INTERPRETATION OF SCHIZOPHRENIA

Study of Catatonic Patients

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As we have seen in Chapter 3, the manifest symptomatology of catatonia has characteristics so specific as to make some psychiatrists consider this condition a separate illness, unrelated to the other types of schizophrenia. These specific features are the motor phenomena, which have made several authors think of the possibility of a neurological disorder based on an organic pathology or on some kind of intoxication, such as the one produced by bulbocapnine in experimental animals (DeJong, 1922; and Baruk, 1930a,*b).*

From a psychodynamic point of view, the understanding of catatonic schizophrenia is controversial. Very few cases have been studied psychodynamically. In three recent books on schizophrenia (Searles, 1965, Kantor and Herron, 1966, Shulman, 1968) no psychodynamic study of catatonia is presented. Rosenfeld (1952Z?) has made an interesting report on a case of catatonia; however, the catatonic syndrome is considered there to be incidental and is not studied specifically. Recently Will (1972) has written an insightful report of a case, which I have discussed (Arieti, 1972&). The

occasional reports that have appeared in other recent publications are fragmentary. Catatonic patients are mentioned in passing or in reference to other patients.

The psychodynamic study of these cases is hindered by several difficulties. The first is the rarity of these cases. Whereas in the past catatonic patients were quite numerous, now they have drastically diminished in number. The second difficulty lies in the manifest symptomatology, which lends itself to a psychodynamic study much less than do other types of schizophrenia. The typical patient is mute, or almost. One of the ways to obviate this second difficulty is to study patients who are not typical from the point of view of the manifest symptomatology, and this is what I have done. The first two cases reported in this chapter had, in addition to catatonic symptoms, many distinct obsessive-compulsive features. The third case is that of a patient who discussed his catatonic episode with me long after it had occurred. I am aware of the criticisms to which these reports expose themselves. And yet the fact that the atypical clinical picture of these patients made them available to psychodynamic inquiry seems to outweigh the fact that they were not typical. As a matter of fact, their study seems to indicate that a typical psychodynamics of the catatonic

type of schizophrenia can be differentiated. As to the reliability of reports, as those of the third case, the doubts are partially mitigated by the genuine flavor of the patient's account, as the therapist experiences it.

In spite of the relative rarity of catatonic patients, it is important for the psychiatrist to become acquainted with what is known of their psychodynamics in order to increase his skill in treating this condition, which is one of the most distressing occurring in human beings. Moreover, no matter how strong is our desire to help these suffering patients, the study of catatonia will soon transcend our therapeutic devotion. The psychodynamic and formal processes of catatonia are intimately related to the problems of human will and its intermediary role between motivation and overt behavior.

I have also made another clinical observation connected with the disappearance of catatonic patients, which later studies must confirm or deny. Whereas cases of full-fledged catatonic syndrome have become very rare, we now frequently see patients who have been for days or weeks in almost complete immobility and inactivity, lying in bed, or closed in the bathroom, and so on. Although these patients lack

the typical catatonic features, and some of them must be considered as suffering from simple schizophrenic withdrawal, some may be recognized as aborted forms of catatonia.

The catatonic syndrome cannot be fully explained in terms of psychodynamics. The reader will have a much greater understanding of this multiform problem after having studied the formal mechanisms of catatonia in Chapter 17.

Sally

Sally was a 23-year-old Jewish married woman who lived in a small town in the vicinity of New York City. She was referred by a psychiatrist who had attempted electric shock therapy. After shock treatment, the patient seemed to make some improvement, but the symptoms returned very shortly. Psychotherapy was tried for a few months, with no appreciable results. The psychiatrist felt that the patient should try another therapist and referred her to me.

The first time she came, she was accompanied by her parents, who gave the following history: The apparent beginning of the illness occurred a few days after her marriage, when the patient was 22.

During the honeymoon the patient had been anxious and disturbed, and had wanted to go back to her parents' home. When she returned and went to her new apartment, she became increasingly distressed by obsessions. She gradually became slower in her motions and finally lapsed into a catatonic stupor. She had to be dressed, undressed, and spoon fed, and she defecated and urinated in bed. She was unable to move and hardly answered questions; often she answered in monosyllables. The striking feature in this case, however, was that this catatonic state was not constant. The patient occasionally was able to move freely, especially outside her own home. However, when she was not in a catatonic posture, she was distressed by obsessional symptoms, which will be described later.

When I saw the patient for the first time, she gave me the impression of a typical catatonic. She was asthenic, very much undernourished and pale, and maintained the same posture throughout the interview; the mimic musculature of the face was practically paralyzed, except for an apparently incongruous smile, which appeared now and then. She gave the impression of being totally flat emotionally. Contrasting with this picture, however, was her ability to talk in my presence. She spoke rather fluently and

expressed herself very well, but her speech was cold and rigid, without emotional inflections.

