TRANSIENT FUNCTIONAL THOUGHT DISORDERS: A COMMON PROBLEM AND ITS TREATMENT

by

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ABSTRACT: Transient disturbances in effective thinking and coherent reasoning are a widespread manifestation of irrational anxiety among neurotics and "normals". Two clinical cases illustrate the problem and the necessary elements for treatment. A key feature is learning to separate feelings from thinking.

INTRODUCTION

A common, but not well understood, problem in psychotherapy is the powerful and pervasive effect that feelings have on the ability to think and to function effectively. Despite general acknowledgement that feelings often push people to say and to do things that they otherwise might not, even seasoned professionals do not often enough realize the extent to which feelings distort our abilities to assess reality, to organize our thoughts reasonably, and to speak rationally.

Though much is written about disorganized thinking in the psychiatric literature, discussions are usually focused on organic brain syndromes such as dementia, on psychotic disorders such as schizophrenia which are typified by disturbances of speech, communication, and thought, or on pseudodementia syndromes associated with major depressive disorders, particularly in the elderly (1).

Descriptions of thought disorders can be found relating to groups of patients who function at a level above those mentioned above. Clinicians have often noted associative drift and sporadic reasoning problems in borderline patients during interviews or therapy sessions where little structure is provided. However, when subjected to highly structured testing such as the Wechsler Adult Intelligence Scale, these persons show ordinary reasoning and communication (2). Singer and Larson (3) found a greater global index of disordered thinking in groups of borderline persons than in normals or neurotics on projective tests such as the Rorschach. They concluded that thought disorganization in borderline patients reflects an inability to maintain a focus, to reason realistically, and to perform consistently when structure is not provided by the task itself or by another person, i.e. the thought disorder is related to the absence of extrinsic structures to help them define

their boundaries.

Thought disorders are not generally known to be associated with people who function at the higher end of the spectrum of personality organization, i.e. those considered to be neurotic. This phenomenon is, therefore, only rarely and indirectly addressed in psychodynamic writings and limited to confusion that exists in psychotherapy patients due to very intense or psychotic transference reactions toward the therapist. In psychoanalytic literature, disabilities in thinking, when mentioned at all, are discussed in terms of adaptive defenses. Disturbances in thinking are explained as behavioral attempts at avoiding the psychic pain of dealing with intrapsychic conflict. Giovacchini (4) touches on the subject as one of a variety of techniques and defenses which the ego musters in an attempt to rid itself of extreme anxiety. He discusses such derangements as dissociation in an otherwise well integrated ego, confusion of reality with transference feelings, or resistances to free association, each in terms of their impact on the analytic process.

Basch (5) comes closer to describing thought disorders among neurotics, suggesting that within the therapeutic setting, patients may actually suffer from what he describes as "functional brain damage". He explains difficulties in thinking as being related to a

limitation in a person's perceptual set, i.e. that one's experiences and the way one interprets them build up patterns of expectations, often unconscious, which one uses to adapt to new situations. In other words, one can only see what one is prepared to see. Basch describes a patient who presents problems to his therapist which have several obvious viable solutions, yet he seems incapable at arriving at any. Basch's explanation for his patient's apparent inability to solve problems is that the particular situation touches on experiences which the patient "needs to avoid". The patient is thus limited in what he is able to perceive and utilize in addressing the problem by an inadequate perceptual framework which is geared to avoiding rather than taking in information. He describes the therapist's task as one of restoring or promoting the ability to experience and organize that which had been selectively eliminated from recognition during development.

But the problem of functional thought disorders is far more common than that. Transient Functional Thought Disorders (TFTD) refers to temporary disabilities in concentrating, in thinking effectively and productively, in reasoning coherently, or in assessing reality objectively. It relates directly to the degree of anxiety present, and is much more disabling and prevalent than an extensive review of the literature indicates.

