s head, simultaneously verbalising that she was doing so. She once again expressed admiration. The candidate placed the patient in front of the mirror and gave the patient a tube of lipstick. The patient was then told to put some on her lips. Without looking in the mirror, the patient did so. She became extremely anxious and agitated. The candidate took her back to the ward. The patient once again adopted her characteristic posture. The therapist pointed out that “Ladies walk with their arms at their sided”, as demonstrated by the candidate. The patient put her arms at her sides. She was returned to the ward as she appeared to become agitated. She was told that the therapist would fetch her the following day.

N.B. It was reported to the candidate by a nursing aide that the patient looked at her shoes and began to dance when the radio was turned on prior to the midday meal. It appeared that, during and directly after the session, she was extremely pleased with her new acquisitions.

The candidate expressed the wish to the nursing staff that the patient be allowed to wear her shoes every day.

**Seventh Session**

The patient was duly fetched from the ward at the appointed time. She responded to the candidate calling her name by walking towards the candidate. On request, she placed her hands into those of the candidate. The patient was taken to a table on which were placed a large amount of plasticine and a large bowl of purple poster paint. There were also large sheets of white paper. The patient made no spontaneous movement towards the objects on the table. The candidate broke off pieces of plasticine and gave them to the patient. The patient placed them on the table. The candidate then dipped her fingers in the bowl of paint and began finger painting. She extended an invitation to the patient but there was no response. The candidate then gave Miss X a paint brush and said: “Here is a paint brush, you can paint with it. Put it into the paint and paint.” The patient then placed the brush into the paint, transferred it to the paper and began making a number of strokes on the paper. She became agitated and the candidate, knowing that the patient did not smoke, offered her a cigarette. The patient did not respond and the candidate persisted in holding the box in front of the patient. For the first time in thirty-one years the patient spoke: “Don’t smoke.” The candidate removed the cigarettes and asked the patient to paint a little more. The patient became extremely restless and agitated. The candidate attempted to place the responsibility on the patient and said: “If you do not tell me what is wrong, I can’t help you.” The patient replied: “Don’t want to paint anymore.” Once again the same approach was used and the patient was asked if she wanted to return to the ward. She replied in the affirmative and was duly returned to the ward.

**Eighth Session**

The patient was fetched from the ward at the appointed time. She responded to the therapist’s voice and placed her hand in that of the candidate. Miss X was taken to the department and reinforcement of body parts was done according to the assessment for. Once again the candidate started with the hands. There was no voluntary response from the patient except for an extension of the hands towards the candidate.

Miss X was placed in front of a full-length mirror. The candidate told the patient that makeup was to be applied. The patient became extremely agitated in front of the mirror; got up from her chair and started making unintelligible noises. The candidate asked the patient what was wrong and said that unless the patient told her, she was not going to be able to help her. The patient replied: “Want to go back.”

The patient demonstrated such excessive agitation that the candidate took her back to the ward.

N.B. Each time the patient spoke, there was no use of the personal pronoun.

**Final Assessment**

1. **Body Part Awareness**

Body part awareness was improved when objects relating to the body part were presented to the patient. The patient would respond when asked where her hands were. No spontaneous movement was made when any other body area was mentioned.

1. **Response to Objects**

The patient made no spontaneous movement towards objects at any time during the treatment. She would only respond if the meaning of the object was interpreted for her.

1. **The Patient’s Response to the Candidate**

Initially there was no response to the therapist’s voice or any physical response to the therapist. In the final assessment, the patient looked at the candidate each time the candidate spoke, and her eyes followed the candidate as she moved about the ward. The patient had been reported to be mute and inaccessible in the ward for thirty-one years. Her verbal response to the candidate was considered to be a break-through by the psychiatrist.

The patient adopted her habitual posture much less during the latter stages of the treatment scheme, although the candidate did have to remind her often that: “Ladies walk with their hands at their sides.” In this way the candidate was appealing to the healthy part of the patient’s ego and also not accepting overt abnormal behaviour from the patient.

**Comments**

One must remember that this patient had been hospitalised or “institutionalised” for thirty-seven years. Not once during that period had she received any psychotherapy and occupational therapy. The patient had regressed to such an extent that she had no bladder or bowel control; would masturbate incessantly if left on her own, and had not spoken at all for thirty-one years. She had to be bathed, washed and dressed every day by a ward attendant.

