Memo from Dr. Osmond: A Talk About Constancy of Perception with Mrs. D.W.

H. Osmond, M.D.[1]

I saw Mrs. DW again to-day. She was still worried about some of her malperceptions, especially those concerned with the trees outside her window, which were moving gently in the breeze.

I discovered that she has not been having the prescribed niacinamide because until quite recently we have had supply problems — now solved — but this means that she has not been getting one of the more important vitamins for as long or in the quantities which I had supposed.

We discussed her method of coping with the failures in perceptual constancy which afflict her and make her so afraid that worse will come. She was quite frank about this; generally speaking she tries to avoid them. She does not look out of windows if a wind is blowing. When walking in the hospital grounds, she walks looking down at the ground not daring to look up because the branches seem to be grasping and groping towards her. She has seldom dared speak of this because she feared that people would surely consider her to be crazy, even those close to her.

I suggested to her that fearful covert glances might be about the worst way of coping with perceptual inconstancy. She had given me an excellent example of how not to do it, but this left unanswered the question of what would be the best way to cope with her kind of perceptual inconstancy.

It has been clear from listening to her that anxiety seems to be the starting point of many of her malperceptions. She seems to be sure that the sequence of events is that she becomes upset by something and objects at a distance begin to become uncertain. Trees are particularly apt to do this, but they are not the only manifestations of perceptual instability. People, automobiles, buildings, her own face in the mirror can all become unstable. When she is at her best she says "a tree is just a tree", but when she is at her worst, the outside world is infinitely fluid and invasive. When this happens she panics, feels desperate, dares not talk about anything to anyone, and eventually, despairing, makes a suicide attempt. It seems from her story that she has sometimes become catatonic or stuporous and loses her sense

Bryce Hospital, Station 3 Tuscaloosa, Alabama 35401

of space/time completely. She does not know where she is when this happens.

From her account it appears that, generally speaking, things which are close to her are more likely to maintain their stability than things which are far away.

Since perceptual inconstancy triggered by anxiety seems to play a large and harmful part in her illness, I began to ask myself how might this be remedied.

How do we normally adjust to unfamiliar situations which generate anxiety in us, both because they seem less predictable and because they are less constant? Constancy is a construct by which the mind brain produces a steady state world out of the most improbable ingredients. I recall walking from the gangway of HMS Volunteer on to the dock-side at St. Johns, Newfoundland, as soon as we came alongside after three weeks at sea in full Atlantic gales. I had been injured and was going to hospital. To my surprise and dismay the dockside began to heave under me. I felt as if my legs were losing control. It took me a few minutes to realize that they were adjusting automatically to movements of our ship which were no longer occurring. After I had walked about a bit on solid dry land, I no longer noticed the heavings; my eyes and semicircular canals were once again in tune. Mv behavior could have easily been mistaken for drunkenness, which would have been reprehensible in mid-morning even in those stirring days of small ships and submarines.

This is a simple example of the more general question which is: "What are the more general social problems of failures in constancy?" I shall not detail this here, partly because I do not know what they are and do not know where to find a full listing of them, and partly because that is not the intention of this memo. However, I shall suggest two main areas which seem to be separable.

1. Direct Effect upon Personal and Other Relationships. Such relationships and the appropriate methexis depend upon our ability to maintain at least one person steadily in time and space. This is essential if statuses are to be assessed and if manners suited to the occasion and relationships are to be assumed. One sees this erosion of temporo-spatial certainty very clearly in some drunks and in many mentally ill people. Over familiarity and over ceremoniousness are equally harmful to relationships. When one considers just how much judgment one needs to tell a dirty story in mixed company without giving offence, and equally how much judgment is needed to respond appropriately to such a story, it would not be surprising if misperceptions resulted in a variety of social difficulties, some of them corrosive to good human relationships. Inappropriate laughter or a failure to laugh can in a particular context undermine friendship and even make love insecure. I believe that we need to examine a number of EWI records especially in the realms of sensory perception, time perception, and perception of others and then ask ourselves just what the social consequences would most likely be.

2. Less Direct Effects Due to a Failure or Uncertainty about Validating Another Person's Experience. Mentally ill people report that they suffer from being unsure whether some of their experiences are real or not. They, like everyone else, require social validation, and in seeking to obtain this, may make those who do not share their experiences uneasy or even terrified. (Eileen Garrett, the great sensitive, told me on several occasions about her perplexity when her vivid imagery, usually well under control, would get out of hand and intrude upon everyday affairs. This would be more likely to occur if she was fatigued, but sometimes it seemed that these images, indistinguishable from real percepts were generated by the psychic needs of other people, which could be inconvenient). A dramatic example of this need for social validation of unusual or improbable experience is the folie a deux or even more widespread folies where the perceptually disturbed person imposes his/her experience on the perceptually stable person. Much work needs to be done on this because it is the reverse of this process which should be used therapeutically.