Temporary, but frequently recurring, thought disorders are not limited to the therapeutic setting and not limited to patients diagnosed as having organic brain syndrome, schizophrenia, pseudodementia, or borderline personality (6). Transient thought disturbances are one of the most common and disabling expressions of anxiety--affecting most people, even high functioning neurotics and "normals", at some time (7).

This paper addresses the ubiquitous nature of Transient Functional Thought Disorders and discusses its root causes and its treatment. TFTD's manifest primarily in two ways:

1. as a disintegrative process where gross confusion occurs, and

2. as a ruminative process where preoccupied musing produces seemingly comprehensible language, but severe impairment of intellectual functioning nonetheless exists. This is the result of cyclical busyness with thinking that is bereft of actual thoughtfulness.

The following vignettes illustrate the problem and the therapeutic work required to overcome it. A central feature of the task is learning to separate feelings from thinking.

CASE 1:

Emma is a 37 year old computer programmer who has

been in individual and group psychotherapy for almost a year. Employed by the same firm for fourteen years, she works hard to accommodate her employers and has been promoted to positions of increasing responsibility. She speaks haltingly and cautiously, always on guard against saying the "the wrong thing". Polite and socially appropriate, she readily engages people in conversation. Although her manner is outgoing, she frequently appears to have a far-away look, reflecting her tendency to withdraw into herself.

Emma's parents were emotionally distant and narcissistically involved with themselves. As hard as she tried to please them, she found them critical, remote, and unpleasable, her mother more so than her father. The youngest of three children, little was expected of her as she grew up. She was rarely encouraged to push herself to function at a level beyond that which was comfortable or easy for her.

Despite Emma's propensity to keep lists, she is disorganized, and has difficulties with concentration. She monitors her personal time and money poorly. Her financial status is in disarray; she is in debt to family, friends and a number of creditors. From the beginning, Emma also has had significant difficulty arranging her finances in order to pay for her therapy. During the last session of the month, and before her

regular payment was due, she proudly announces that in an effort to plan ahead, she would like help in figuring out her bill, though she usually arrives at the sum herself. She now asks her therapist for the total of the statement, explaining her difficulty in calculating it due to an additional half session she had had last week.

Therapist: Apparently, you have kept track of the sessions, so what is the total?

Patient: That is what I asked you. I don't know.

Therapist: How about you figure it out.

Patient: I tried, but I can't. (Her eyes widen--she shifts about in her chair and starts pulling on her fingers.) I mean, I did, but now I don't. (Pauses again and gazes down at her feet.) It doesn't work anymore. See July, well, it was a long month besides I had that extra car payment because I fell back a month when the refrigerator broke... (Her eyes well up with tears, she stares blankly out the window with a distant look in her eyes and becomes mute.)

Therapist: Emma, where are you going? What is happening to you?

Patient: (Long pause) I don't know. (Mumbles something unintelligible.) I don't know. I just feel stupid. I'm...(She continues to berate herself in a

muttering tone as she repetitively tugs on her fingers. She is pale.)

Therapist: Emma, stop and look at me. Take a breath of air.

Patient: (Takes a deep breath, pauses, and looks briefly at her therapist before her eyes move downward.) I forgot your question. (Pause) I think I'm confused.

Therapist: O.K. I'll wait for you. Let me know when you are ready to continue.

Patient: (She looks up and seems to see her therapist for the first time since this topic came up.) I'm ready.

Therapist: Good. You want to know what your statement should read this month. What do you figure?

Patient: (Long pause, but continues to look at the therapist.) The usual for five weeks plus the charge for an extra half session.

Therapist: Go ahead. (A cloud again appears to come over Emma's face. She looks away, then starts to take out pen and paper from her purse.) Emma, look at me. You don't need that. I'm certain that you can figure this out in your head.

Patient: (Faintly, with a crack in her voice,) I can't. This is... I... I lost my insurance form that Blue Cross sent but the new one didn't come yet but I can

get... I don't understand. I can't do this stuff under pressure. There's always too much pressure. It's... (Pause) I would have to divide $75 by two. Umm... I... $42.50? I don't know. (She again looks down and stops speaking.)