Sally gave me an accurate description of her symptoms. When she was not in a catatonic state, she had the impression that small pieces or corpuscles were falling down on her body or from her body. She preferred not to move, because she was afraid that her movements would cause small pieces to fall. She had to reassure herself constantly that pieces were not falling down, and she had to check herself constantly in an obsessive way. If she moved, even if she made the smallest movement, she had to think about the movement, dividing it into small parts to reassure herself that each part of the movement had not been accompanied by the falling of small bodies. This task was terrific; it kept her in mortal fear of any movement and compelled obsessive thinking from which she could not escape. She used to ask her relatives to help her do the searching for her, to reassure her that no bodies were falling down.

In the beginning her relatives refused to give in to her symptoms. When she felt unable to satisfy the obsessions and became overwhelmed by them, she lapsed into a catatonic stupor. Later on, at

the suggestion of the first psychiatrist who treated her, the relatives were much more tolerant. They did a great deal of looking for her, and consequently she was not in a stupor so often; but if she was not in a stupor, she was extremely compulsive, always looking around or asking other people to look for her. Even when she could move, she tried to reduce her movements to a minimum because each motion would entail a tremendous amount of compulsive looking and thinking. Therefore, everything had to be done for her; she had to be dressed, undressed, fed, and even wiped when she went to the toilet. If other people did these things for her, the movements that were necessary for these activities were not "so much" her "responsibility." She spent most of her time in bed and was fed only once every twenty-four hours.

The following is a brief description of the family background and personal history as obtained later on from Sally herself. Her mother was a seemingly warm person, very much interested in the welfare of the patient. She was, however, overprotective, overbearing, and domineering. With the pretext of helping the patient, and giving good advice when it was needed, she did not allow Sally to develop the capacity to make a choice. Sally's mother was always choosing for her;

until Sally was in her teens she was not allowed to cross the street alone, for fear of the traffic; when the other children were going to a picnic or ice skating, and Sally wanted to join them, her mother would never let her go: “It is better to listen to Mommy; those activities are dangerous and must be avoided.” Sally was even told what friends to have. When she was older and wanted to go to art school or take dancing lessons, her mother was very discouraging; she believed that those things were not practical. If Sally needed to buy clothes, even after her marriage, her mother wanted to be consulted in their selection. A few times Sally had bought a dress by herself and had been strongly criticized. The mother had rigid norms for everything. For instance, when the gas had to be turned on, the flame had to be of a certain size. If Sally made it a little higher or lower, she would incur her mother’s disapproval. The mother also had always put tremendous emphasis on cleanliness. She was not very religious, but kept a strictly “kosher” home.

Sally constantly felt under pressure from her mother, always believing that her mother must be obeyed, that her advice must be good, even if unpleasant, and must be followed.

Sally's father was different from her mother in that he was not domineering, but weak. Sally felt that although he had the same point of view as the children quite often, he always supported her mother in her requests, maintaining a united front with her. The father was too weak to oppose the strong-willed mother and always yielded to her wishes. Sally, therefore, had even more contempt for him than for her mother; he was the one who could help her, and instead he was her mother's ally in crushing her desires. Sally experienced a sense of suffocation and pressure when her parents were around. Her only happy time had been at night when everybody was in bed. Then she could feel free to do what she wanted. But even then her freedom did not last long. Soon she would hear the voice of her mother saying, "Sally, it is late. Go to bed." To prolong this time of solitude, she would take long baths and showers. She remembers, however, that quite a few times, when she purposely prolonged her baths, she had the impression that her mother came into the bathroom and stabbed her in the back with a dagger. If the water was running from the faucet, making noise, she was particularly afraid her mother could come in, and she would not even hear it. But she knew that this was just a fantasy, and she tried to dispel it, although some fear remained.

The patient had two siblings, a sister and a brother, who were older. She had never been close to them. Living with the parents was an aunt, her mother's sister, who had been married a few years before, but had gotten a divorce a few weeks after her marriage. At the time of the divorce the aunt had not sold her new furniture, but had put it in storage to be used again if the opportunity arose. This detail is relevant, as we shall see later.

At the age of 18, Sally had started to go out with a young man named Robert, with whom she very soon became infatuated. Robert was different from her parents; he was intellectual, spoke about science, the arts, and especially about modern art. They would go to museums together. For Sally, he represented the artistic and intellectual life of New York City, in contrast to the life of the small town where she lived. Sally and Robert had satisfactory sexual relations.

As soon as they had started to talk about marriage, Sally's parents had begun a campaign against Robert. He was not the man for her. He was not practical enough; he was a dreamer. At first Sally tried to resist her parents, but it was too great a strain and created too much

suffering for her. Soon she became convinced that Robert was not the man for her, and she severed the relationship. A year later she met another young man, Ben, who became interested in her. Ben lived in the same town as she and had the same views about life that her parents had. Her parents liked him very much and encouraged her to marry him. She became convinced that that was a good thing to do, and she agreed to marry him. The wedding was soon arranged. Because the couple did not have much savings, Sally's parents felt that they could use the aunt's furniture, which was still new, although it had been kept in storage for several years. Sally did not like the idea, but she and Ben soon realized that this was the most practical thing to do, because the aunt was generous enough to give them the furniture. Sally agreed to accept her aunt's furniture, with one exception. The aunt had a painting that Sally did not like at all. That painting was not to enter her new home.