At a less dramatic level, the misperceptions of the mentally ill person call into

question, directly or indirectly, the experience of well people and so generate among them feelings of unease which can grow to uncertainty, panic, and terror. This is particularly likely to occur if the mentally ill person is not in the sick role, is older, of higher status, more extroverted, and able to inspire the well person. However, even when all these factors are not present, few of us realize how uncomfortable we become if someone questions or challenges our sensory perception. This can be seen frequently in any test of color vision when a color sighted and a color blind person are exposed simultaneously to the same Ishihara Test Card. One is convinced that the card shows the figure seven and the other sees the figure two. There is no way of settling this until the tester gives the verdict as to who does and who does not have normal color vision.

Few of our patients and fewer of their relatives know much about misperceptions, and hardly any of them know much about their capacity for harming social relationships. Yet with such relatively simple perceptual problems as blindness and deafness, patients and families both require information — indeed, the Association for the Deaf has admirable TV programs which are highly informative. Deaf persons are depicted as being socially excluded and often considered stupid because they do not always respond appropriately to what is said to them. Many deaf people are aware of this exclusion and feel hurt, ashamed, and often resentful.

There are undoubtedly other ways of classifying the consequences of misperceptions, but these will emerge, no doubt, as we acquire more knowledge and understanding.

To return to Mrs. DW, what could be done to help her regain perceptual constancy? My psychologist colleagues tell me that more seems to be known about disrupting constancy than about restoring it, but we know that it has a tendency to reassert itself. Most people, for instance, recover from seasickness after a few hours or days. This is the restoration of constancy disrupted by vestibular disturbances.

What I was looking for was an easily 'domesticated' inconstancy which we could observe, study, and manipulate but which would always be under Mrs. DW's control. It struck me that one of the most convenient agents for this is the human hand, which can be moved quickly from about two feet from the face to direct contact with it. Doing this on myself, generally speaking, my hand is nearer or further away but I can perceive it as being larger when very close.

I asked Mrs. DW to do this, and after a few movements in which she brought her outstretched palm and fingers towards her face, constancy began to break down. She was not comfortable. The palm of her hand became much bigger as she moved it towards her face. In other words we had a simple demonstration that constancy was not particularly stable.

Since she has a piece of Alex Schauss' pink paper and is relaxed by this, it struck me that after staring at the paper and repeating Om for 15 to 20 seconds she might be able to delay the loss of constancy a little. She did this and we found that she could double the number of movements without discomfort or perceiving her hand as getting bigger. Instead of four she could do eight.

I have left her with instructions to perform these exercises using the Schauss paper and her hand for five minutes every hour on the hour. I do not know whether she will do this or whether it will work, but supposing it does work even to some extent in some people then we shall have:

1. A simple and crude way of demonstrating and measuring the maintenance of constancy in some people.
2. A way of seeing whether fatiguing this aspect of constancy (moving the open palm from the limit of the extended arm towards the tip of the nose) disrupts other constancies, visual or otherwise.
3. A way of increasing constancy using the Schauss effect and its auditory equivalent. It seems likely that any effective relaxing procedure would help to restore and maintain constancy.
4. A way of devising exercises for maintaining constancy and reducing disruption and restoring it when disrupted.

All these findings are very crude, but if one can get some benefits from something so simple it is likely that we can devise much more refined and effective methods later on. For instance, it should not be difficult to extract from both the HOD and the EWI constancy, or perhaps one should say **i**nconstancy scales, which would make it possible to quantify the amount of temporo-spatial fluidity a particular person was experiencing.

It is, I believe, essential not to forget the temporal aspects of inconstancy which play such a large part in the social disruption experienced by our patients. Social relations are extended in space-time from the simplest gestures of politeness such as eye contact, handshake and greetings to much more complex matters such as how long is an evening visit or a weekend? What constitutes a stranger, a new acquaintance, a new friend, an old friend, a very old friend, a relative? Most of these relationships depend in part upon the passage of time. It is a grave error to introduce a new acquaintance as "one of my oldest friends" or as a member of one's family. It is an equally serious mistake to fail to recognize an old friend or relative; yet recognition of such relationships is closely bound up with one's perception of space and time.

I believe that a small investment of energy and time here can yield much valuable information and the strong possibility of our developing some new therapeutic methods which can be put to use quite quickly.