Therapist: It will be easier for you to think if you stay with me. Don't retreat into yourself, even if you are embarrassed at the moment. (Emma looks up.) Check your figures.

Patient: I... I feel so stupid. I hate this. I can't think straight. (Slightly annoyed and louder than before) What do you want from me? (She pauses, never breaking eye contact, takes a breath and continues.) O.K., O.K. already, let me think. Two goes into seven three times... (Her voice trails off, but she maintains eye contact.) $37.50.

Therapist: Are you sure?

Patient: Yes.

DIAGNOSTIC OBSERVATIONS:

Emma's behavior can be explained on the surface as manipulative helplessness reflecting her transferential wishes to be cared for by her therapist. Her distorted self-image results in her seeing herself as essentially stupid or worthless during this exchange. Though correct, these psychodynamic formulations do not account

for the disintegrative process that was illustrated.

Seemingly inexplicably, Emma becomes tongue tied and confused. As soon as the therapist returns Emma's question unanswered, her anxiety starts to swell. What may well have started out as a simple, neutral inquiry on her part, leads to temporary mental deterioration. Her reaction is immediate, automatic and massive, plainly evident in her wide eyes, repetitive bodily movements and grossly inadequate intellectual response. The content of Emma's language is disjointed and often incoherent as she begins to recede into her shell, breaking contact with her therapist and with the rest of her environment, staring off into space. The confusion that follows cannot be explained as merely a transferential response to her therapist. In fact, she becomes at times almost unaware of her therapist's presence. Her anxiety is lessened as she withdraws into herself, tugging on her fingers and muttering, as if she were alone in the room.

Observation of her regressive, repetitive body motions and the disorganized pattern of her thought and speech would lead one to describe her as psychotic-like, if one were to describe her based on this brief interchange alone. Though she has the capacity to function at a much higher level, and usually does, this type of temporary mental disorganization typically occurs in her day to day life and in large part accounts for her

chronic disabilities in handling time and money. More than simply acting out a wish to be taken care of, Emma's anxiety seriously interferes with her ability to think, to reason, to assess reality and to calculate. She is genuinely confused.

THE ROLE OF IRRATIONAL FEAR:

There is no question that the patient has the intelligence and mental capacity to do the simple arithmetic required to figure her bill. Like many other normally competent and intelligent people, Emma not infrequently finds herself unable to communicate in response to real or imagined verbal challenges or criticism. Massive anxiety or irrational fear, the subjective residue of events from early life and not at all fitting the current situation, is stimulated by what is felt as an actual threat. In such a moment of panic, she mentally escapes the situation by becoming numb and confused. It is as if she mentally faints, much as a person might collapse physically in response to extreme pain or a life threatening situation.

Such confusion is experienced as a direct threat to one's core sense of self. A raw and frightening sense of vulnerability commonly accompanies such an exposure to one's own irrationality. The anxiety and shame associated with such mental disturbances are often

experienced as intolerable, and lead to rationalizations and other, often unconscious, facesaving maneuvers. For example, Emma tries to cover her confusion with subjectively important but irrelevant facts as she rambles about the length of the month of July, car payments, and her refrigerator breaking down. She repeatedly retreats into herself as her anxiety and embarrassment increases. Her unintelligible mumbles are desperate attempts to reestablish control and thus minimize the anxiety of the moment.

THE ROLE OF SELF INDULGENCE:

Although irrational fear is the major component that underlies transient thought disorders, a second factor also often plays a role. When a person's anxiety level is relatively low, either because it is well bound defensively or as a healthy result of effective psychotherapy, there is room for self-indulgence. A common pathologic aspect of even many "normal" people, self-indulgence refers to conscious or pre-conscious willful regression at a moment when one is not dominated by irrational fear. It is frequently expressed emotionally as wallowing in hurt or anger, and behaviorally it may appear as a refusal to act competently.