The parents told her that they would fix up her new apartment while she and her husband were honeymooning, and that they would find everything ready when they returned. During the honeymoon Sally did not feel well, and the newlyweds returned sooner than they had anticipated. When they walked into their apartment, Sally's

parents were arranging the furniture, and what were they doing at that moment? They were hanging the painting that Sally detested over the headboard of the bed. When Sally saw that, she became very distressed. When I asked her to explain why she disliked the painting so much, she said, “It was an old painting, representing French aristocrats in wigs; it was a traditional painting, so different from modern art.” In other words, the painting symbolized for her the life of her parents and of Ben, in contrast to the life with Robert.

Soon Sally became afraid that she would not be able to fulfill her duties as a wife, that she would not satisfy Ben’s expectations. She became slower and slower in her actions and was unable to do the work in the house. The parents became worried and asked her and Ben to come to live with them so that Sally would not have to take care of the apartment. In her parents’ home Sally became worse and gradually fell into a state of catatonia.

Later on, when Sally could explain her symptoms, she said that she could not move, because if she moved, she felt guilty, inasmuch as she was always afraid of doing the wrong thing. Later, when she resorted to compulsions, this feeling of doing the wrong thing was at

least partially removed, if she could assure herself that she was accurately following her compulsive ritual. The compulsive ritual consisted of reassuring herself that bodies had not fallen. In going back over her movements in her thoughts, she followed this formula: "Do, feel, done, on, off, see, hear, think, and what else." This formula meant that she should think or revisualize in her mind what she had done, how she had felt, what she should have done, whether or not anything was on her, whether or not anything had fallen off, what things she had seen, what sounds she had heard, what thoughts she had had. "What else" stood for a final mental checkup.

All these symptoms, including the tendency not to move at all, were much more marked in the presence of her parents and Ben. Even in the first few months of treatment, the patient became aware, after discussion of many small episodes, that her symptoms had something to do with her feelings, especially the feelings of guilt and resentment toward her parents and Ben. She was able to understand this relationship when she was reassured that she did not have to feel guilty with the therapist, and was willing to accept his support. She realized that she was afraid to act, because no matter how she acted, she would incur the disapproval of her real mother, or the disapproval

of the mother that she had incorporated. When she would snap out of immobility, she could do so only with the protection of her ritual. Her ritual was not only a protection against guilt, but also a retaliation against her relatives. She realized that when she was particularly angry at her parents or Ben, her ritual increased and produced a disturbance for the whole family. They had to take care of her, and do the looking for her, no matter how reluctant they were to do so. This was the only way she was capable of expressing anger.

Although Sally acquired this degree of insight early in treatment, she could not refrain from indulging in her symptoms. Thus, it became obvious to me that no improvement could be expected from the treatment alone; her living conditions reactivated her anxiety and made it necessary for the symptoms to occur. Therefore, I decided that it would be better for her, at this stage of the treatment, to be in a situation where she did not need to feel guilty and resentful. Five months after the beginning of treatment, arrangements were made for Sally to live with a social worker, who would devote herself entirely to the patient.

When Sally went to live with this social worker, whom we shall

call Barbara, a dramatic change occurred in the condition of the patient. For the first time since the beginning of the illness, she started to do things by herself. Barbara gave her progressively more difficult tasks, which the patient was able to undertake, with some effort. Thus she started to dress and undress, and to do a little work in the house. It was necessary to give her a great deal of praise. In the beginning, she felt that Barbara was a great friend; they were two girls living together in mutual friendship. Her entire outlook toward life changed. The necessity of resorting to her ritual decreased, and there was a progressive reawakening of her emotions. Her face was no longer masklike, but responded emotionally to the surroundings. She also started to eat by herself and gained a lot of weight. This state of affairs, however, did not last very long. After a few weeks, Sally began to think that Barbara was making too many demands on her, that she was not patient enough with her slowness, that she was pushing her even more than her own mother had. Possibly there was some truth in these allegations. Although Barbara was an excellent social worker who had undergone intensive psychoanalytic treatment, and who had a great deal of understanding for psychiatric patients, perhaps she was not the best person to work with someone like Sally. Being a very

active person, Barbara experienced some kind of frustration at Sally's slowness.

Sally herself decided to return to her parents, called up her husband, and insisted that she be taken back immediately. When she returned to her parents' home, there was some relapse, but the symptoms were not as severe as they had been. It was obvious, however, that Sally was retrogressing, especially in the presence of her parents. It was then arranged that a young woman psychologist, Rhoda, would visit her in her parents' home every weekday, from early in the morning until half-past five, when Ben came home from work. In the company of this psychologist, Sally continued to improve and was able to accept and fulfill bigger and bigger goals. Whereas she had not been able to assert herself with Barbara, whom she had felt obligated to obey, no matter how reluctantly, she was able to reveal her anger to Rhoda, whenever she felt the latter had slighted her. She felt like a peer of Rhoda, and a feeling of warm friendship developed. Rhoda was able to avoid becoming a mother-substitute; but, by praising Sally a great deal, as one would do with a little child, she gradually built Sally's confidence in herself, confidence that she had never had. Sally became willing to do things and dared to accept bigger and bigger

goals. Occasionally, tendencies to misinterpret and the desire to put Rhoda into a mother's role again occurred. During treatment these tendencies were worked out.

