

INTERPRETATION OF SCHIZOPHRENIA

Changes of the Body Image

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Changes of the Body Image

I The Body Image

Disturbances of the body image in schizophrenia have been stressed by some authors and neglected by others. They do not occur in every patient, but in some they cause intense preoccupation. In some patients the distortion of the body image becomes the focal point of the psychotic transformation. The body image can be studied from three different points of view: (1) as a body schema, or a neurological engram; (2) as a percept, or, in a more general way, as an experience; (3) as a concept, which is altered by the delusional ideation or at least by the psychodynamic conflict of the patient. Perhaps in almost all cases there is a mixture of at least two of these aspects.

The body image as a schema is a notion first developed by Head (1920). He interpreted the body schema, not just as an integration of past sensations and perceptions, but as a unity integrated in the cortex. The body image would consist of postural schemata dealing

with position, movement, and space. Reviewing all the neurological knowledge in reference to organic disorders responsible for an alteration of the body image, Critchley (1953) concluded that in these conditions “the parietal lobe of the non-dominant hemisphere would obviously be identified as the locus which comes most frequently under suspicion.” Schilder (1953) emphasized that the body image, even as a schema, is subject to continuous change and rebuilding. Individual experiences are constantly integrated with the body image.

The body schema is difficult to distinguish from the body percept if we concentrate on the physiological aspect of the body image. The body, however, can be considered as a very rich experience. I could examine my own body merely as an object, like many others existing in the world. The body becomes only an object of my observation. On the other hand, my own body may be me, or at least part of me. My body belongs to me; it is in me, in my possession. The authors who use the German phenomenological terminology distinguish a *Leib*, or body for me, from *Körper*, or body in itself, an object (Cargnello, 1964).

The experiences that make up the body image are not only subjective experiences originating exclusively in the individual.

Schilder (1935) stressed the importance of interpersonal and environmental factors, such as social relations and morality, in the building of the body image.

The body image as a cognitive construct consists of many ideas, referring to one's own body, associated with various emotions. The body may be conceived in the following ways:

1. As the self, or as most of the self, or as the representative of the self. It confers identity, not only in relation to sex, but also in relation to the whole person. Although the body, as a lived experience, gives a sense of continuity of the self to the individual, such continuity is conceptualized as a self, or identity of the self.
2. As a carrier of sexual feelings, or as a sexualized object. Again in this case the concept is connected with the experience.
3. As a means to relate to others.

In discussing what he called ego-feeling, Federn (1953) distinguished between body scheme, body image, and bodily ego. He wrote, "The body scheme represents the constant mental knowledge of one's body; the body image is the changing presentation of the body

in one's mind. Throughout the changes, the bodily ego is the continuous awareness of one's body. Image, scheme, ego, all three are themselves not somatic but mental phenomena."

II Patients' Experiences of Their Own Body

It is common clinical experience to treat schizophrenic patients who have distorted ideas about their own bodies. The face is the most common cause of complaint and preoccupation. A 23-year-old girl described her experience as follows: "I look at myself in the mirror, and it is not really me that I see. I don't have any definite image of myself, but many different ones, all of them horrible to me. I look like a man." She demanded that plastic surgery be done on her. Some patients demand plastic surgery to change the look of their eyes, ears, nose, face, head, legs, breasts, and so on. They have the idea that their arms are shrunken, legs expanded, eyes dislocated. Kinesthetic delusions of any kind are very common. Some patients are *dysmorphophobic*, that is they are afraid that their body is going to change appearance. Typical hypochondriacs instead have the conviction of having a bodily illness.

Some authors have followed accurate procedures to investigate more deeply these clinical findings. Weckowicz and Sommer (1960) studied the patient's reaction to his reflection in a large three-paneled mirror. They found that schizophrenic patients, when compared with nonschizophrenic controls, underestimated the size of the distinct parts of their bodies. With a different technique, Burton and Adkins (1961) obtained different results. They found that schizophrenics have the tendency to overestimate some parts of their bodies, especially those parts that "have a libidinal and interactional charge."

De Martis and Porta (1965) repeated the tests of Weckowicz and Sommer and added new ones in a study of sixty patients and twenty control subjects. Six patients did not recognize themselves in the mirror; many saw more than three images; twenty-six saw their own limbs decreased in size or completely absent.

Faure (1971) has vividly described some phenomena experienced by some patients: the fluctuation of the self-image and the insecurities about the limits of one's own body. According to Faure some patients see in their own photographic picture "a possibility of occult influences susceptible of hurting them"; some others see in their

pictures “a second presence of themselves.” The picture acquires an autonomous existence.

III Interpretation

For a more detailed interpretation of the disorders of the body image in psychiatric conditions the reader is referred to the writings of Schilder (1935), Kolb (1959a, b), Lukianowitz (1967).

Weckowicz and collaborators have intensely studied perceptual constancy in schizophrenia (Weckowicz, 1957; Weckowicz, Sommer, and Hall, 1958; Weckowicz and Sommer, 1960). They believe that some of the changes in the perception of one’s own body can be attributed to “a breakdown in perceptual constancy.” Many other authors do not share this point of view. We know, however, that with the administration of LSD both normal persons and schizophrenics overestimate the size of their heads (Liebert, Wapner, and Werner, 1957). De Martis (1964) and De Martis and Porta (1965) do not believe that the body schema is altered in schizophrenics. De Martis (1964) interprets the alterations in the body image as belonging to one of the following four categories:

1. Symptoms of hypochondriac nature, similar to those found in neurotics. These symptoms are symbolic in their content.
2. Manifestations of depersonalization to be interpreted as intermediary stages toward either full delusional thinking or toward the reintegration of the psyche.
3. Kinesthetic delusions.
4. Global disorders of soma-psyche integration, secondary to loss of libidinal investment. "The body appears as a disarticulated structure, with unclear boundaries, confused in the most pronounced cases with external reality."