Children who have been allowed by parents or

circumstances of their life situations to cling to the delusion that someone will always be available to care for them and gratify their wishes, grow up with a significantly underdeveloped sense of self-discipline. They usually function at a level well below their capacity, limited by their resistance to accept responsibility for themselves. Such unwillingness to attend to the demands of reality appropriately may be played out on various levels of consciousness. It always interferes with the development of self sufficiency.

Self-indulgence takes many forms, one of which is a refusal to think. Confusion based on self-indulgence often looks the same as that based on fear, though the former represents a defiance against exercising one's ability to think, rather than an actual, albeit temporary, incapacity to do so.

Early in this exchange several physical signs indicate that the patient's confusion is primarily fear based; the eyes widen, the skin blanches, and the breathing becomes shallow. These autonomic reactions are characteristic responses to acute fear, in this case due to an internal process as there is no real danger to the patient at this time. Towards the end of this exchange, these reactions subside and Emma is less withdrawn, indicating less fear. Though her speech is still disconnected, as indicated by the introduction of

unrelated information such as the lost Blue Cross form, she remains involved in the relationship. She ultimately responds with annoyance and impatience directly at the one who confronts her. This expression of anger indicates that, at least for that moment, a sufficient sense of safety exists. Only then can self-indulgent wishes be expressed.

The therapist's interventions have two main objectives:

1. to help the patient separate her archaic and irrational fear from the reality of the current situation, and

2. to push her beyond her habitual resignation and preconscious refusal.

In Emma's case transient thought dysfunction arises mostly from an overload of anxiety, therefore it is first necessary to help the patient realize that reality does not corroborate her sense of utter rejection and total worthlessness. This causes irrational fear to subside for the moment, affording the patient the freedom to think. The second intervention can only be effective once she recognizes her confusion and the anxiety that underlies it, at least cognitively.

A basic element of this process is a therapeutic framework which the patient experiences as emotionally safe. Though Emma initially withdraws in fear, the

therapist continuously works toward maintaining contact with her. The therapist's forceful interventions into Emma's pressured and disconnected process, i.e. "Emma, stop and look at me, take a breath of air", are intended to interrupt the flow of emotions, in the midst of which the patient feels like a rejected child, and allow her mature and thoughtful self to emerge. Interfering with the self-berating process affords her the opportunity to begin to engage her self-observation and reality testing, i.e. that she is, in fact, a capable adult woman in her doctor's office, tallying up her bill. Interpretations related to the content of her distracting language would be detrimental at this juncture as they would reinforce her confusion by masking the fact that despite her verbal productions, she is not making sense.

Emma's statement, "I forgot your question, I think I'm confused", is the first step toward recognition that her feelings have been at the helm of this interaction. Her cognitive awareness of the confusion indicates that fear is no longer blurring the self-observation process. The therapist recognizes this shift and uses this opportunity to ally herself with the patient's healthy ego functioning by joining Emma's attempt to extricate herself from her confusion, assuring her by saying "I'll wait for you". Emma feels safer. She is again beginning to be able to reason and be thoughtful.

Fear is deeply rooted and the sense of safety is tenuous. Emma's embarrassment, another form of fear, repeatedly intrudes. As she tends to drift off into herself again and again, her contact with the therapist acts as the grounding wire to the world around her. Reminders to see the therapist and to not break visual contact are one concrete way to help keep her involved in the here-and-now and outside her shell. Much as a parent rouses a frightened child out of a nightmare by turning on the lights, showing him his room, and talking to him in a familiar and calm voice, so the therapist imposes reality to rouse the patient out of her confused and withdrawn state.

By the end of the present vignette, Emma begins to be impatient with her regressed self, and annoyed at her therapist whom she experiences as pushing her to do something that she feels incapable of doing. By maintaining pressure on Emma to think, the therapist elicits anger from the previously numb patient. Such momentary behavioral change is both desirable and necessary since it is a precondition for a vital inner shift from fear, self-denigration, and resignation to reality based annoyance, self-assertion, and self-respecting protest. Appropriate anger without breaking contact with others is a healthy adult reaction to noxious stimuli in the here-and-now, and it provides a

sense of one's own power.