Both a prolonged relationship with a healthy human being and psychotherapy with the psychiatrist were necessary. One of the purposes of the treatment was to examine this new, healthy, interpersonal relationship and to see to it that the old patterns of the patient did not force her to misinterpret it and spoil it. Sally became progressively more assertive and dared to ask questions and to disagree. After a year of treatment, she was able to leave her parents' home and to have her own apartment with her husband. She started to take piano lessons and showed considerable interest and talent in playing that instrument. Her relations toward her husband improved to a great extent as she progressively became aware of the fact that she identified him with her mother and acted toward him almost exactly as she had acted toward her mother. Many of the bad qualities that she had projected on him were the result of this identification. She also learned to consider herself, not as a shadow of her mother, but as a person living in her own right.

After two years of treatment the patient was able to secure a position as a saleswoman.

Sally continued to come for treatment, and there was progressive improvement. At a certain stage of therapy she felt that she had never been so well. The illness, in spite of the symptoms ranging from catatonic immobility to distressing obsessions and compulsions, made her a different person. She finally was able to free herself from those conditions, which she never accepted. Her interests in various aspects of life expanded and she was able to sustain these interests, not only without shame or guilt, which she had formerly, but with confidence and inner feeling of satisfaction.

Richard

Richard was a 23-year-old white, Protestant, single, unemployed male who sought psychiatric treatment a few months after his discharge from a state hospital. His immediate problem was that he had a tremendous desire to commit himself to the state hospital again. He remembered the time he spent there with great pleasure. He felt that in the hospital he had spent the best time of his life; he had had

nothing to worry about, everything had been taken care of for him, he had been able to work, and had had no difficulty in getting along with people. When he expressed to his family his desire to return to the hospital, they became worried and encouraged him to seek private treatment. Richard himself had had this intention, but the family had previously discouraged him from doing so.

The following is a brief family and personal history as it was obtained from the patient himself in the course of treatment. The father was born in Europe. After a few years spent in the United States, he returned to his native country, where he married and had two children. He returned to America with his family a few years later, against the wishes of his wife. In Europe he was a farmer, but in this country he worked as a cook and kitchen helper and a waiter. He was described by the patient as a very quiet man, submissive, and entirely dominated by his wife. He had little contact with his children, because he worked at night and slept during the day. The mother was described as a very unhappy person, hypochondriacal, and a constant nagger. She was always complaining of pains and aches and had undergone several operations. She had always been dissatisfied with Richard. He remembered violent scenes that had occurred in his

childhood. His mother was utterly disgusted with him when he did not want to obey her. She would even spit at him, kick him, and throw dishes and other objects at him. She never praised him, but nagged him constantly. If he turned on the radio, it was to the wrong program; if he looked for a job, it was always for the wrong job, and so forth. His mother used to tell him that he had been a pest since his birth, and that when he was an infant he had always cried, causing her terrific headaches.

During the course of treatment, Richard realized that the marriage of his parents was a very unhappy one. His mother was taking out on the children, and especially on Richard, who was the eldest, the resentment that she had toward her marriage. When there were open arguments between the children and the mother, his father usually was not there because he was working; on the few occasions when he was present, he would offer only a very weak defense for the children. Richard remembered that when he was a small child, once at the age of 5 and another time when he was 8, his mother went to the hospital for operations, and he was taken to a children's shelter. He retained a very happy memory of the two times spent in the shelter, which he considered the best experiences in his childhood. He was

very unhappy when he had to go back home. Later in his childhood and in early adolescence, he became very religious and had the intention of becoming a minister. He used to pray quite often; he prayed to God to let him win a ball game, have a girl friend, be successful on a job, and so on.

In high school, Richard was an average student. After graduation from high school, he was drafted into the army, where he felt unhappy because the other enlisted men bragged about their sexual exploits and he was not able to offer anything in that field. After his discharge, he wanted to enter some kind of musical career, but gave up the idea because it did not offer financial security. He had several jobs, for example, as a delivery boy, elevator man, and hospital helper. He could not keep a job for any length of time because he was very sensitive to criticism and was always afraid that he would not satisfy his bosses.

Richard remembered this period, after his discharge from the army, as one of the worst in his life, even worse than his childhood. Throughout his life he had been very sensitive and had always taken things too much to heart, but after his discharge, when he was supposed to do things on his own and show what he was able to do, his

sensitivity increased. He was “eating his heart out” for unimportant reasons; any, even remote, anticipation of disappointment was able to provoke attacks of anxiety in him. He could never be indifferent or detached, but was very much involved in everything. After his discharge from the army his life had become a series of crises.