In view of the fact that the patient had only eight treatment sessions with the candidate, her progress, although extremely limited, was not considered valueless. This patient needs intensive treatment over the period of a number of years.

In his last report, the psychiatrist prescribed the continuation of the treatment.

**Conclusion**

The candidate has arrived at the conclusion that an intensive treatment scheme involving the suggested techniques or modifications thereof has potential with regressed schizophrenics. Basic to the successful implementation of the scheme is, however, treatment over a long term by the same therapist.

The candidate regrets that the time available was the most stringent limitation. In view of the fact that the patient discussed had been institutionalised for thirty-seven years, it is obvious that the time spent with this patient was hardly sufficient. With the hospitalisation of many chronic patients, abnormal pathology is accepted as “normal” by many of the hospital staff, and consequently the pathology becomes reinforced by the acceptance of its manifestation. When treating these patients one has, therefore, not only to contend with the basic symptomatology of these patients but also with the effects of a detrimental environment.

The loss of personal effects, the effects of long term medication and the sharing of communal clothing, as well as the stereotyped hairstyles for these patients, contribute pathetically little to the awareness of the patient that he is, in fact, unique, separated and differentiated human being with dignity and worth. The “institutional neurosis” as described by Barton has probably a more devastating effect on the long term patient than the actual illness itself.[[38]](#footnote-38) Were the environment conducive to the maintenance of the intactness of the patient, the question of the need for a technique of stimulating self-awareness arises. However, in view of the fact that this is a serious defect in the present system of hospitalisation, the need presents itself as a very real and important one, and an area in which the occupational therapist is perfectly capable of making a valuable contribution to the health of the chronic, regressed schizophrenic.

The literature available on the chronic type schizophrenic reaction, body boundaries and object relationships was found to be quite adequate for research. Literature pertaining to ego disintegration was thorough and easily obtainable, yet literature relating to specific treatment by the occupational therapist in this sphere was sadly lacking. It is the candidate’s sincere desire that the occupational therapist should immediately begin research to ascertain scientific methods for the treatment of the regressed schizophrenic, and that as much literature as possible be published by the occupational therapist who has the privilege of working with these forgotten people, who constitute the bulk of the population in mental hospitals, so that many can benefit from the experiences of the practicing therapist.

If the candidate had the opportunity of starting this project anew, alterations to the basic assessment scheme would be made. From the research done by the candidate, it was found that awareness of the hands was the first to be consolidated. It is, therefore, presented as a tentative suggestion, that the therapist who plans to execute this technique should emphasise the patient’s hands from the initial stages of the treatment.

A factor which emerged was that mirrors should be used with discretion. As noted in the case study of Miss X, the patient became extremely agitated when confronted with her image in the mirror. The candidate thought that this may possibly be due to the fact that the patient’s identity was not yet established; that the patient’s object relationships may have been confused, or that her own image may have been distressing to her.

Although there was little marked improvement, the candidate does not think that this is cause for concern, as the candidate is convinced that this was due to severe limitation of time.

If more time had been available, many other types of stimuli would have been used to stimulate self-awareness in this patient. Activities such as swimming, where the whole body surface is subjected to the impact of cold water, would have been used. In order to offer an opportunity for the realisation of other persons, it is suggested that resisted exercise could have been introduced in pairs, each patient resisting specific movements performed by the other. The routine schedules of free physical exercises could be employed where the patient is required to imitate the actions of the therapist. Of necessity, the therapist would have to verbalise during these exercises, stressing body parts through speech.

It is, however, important to note that even within the very limited and totally inadequate scope of eight intensive occupational therapy sessions, the emergence of self-awareness was apparent in Miss X. For the first time in many years the patient began to be aware of the fact that she had hands, that objects could be purposefully employed in relation to herself. The emergence of the self-awareness and the delicate unfolding of “directional poise”[[39]](#footnote-39) of the patient was the most thrilling moment experienced by the candidate.

If the practicing occupational therapist should desire to grade her treatment according to the levels of the personality reconstruction scheme suggested in the first chapter, it would be necessary that the occupational therapist should have defined exactly what characteristics in the patient would be significant differentiating factors for each stage. In this way, the patient could be in one of the six stages, in this case, the stage of self-awareness.

Considering the advances continually being made in psychiatric medicine, it is essential that the occupational therapist in this field should employ equally scientific methods if she wishes to function in a paramedical capacity.

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