This shift inside Emma is made possible here by the therapist's emotional "holding" of the patient with her eyes and voice. Emma's rising anxiety has ebbed. Her self-indulgent refusal has also come out into the open and been given an adult voice. Like an athlete who knows that his trainer will go the extra mile with him, so Emma accepts the push and forces herself beyond her feelings. This is one small step in the long process to reduce the internal pressure caused by anxiety that too often paralyzes Emma, as it regularly does to many others like her.

CASE 2:

The following vignette represents a more subtle form of thought disturbance than the scattered thought processes illustrated above. Ruminative thought dysfunctions are generally more coherent and organized and therefore more comprehensible, at least superficially. Nonetheless, they too, represent distorted thinking and are equally non-productive intellectually.

Mike is a 32 year old, highly intelligent law student who sought therapy several years ago because of difficulties in his relationships with women. An

entrepreneur, he has amassed substantial wealth by buying, managing, and selling real estate. Despite his business savvy and inherent intelligence, it is frequently difficult to engage him in conversation since he typically speaks as if he were addressing an audience.

Mike is an only child, born to very young and immature parents. The family moved many times as he grew up such that he changed schools and neighborhoods almost annually. He rarely found anyone with whom he could talk honestly or freely, or share his inner thoughts. As such, he has lived an isolated existence, finding more comfort in having private conversations with himself than with others. He enjoys playing chess in his head, though he rarely finishes a game.

During the course of therapy, Mike has slowly begun to trust his therapist and members of his group as people who might be helpful to him in his struggles. He is beginning to reach out and seek the advice of others, though he still frequently gets lost in his own words and thoughts, at times leading to considerable disability in conveying his ideas to others.

In a recent group therapy session, Mike sat silently with the conscious intent of asking for help with a problem that was causing him much anxiety. He fidgeted as he waited for "the right moment", as always. Another patient, Rick, was talking about consulting a divorce

lawyer after a prolonged and painful struggle to salvage his marriage. There is a brief lull as Rick pauses momentarily to blow his nose. As he is about to continue, Mike interjects.

Mike: (Speaking loudly, stiffly and looking at no one in particular) Good morning everyone. I want to tell the group something.

Therapist: Easy, Mike, easy. Did you notice that Rick was in the middle of a sentence?

Mike: Yes but, o.k. Well, sorry. (He continues with the awkward formality of a pre-recorded message) I mean I just want to tell the group something, to get help with this problem. (His forehead furrows. He leans far forward and continues in a tight and monotonous voice.) I just want to tell the group that I don't think I did well on my exam and I was thinking of asking the professor if there was some way of re-testing me since I am sure I know the material. I mean I know that I don't know how I did since we won't get it back until next week but...

Therapist: Mike...

Mike: (Continues, apparently oblivious to the therapist or the other patients, with gravity in his voice and intense seriousness on his face) I've been thinking about this a lot and I figure that if I can, I

really ought to re-take it since in the long run it would probably do me good, that is, in terms of maintaining my standing, even though I don't really want to sit for another exam, but I suppose I could...

Therapist: (Louder) Mike. Stop.

Mike: (His back stiffens as he becomes flushed, then pale. His body is very still except for his left foot which begins to tap mechanically as he pushes past the therapist's words.) The other thing is that I don't know exactly what, I mean, I'm not sure of, you know, how to ask the prof so I want to talk to the group. I thought if I brought it up here first even if I passed...

Rick: For Chrissake. It's bad enough you interrupt me, but who wants to listen to you going on and on?

Mike: (Somewhat embarrassed, continues, stammering and tapping his foot more forcefully and quickly.) I, I just want to tell the group something so I can get your help. I don't... I want to... Umm... I... Damn!

Therapist: Mike, no point in trying so hard, it doesn't work anyway.

Mike: I think that these things happen where you need to talk about things but you can't exactly...