Approximately two years after his return to civilian life, Richard left his job because he became overwhelmed by these feelings of lack of confidence in himself, and he refused to go look for another one. He stayed home most of the day. His mother would nag him that he was too lazy and unwilling to do anything. He became slower and slower in dressing and undressing and taking care of himself. When he went out of the house, he felt compelled “to give interpretations” to everything he looked at. He did not know what to do outside the house, where to go, where to turn. If he saw a red light at a crossing, he would interpret it as a message that he should not go in that direction. If he saw an arrow, he would follow the arrow interpreting it as a sign sent by God that he should go in that direction. Feeling lost and horrified, he would go home and stay there, afraid to go out because going out meant making decisions or choices that he felt unable to make. He reached the point where he stayed home most of the time. But even at home, he

was tortured by his symptoms. He could not act; any motion that he felt like making seemed to him an insurmountable obstacle, because he did not know whether he should make it or not. He was increasingly afraid of doing the wrong thing. Such fears prevented him from dressing, undressing, eating, and so forth. He felt paralyzed and lay motionless in bed. He gradually became worse, was completely motionless, and had to be hospitalized.

In the state hospital, Richard was diagnosed as a case of schizophrenia, catatonic type, and electric shock treatment was recommended. He remembers that prior to the shock treatment, even in the hospital, he had to interpret everything that occurred. If a doctor asked him a question, he had a sudden impulse to answer, but then feared that by answering he would do the wrong thing. He tried desperately to find signs that would indicate to him whether he should answer or not. An accidental noise, the arrival of another person, or the number of words the questions consisted of were indications of whether he should reply or not.

Being undecided, he felt blocked, and often would remain mute and motionless, like a statue, even for days. He had always been more

or less afraid of being with people because he did not feel strong enough to take their suggestions or to refuse them; in the hospital such fear increased.

After shock treatment, which consisted of a series of twenty-one grand mal seizures, the patient felt much better. He found in the hospital an environment that he liked very much, one in which he was not afraid. He became very friendly with other patients, helped them, liked his doctors, followed their guidance, and participated in occupational therapy classes; when he was in the process of doing things, he was not tortured by the previous horrible anxiety. In the hospital he was told what to do by authorities whom he was willing to accept. He improved so rapidly that the doctors wanted to discharge him. He begged them not to do so, because he was very happy there, much happier than outside; but after many delays they discharged him nevertheless. Outside the hospital, his difficulties tended to return, and therefore he sought treatment.

For many reasons, this patient presented several difficult problems in the therapeutic situation. First of all, he was exposed again to the influence of the family. His mother was nagging him to

find a job. The same acrimonious scenes were going on between the constantly disapproving mother and the patient. The economic conditions of the family were such that it was impossible for Richard to live by himself, or to have an additional person, as Sally did, who would work with him.

Although Richard was afraid to do things, his "stormy personality" pushed him again to act a great deal and try new things, in spite of his fear. He would go out quite often; he was eager to start friendships with girls, but later he would feel extremely frustrated and rejected by them, at the least provocation. Although he was afraid to have sexual relations, he would proposition girls who he knew were virgins and modest and then would feel painfully rejected when they did not accede to his request. He worked as an attendant in a general hospital, and there he was afraid that the nurse in charge of the ward did not like his work. He was very active and ambitious in spite of his fears and anxiety. Thus, he decided to register in a school of music, where his tuition would be paid by the government under the GI Bill of Rights. At school his difficulties greatly increased. At first he did not know which instrument to choose; later he felt that the teachers were dissatisfied with his work and were not friendly enough. At the same

time, his mother was criticizing him for his interest in music and his lack of practicality. His anxiety increased in the same proportion as the wish to be back in the state hospital.

One afternoon, when he was supposed to be in my office for a session, I received a telephone call from an admitting physician of the state hospital, who told me that the patient had entered the hospital again on voluntary admission. He stayed in the hospital a few months. This time he was not as satisfied as he had been the previous time; when he was discharged again, he did not return for psychotherapy. He decreased his ambitions and was able to make a subliminal adjustment. The therapy of this patient was not entirely successful, although it prevented the occurrence of another catatonic attack.

John

John [1] was an intelligent professional man in his thirties, Catholic, of European background, who was referred to me because of his rapidly increasing anxiety—anxiety that reminded him of the anxiety he experienced about ten years previously, when he developed a full catatonic episode. Wanting to prevent a recurrence of the event,

he sought treatment.

The following is not a complete report, but only a brief history of the patient and a description of his catatonic episode, as it was reconstructed during psychotherapy.

The patient was one of four children. The father was described as a bad husband, an adventurer who, although a good provider, always caused trouble and home instability. The mother was a somewhat inadequate person, distant from the patient. One of his sisters is said to have led a very promiscuous life since youth. John was raised more or less by a maternal aunt, who lived in the family and acted as a housekeeper.

Early childhood memories were mostly unpleasant for John. He recollected attacks of anxiety going back to his early childhood. He remembered also how he needed to cling to his aunt; how painful it always was to separate from her. The aunt also had the habit of undressing in his presence, and this caused him to have mixed feelings of sexual excitement and guilt. Frequently he would experience pain in his stomach, for which there was no apparent reason. Between the age

of 9 and 10 there was an attempted homosexual relation with his best friend. During his prepubertal period he had strong desires to look at pictures of naked women, and occasionally he would surreptitiously take some pornographic books or magazines from his father's collection and look at them. Fleeting homosexual desires would also occur occasionally. He masturbated with fantasies of women, but he had to stimulate his rectum with his fingers in order to experience, as he said, "a greater pleasure." Among the things that he remembered from his early life were also obsessive preoccupations with feces of animals and excretions in general of human beings. He had a special admiration for horses, because "They excreted such beautiful feces coming from such statuesque bodies."