In a review article Kolb (195%) asks, among others, the following questions:

Is this maldevelopment [of the body image] the consequence of disturbances in the communicative process between mother and child or, to put it another way, does the interaction between the mother's and the child's bodies, the mother's attitude and feelings as they are conveyed to the child in the very earliest times, lead to a disturbance in the capacity of the cortex to evolve a stable concept of the body, as well as altering later concepts of the body? If this is the case, what are the peculiarities of the mother-child relationship which contribute to the evolution of the

disordered body-ego complex in the schizophrenic child? Is it that these children were not fondled enough, were not handled consistently, or were handled in a manner which produced such variables of sensory and emotional arousals that the cortex failed to integrate a stable body image?

Kolb's questions have not yet been satisfactorily answered.

The original psychoanalytic theory (reviewed by Fenichel, 1945, and also by Arlow and Brenner, 1964) is that the patient has turned his interest (cathexis) from the outside world to the body. Because of this change many somatic processes that are usually unconscious reach consciousness. The somatic symptoms are symbolic and use a body language, in which a sexual meaning predominates. Fenichel summarized the view of classic psychoanalysis in the following way: "Many schizophrenics begin with characteristic hypochondriacal sensations. The theory of hypochondriasis, which maintains that organ cathexis grew at the expense of object cathexis, makes this early symptomatology intelligible. The beginning of the schizophrenic process is a regression to narcissism." See also the section on Freud in Chapter 2.

Szasz (1957b) advanced another hypothesis within the

framework of classic psychoanalytic theory. He does not believe that bodily feelings reduplicate ego-experiences characteristic of infancy or childhood. In the prepsychotic stage there is fear of object loss. A trauma, like a mourning reaction, may actually precipitate loss of objects. Then “the ego takes the body as the only remaining object to which it can relate (with more or less safety). The body now functions as an object vis-a-vis the ego, just as personal objects did heretofore” (Szasz, 1957b). In simple language, at the beginning of schizophrenia there would be a change of interest from interpersonal relations and the world at large to one’s own body. This change certainly occurs in many patients, but by no means in all of them. This interpretation explains increased *interest* in one’s body, but it does not explain the distortions of the body image.

In my opinion, attributing one’s own difficulties to the body is another instance of concretization. The psyche is no longer involved with its abstract, complicated, interpersonal, and symbolic processes; the body is “blamed.” It is safer to concentrate one’s interest on one’s body and to overlook the anxiety originated with the world at large.

Selvini (1963, 1970) has described how in anorexic girls the body

becomes the persecutor. It is the “fault” of a part of the body that the patient is in a predicament. For instance, her face has changed, and she is unappealing to men.

I have found that the parts of the body that have more meaning in interpersonal contacts (the head, the face, the eyes, the hands) are the most frequently involved in delusions. Some patients try to remove their difficulties by changing their body images. They request plastic surgery, in order of frequency, on their nose, face, breasts, or legs. Plastic surgeons must be very careful to recognize this type of schizophrenic from normal persons who request plastic surgery. In fact, many of these patients (generally, but not exclusively, female) are not satisfied after surgery. They may intensify their delusions about the part of the body that underwent surgery or may shift the delusions to other parts of the body. In some cases they may even involve the surgeon in their delusional system. (The surgeon is a persecutor: he has made the patient’s body worse.)

Often the delusional change in the body image indicates metaphorically what the patient thinks about himself: the body is little, deformed, looks like a man’s body instead of a woman’s body, or vice

versa. The body smells; is too short or too tall; the penis and testicles are too small; the vagina is either too big or too little; the breasts are also too big or too small; the hair is falling. The brain is melting; something happened that destroyed a part of the brain. The sight has changed so that the patient cannot see things properly or cannot focus on any particular object. At times there is an element of truth in the complaints of the patient (for instance, about the nose or the breast), but the significance of the condition is exaggerated to an enormous degree. At times the patient may have a real psychosomatic condition (like a vasomotor rhinitis; constipation), but he adds to it a delusional structure. Often the complaints have no basis in reality at all and seem ridiculous to others.

Some authors (for instance, Meth, 1974) have reported among Chinese and Indonesians a phobic condition called *Koro*. The patient becomes fearful that his penis will disappear into his abdomen and he will die. I have seen in schizophrenics a related delusion (that the penis or testicles have already entered into the abdomen), at times because of some medical treatment allegedly received from unscrupulous doctors. The patient is not afraid to die but to lose his masculinity. Generally the patient with this or similar delusions is

afraid of being homosexual, %: of being considered homosexual, or of having lost his potency.

As a rule, delusions about sexual organs and functions are accessible to psychotherapy with good results, because they lead easily to analysis of many problems. On the other hand, I have found that delusions concerning brain, face, and nose are very resistant to any type of therapy. The patient seems to have focused all his concern on that part of the body and clings tenaciously to his belief.

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