Therapist: Mike. Don't talk. (Pause) Close your eyes,

(Mike opens his mouth apparently to ask the therapist something, but is interrupted) and don't speak. (Pause. Mike closes his eyes and mouth.) Good morning.

Mike: (Sighing heavily, with eyes closed, in a voice that is much louder than the therapist's) Good morning!

Therapist: (Softly) Good morning.

Mike: (Hearing the contrast in their voices he responds softer and slower) Good morning.

Therapist: (With deliberate slowness) What day is it today? Don't answer, (Pause) take a moment.

Mike: (After a brief pause) Wednesday. (Mike's foot has stopped moving.)

Therapist: (Slowly) Keep your eyes closed. What color shoes are you wearing? Don't answer yet. Ask yourself the question. You may have to move your feet around in your shoes to remember. Take a moment.

Mike: (Longer pause. He relaxes his shoulders which had been raised and braced, and in a more normal, conversational tone) Brown.

Therapist: Good morning.

Mike: (Pauses and sighs) Good morning. (One tear trickles down his cheek. He opens his eyes, first sees his therapist, then looks at others in the room. He addresses Rick.) Good morning.

(Mike goes on to talk in a self observant way about his unfounded fear of failing out of school and his self image as an unsuccessful loner. He later arrives at his own conclusion to wait until next week for the test results and to do nothing regarding the exam at this time. The following week he reported scoring 91.)

DIAGNOSTIC OBSERVATIONS:

Mike's speechifying is explainable psychodynamically as a compulsive and/or narcissistic attempt to dominate the conversation. Though Mike's personality traits are consistent with this explanation, the single track ruminations serve a purpose of their own. Although Mike's words are comprehensible, his unyielding push to speak, as reflected in his gross inattention to the reactions of those from whom he consciously wishes assistance, is evidence of a lack of thoughtfulness. Like the disintegrative process described in the previous case, Mike's unobservant speaking represents a brain that is neither taking in, nor processing, current information. Instead it is forming words to bind irrational anxiety.

Pressured ruminations, verbal outpourings, and circular reasoning are vocalized distractions that come under the guise of rational thought. Closer inspection reveals that the content of ruminations can not be

discussed logically since they are not adjusted to reality. Repeated verbal deliberations by Mike of what to do next help to allay his anxiety, as if he were actually accomplishing something. Though he truly means to be thoughtful, he is so busy talking he does not realize that he is not. Even as he means to use the group as a resource for himself, he is not aware that he is speaking in a way that virtually insures that he will not get the help he seeks. An unfortunate consequence of such busyness of the mind and mouth is that it comes at the expense of the ability to think.

Ruminations and other types of self-absorbed "thinking" are very common, though typically denied or dismissed. The powerful ability of anxiety to overwhelm thinking is not generally recognized. As a result, almost any thought that crosses a person's mind is often mistaken for thoughtfulness. The content of ideas or words born of anxiety thereby gains unmerited importance. Interpretations of the content of material misses the primary purpose that such words and thoughts serve--to bind anxiety in an attempt to ward off experiencing it as global and overpowering. This may be one reason why temporary disturbances in thought are rarely mentioned in psychoanalytic literature. Since the very nature of the methods used in the analytic setting focus on the content of descriptions of primary process dreams and the

disordered thinking of free association, Transient Functional Thought Disorders would be less likely to be recognized.

SUMMARY:

"Learning to really think requires first that we make room for it by diminishing the domain of feelings" (8). The mind which is otherwise occupied by overwhelming anxiety is too busy to attend to this task. To overcome the common disabling condition of Transient Functional Thought Disorders, the following elements are necessary aspects of successful treatment:

1. Recognizing the confusion in thinking and identifying the underlying anxiety.
2. Eliciting the expression of feelings in a safe therapeutic setting.
3. Helping the patient separate his subjective experiences from reality considerations.
4. Pushing beyond the point of resignation.
5. When self indulgence is present, pushing beyond the habitual refusal to progress towards competence.

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