In spite of all these circumstances, John managed to grow more or less adequately, was not too disturbed by the dealth of his aunt, and did well in school. There were practically no dates with girls until much later in life. After puberty he became very interested in religion, especially in order to find a method to control his sexual impulses. The possibility of becoming a monk was considered by him several times. When he finished college, at the age of 20, he decided to make a complete attempt to remove sex from his life. He decided also to go for

a rest and summer vacation to a farm for young men, where he would cut trees, enjoy the country, and be far away from the temptations of the city. On this farm, however, he soon became anxious and depressed. He found out that he resented the other fellows more and more. They were rough guys, they used profane language. He felt like he was going to pieces, progressively. He remembers that one night he was saying to himself, "I cannot stand it any more. Why am I in this way, so anxious for no reason? I have done no wrong in my whole life. Perhaps I should become a priest or get married." When he was feeling very badly he would console himself by thinking that perhaps what he was experiencing was in accordance with the will of God.

Obsessions and compulsions acquired more and more prominence. The campers had to go chopping wood. This practice became an ordeal for John because he was possessed by doubts. He was thinking, for instance: "Maybe I should not cut this tree because it is too small. Next year it will be bigger. But if I don't cut this tree, another fellow will. Maybe it is better if he cuts it, or maybe I should do so." As he expressed himself, he found himself "doubting, then doubting his doubts, and finally doubting the doubting of his doubts." It was an overwhelmingly spreading anxiety. The anxiety gradually

extended to every act he had to perform. He was literally possessed by intense terror.

One day, while he was in this predicament, he observed another phenomenon that he could not understand. There was a discrepancy between the act he wanted to perform and the action that he really carried out. For instance, when he was undressing, he wanted to drop a shoe, and instead he dropped a big log; he wanted to put something in a drawer and instead he threw a stone away. However, most of the time there was a similarity between the act that he had wanted and anticipated and the act he actually performed. The same phenomenon appeared in talking. He would utter words that were not the ones he meant to say, but were related to them. Later, however, his actions became more and more disconnected. He was mentally lucid and able to perceive what was happening, but he realized he had no control over his actions. He thought he could commit crimes, even kill somebody, and became even more afraid. He was saying to himself, "I don't want to be damned in this world as well as in the other. I am trying to do good and I can't. It is not fair. I may kill somebody when I want a piece of bread."

Fear had by now become connected with any possible movement. The fear was so intense as to actually inhibit any movement. He was almost literally petrified. To use his own words, he "saw himself solidifying, assuming statuesque positions." However, he was not always in this condition. As a matter of fact, the following day he could move again and go to chop wood. He had one purpose in mind: to kill himself. He remembers that he was very capable of observing himself and of deciding that it would be better for him to die than to commit crimes. He climbed a big tree and jumped down in an attempt to kill himself; but he inflicted upon himself only minor contusions. The other men, who ran to help him, realized that he was mentally ill, and he was soon sent to a psychiatric hospital. He remembers understanding that he was taken to the hospital and being happy about it—at least he was considered sick and not a criminal. But in the hospital he found that he could not move at all. He was like a statue of stone.

There were some actions, however, that could escape this otherwise complete immobility; namely, the actions needed for the purpose of committing suicide. In fact, he was sure that he had to die to avoid the terror of becoming a murderer; he had to kill himself

before that would happen.

During his hospitalization, John made seventy-one attempts at suicide. Although he was generally in a state of catatonia, he would occasionally have impulsive acts, tear the straitjacket to pieces, and make a rope with it to hang himself. Another time he broke a dish in order to cut the veins of his wrist with some pieces of it. Other times he swallowed stones. He was always put under restraint after a suicidal attempt. However, he could understand everything that was going on. As a matter of fact, his acuity in devising methods for committing suicide seemed sharpened.

When he was questioned more about this long series of suicidal attempts, John added that the most drastic attempts were actually the first ten or twelve. Only these attempts could really have killed him. Later the attempts were not very dangerous, like, for instance, swallowing a small object or inflicting on himself a small injury with a sharp object. When I asked him whether he knew why he had to repeat these token suicidal attempts, he gave two reasons. The first was to relieve his feeling of guilt and fulfill his duty of preventing himself from committing crimes. But the second reason, whose full

meaning he discovered during psychotherapy, was even stranger. To commit suicide was the only act that he could perform, the only act that would go beyond the barrier of immobility. Thus to commit suicide was to live, the only act of life left to him.

