Editorial

"Time Dimension" Revisited in Clinical Practice and Research in Psychiatry

Time, as the fourth dimension, seems to be the core of objective reality of human existence. Almost all aspects of judgement, insight, object relation, sense of reality and other psychic functions are time related.

Disturbances related to time dimension, recorded as circumscribed symptoms, are usually included under disorders of the sense of time (e.g stagnation, cessation, nihilism, galloping, interruption and distortion). This is essentially related to what the patient records (subjective experience) as well as to what the clinician could grasp (usually described as objectively assessed). Time assessed as overt behavioural variable is usually related to what is known as "clock time" which could be described as the linear chronological quantitative aspect of time. The unit of such assessment is definitely crude.

After the vast advance in reorientation about time dimension, psychiatric practice has to sharpen and rearrange its clinical tools and intuition as much as its theoretical background about this dimension.

Certain patients describe time as visible phenomenon. This could be related to what Arieti called active concretization (Arieti, 1972). Other patients describe time as if the magnified seconds are arranged, one after another, in a slow motion pattern like looking in the raw picture of an old cinema film (Rakhawy, 1999). This is very close to trailing phenomenon described as a variant of disorders of the process of thought. When time disorder in certain schizophrenics or epileptics is described as gushes and stops (Okasha, 1988), this may refer more to some longitudinal disharmony (disorganization) in time dimension.

From a functioning teleological point of view, it is not possible to consider time apart from events occupying it. Any fixed lasting (psychic) game, script or mental mechanism could refer to the possibility of functional cessation of time. The interpretation of repeated behaviour of OCD is that what is done (or said or thought of) was not recorded as done, since time is claimed to act in a closed circuit pattern. This would make the patient do it again and again in a trial to vitalize the proper function of time, but usually in vain. Almost all repetitive symptoms such as tics, rituals, stereotype, perseveration, catatonic posturing, and mannerisms are to be considered as declaring some sort of such cessation of time.

Considering growth as the continuous positive march of time, it could be assumed that any marked slowing down or cessation of such march is responsible for some sort of abnormal pattern of growth. The positive march of time includes expansion of awareness, responsibility, mature object relation, dialectic relation to reality and the open ended creative rebirth along the extended biorhythmic pulsations.

Particularly in schizophrenia, the march of life cycles could hold in a standstill

moment for some long time or for good (Rakhawy, 1979). This is explored through intensive therapy and is said to declare severe cessation of time, which if irreversible, could be considered as death of time with morbid outcome.

From a structural biorhythmic point of view (Rakhawy, 1979), personality disorders at large are viewed as life long fixed script, replacing spiral dialectic positive growth. Such script could be read as abolished function of time dimension.

Classical psychiatric practice is putting more and more emphasis on the dose and duration of giving certain psychopharmacological agents. Timing and duration of such medication is adjusted once and again all through management and follow up. No psychopharmacological effect is possible to be properly evaluated without considering time variable.

In psychotherapy, considering the duration at the outset is one of the most essential items of preliminary contracting. Such definition would shape the how and stages of whatever psychotherapy given. During psychotherapy in general, and in lengthy one in particular, timing is another very crucial responsibility. When to do (and not to do) or what to say (and not to say), is one of the basic skills that should be cultivated by the therapist.

From a biorhythmic aspect, as Oatley and Goodw in (1976) state: "the brain is a sophisticated computing device. (To ensure) that sequence of events occur in right order and that related processes interlock temporally, (it requires) .. timing, and timing is difficult to imagine without some oscillatory process". The unit of time of such biorhythmic activity varies form microseconds in biochemical processes to fractions of a second in nerve firing up to infradian rhythm surpassing the daily circadian rhythm. The analogous model of recapitulation theory as applied to growth cycles on one hand (macrogeny), and to thinking on the other hand (microgeny), invites high power microscoping the unit of time at the profound basis of human march (especially related to biorhythmic activity). It seems that, both in dreams and creation, unfolding occurs, to start with, in a very short unit of time. This is manifested behaviorally as inspiration in creation and possible as the primal dream (Edit dream, Rakhawy, 1985).

As far as objective assessment in clinical practice is concerned, this assumed minitime is not amenable to any sort of assessment. This is more true in research, particularly if such researches focus on the process of change rather than the outcome.

Inspiring Zowail's achievement picturing certain chemical reactions in what is called phemto-second, one can hope (or dream) that one day the biological shifts or processes could be accessible to such sophisticated recording, some way or another. Putting this in mind would motivate psychiatrists, both in clinical practice and research, to record whatever possible minute qualitative changes that may be observed or assumed through clinical intuition. Follow up of such mini-alteration may prove that this has been the turning point during the process of therapy. This assumption is apt to reinforce optimistic attitude, objective waiting and to minimize reductionism of the patients' experience to what could be recorded crudely as gross overt behaviour.

Y.T. Rakhawy

REFERENCES

Oatley, K. and Goodwing, B. (1976) In Biological Rhythms and Human performance . 'The Explantion and Investigation of Biological Rhythm', 7-39.

Okasha, A. (1988) Okasha's Clinical Psychiatry. The Anglo-Egyptian Bookshop, Ciro.

Rakhawy, Y.T. (1979) A Study in Psychopathology Cairo: Dar El-Ghadd. (In Arabic).

---------- (1985) Biological Unfolding in Dream, Psychosis and / or Creation A Unitary Hypothesis, Egypt. J. Psychiat.

---------- (1999) Descriptive Psychopathology, Cairo.