The patient was given a course of electric shock treatment. The exact number could not be ascertained. He improved for about two weeks, but then he relapsed into catatonic stupor interrupted only by additional suicidal attempts. While he was in stupor, he remembers a young psychiatrist saying to a nurse, “Poor fellow, so young and so sick. He will continue to deterioriate for the rest of his life.” After five or six months of hospitalization his catatonic state became somewhat less rigid, and he was able to walk and to utter a few words. At this time he had noticed that a new doctor seemed to have some interest in him. One day this doctor told him, “You want to kill yourself. Isn’t there anything at all in life that you want?” With great effort the patient mumbled, “Eat, to eat.” In fact he really felt hungry because on account of his immobility he could not feed himself properly and was spoon fed poorly. The doctor took him to the patients’ cafeteria and told him, “You may eat anything you want.” John grabbed immediately a large quantity of food and ate in a ravenous manner. The doctor noticed that

John liked soup and told him to take even more soup. From that day on John lived only for the sake of eating. He gained about sixty pounds in a few weeks. When I asked him why he ate so much, was it because he was really so hungry, he said: “No. That was only at the beginning. The pleasure in eating consisted partially in grabbing food and putting it into my mouth.” Later it was discovered by the attendants that John not only ate a lot, but also that he hoarded food in his drawers and under his mattress.

John continued to improve and in a few months he was able to leave the hospital. He was able to make a satisfactory adjustment, to work, and later went to a professional school and obtained his Ph.D. degree. As a whole he has managed fairly well until shortly before he decided to receive psychotherapy. Important, however, for our topic are the following additional details. Two years after recovering from the psychotic episode he noticed an incoordination of movements and fear of this incoordination would occur when he was anxious. He had to force himself to win against this resistance to moving; but the movements, to use his own words, “were pasty.” Up to a short time prior to psychotherapy, when he would undergo fits of anxiety, he would often think of inanimate objects, like iron, wood, and so on—

things that cannot move and cannot feel anxiety.

These three cases confirm some pathological developments described in Chapters 5, 6, 7, and 8 and disclose additional factors frequently encountered in catatonic schizophrenia.

We have many details about the unhappy childhood of Sally and Richard and the unhealthy atmosphere in which they were raised. In both cases the mother was the parent experienced as actively destructive, whereas the father was a weakling who was unable to compensate for the mother even to a minimal degree.

In both cases the patients complied with their mother's wishes, not really because they wanted to. Contrary to what happens in the person who develops a compliant neurotic personality, these two patients never accepted their mothers' way of living. They did what the mother wanted at all times, but they secretly rebelled. Richard was so unhappy when he was with his mother that he remembers the time spent in the children's shelter as the best in his childhood. Later on, when he wanted to go back to the state hospital, he tried to repeat the same situation, to go away from his mother, from the place where he had to be active and was therefore subject to criticism. In other words,

going to the state hospital was not only an escape from his mother, but also an escape from action: we may say that it was a partial catatonia. At the same time, going to the hospital meant going to an omnipotent overgenerous mother who would take care of him completely; a mother who corresponded to the image of the good mother that he had possibly conceived when he was a baby.

One finds that in cases of catatonia, more than in the other types of schizophrenia, the parents not only have imposed their will on the reluctant pseudo-compliant children, but also have made it difficult for the children to develop the capacity to will, and therefore, to a certain extent, the capacity to act according to their own wishes. These children are unable to accept their environmental conditions, and at the same time they are unable to fight them. The situation that produces the least anxiety in them is one of *ostensible acceptance,* that is, compliance in spite of themselves. If, on the other hand, they act according to their own wishes, they are either afraid or they feel guilty. Their ability to will, to make a choice, will always remain impaired. They will always experience indecision and ambivalent attitudes. If these patients make their own decisions, they feel that the mother will be angry or that the action will turn out to be wrong, and they will feel

responsible for the failure. The ambivalent attitude is due to the conflict between their own wish, which they do not *dare* to accept, and the parental wish, which they do not *want* to accept. Later on in life, when the parents are not physically present, the incorporated image of the parents (the Freudian superego) continues to argue against the patient's own wishes. One of the frequent methods by which they try to solve their difficulties is by giving up their will and making themselves completely dependent on another person, a symbolic omnipotent mother who will do everything for them. At times the omnipotent good mother is represented by an organization or institution (army, religious order, and similar organizations).

Our third patient, John, wanted to become a monk, put himself entirely under the protection of God, and in this way remove sex and other evil impulses from his life. John, however, never actualized this idea.

If the patients cannot find this kind of solution, and their difficulties of living pile up, the inability to make decisions, to will, to act, will also increase. The patients will try to protect themselves from anxiety in any possible way; one frequent method, such as was used by

our three patients, is to resort to compulsive rituals. The ritual sanctions the actions. If the ritual is not enough to eliminate anxiety, catatonia will occur and will abolish action. The anxiety that the patients experience at first in performing certain specific actions, which they think would be disapproved by the real parent, or by the incorporated image, is generalized later to every action. All actions that are willed by the patients may arouse in them either guilt or fear and are therefore eliminated. This process of generalization is responsible for the state of catatonic stupor. The patients may allow themselves to undergo movements imposed by another person or may obey even absurd requests because they do not will them and therefore are not responsible for them. However, the patients may remain in a state of waxy flexibility, because they cannot will any change in the position of their bodies.

This generalization of the anxiety to every possible action would not take place, however, and would not precipitate the catatonic stupor if there were not a general return to a primitive mechanism of willing and acting that attributes to the person who wills a feeling of responsibility and guilt. This mechanism, which will be discussed in Chapter 17, is generally repressed, but is reactivated by the anxiety of

the patient.

As I said before, the state of catatonia, by eliminating actions, removes any guilt or fear connected with them. One of the fears that has not as yet been considered, but that is present in almost every catatonic, is the fear of his own hostility. The action he contemplates may be a violent action against the parent or parent-substitute. Another fear, which I have found several times in European patients, but less frequently in Americans, and which has been frequently described by other authors, is the fear that each and every movement has a sexual meaning. This is probably what happened to John at the beginning of his acute psychotic episode. It is obvious that this patient underwent an overpowering increase in anxiety when he went to the camp and was exposed to close homosexual stimulation. His early interpersonal relations had subjected him to great instability and insecurity and had made him very vulnerable to many sources of anxiety. This anxiety, however, retained a propensity to be aroused by, or to be channeled in, the pattern of sexual stimulation and inhibition. His psychological defenses and cultural background made the situation worse. John could not ignore completely that part of the self that is variously called social self, conscience, or superego, nor could

he go against his cultural-religious background, as his philandering father and promiscuous sister had done. Sex was evil for him, and homosexuality much more so. As a matter of fact, homosexual desires were not permitted to become fully conscious.

When he was about to be overwhelmed by the anxiety while at the farm, at first he tried again, as previously in his life, to find refuge in religious feelings. But as those feelings proved to be insufficient protection, he resorted to obsessive-compulsive mechanisms. The anxiety that presumably was at first connected with any action that had something to do with sexual feelings became extended to practically every action. This extension was not just the result of primitive generalization (see Chapter 17), but also was due to the fact that John had noticed a lack of correspondence between the act, as anticipated and willed, and the act as it was performed. For instance, he was afraid he could kill somebody when he wanted to cut a piece of bread. The significance of substituting actions with analogic ones will be discussed in Chapter 17. Every action of John's became loaded with a sense of responsibility. Every willed movement came to be seen by him, not as a function, but as a moral issue. Every motion was considered not as a fact but as a value. This primitive generalization of

his responsibility extended to what he could cause to the whole community. By moving he could produce havoc not only to himself, but to the whole camp. It became thus his moral responsibility to inhibit every movement. John's feelings are reminiscent of the feelings of cosmic power or negative omnipotence experienced by other catatonic patients who believe that by acting they may cause the destruction of the universe. John had to choose immobility.

In many cases of catatonia the stupor is not complete. Through the barrier of immobility passage is allowed to actions that represent obedience to the will of others or have special meaning for the patient. This selectivity for certain actions should be convincing proof that catatonia is a functional condition, not an organic disease. It is a disorder of the will, not of the motor apparatus.

In the case of John the actions necessary for the suicidal attempts were allowed to go through. Incidentally, these suicidal attempts in catatonics, accompanied by religious feelings and eventually by stupor, have often led to the wrong diagnosis of the depressed form of manic-depressive psychosis. Kraepelin (1919) described suicidal attempts and ideas of sin in catatonics, but did not give to them any

psychodynamic significance. What is of particular interest in John's case is the fact that the suicidal act eventually became the only act of living. It is not possible here to examine in greater detail the encounter of John with the doctor in the hospital. Often the influence of a powerful and at the same time benevolent person has this rapid therapeutic effect on catatonics. The fact that the doctor gave John permission to eat as much as he wanted is important. The only previously possible act (killing oneself) was replaced with one of the most primitive acts of life (nourishing oneself). In Chapter 25 we shall describe the placing-into-mouth habit in regressed schizophrenics. In slightly less regressed patients we find the hoarding habit (Chapter 24), a stage John went through in his progress toward recovery. In acute cases of catatonia we often find symptoms and stages appearing in other types of schizophrenia after many years of regression.

On the other hand, in other cases of acute catatonia the patient lapses into complete stupor without going through the usual previous stages. For instance, Cecile, a married European woman in her late twenties, fell into a state of complete immobility a few minutes before she was supposed to board a taxi that would take her to the airport. She was supposed to go to Europe, where her husband had gone a year

before. The trip would put her in a position to face him after she had become pregnant from another man and had had an illegal abortion. The situation that the patient wanted to avoid was to pretend faithfulness. Such pretension was more guilt producing than having been unfaithful, something that was terrifying.

The cases of John and Cecile reveal that a profound sense of guilt and a consequent threat to an acceptable self-image can be elicited by events in the sexual area. Here again we must realize that some events of sexual life (even in deviant forms like homosexuality) are schizophrenogenic, not in themselves, but because of their significance for some patients and the previous vulnerability of these patients. In the cases of Sally and Richard sex played only a minor role.

The connection between sexuality and catatonia has been reported by other authors. Ferenczi (1950) mentioned a patient who spontaneously explained to him that with all his catatonic postures and movements he was seeking to defend himself from erotic sensations in the various parts of his body. In the same article Ferenczi reports another patient, whom he strangely considered a case of paranoid paraphrenia. The patient, a talented young artist, had

become interested, to a fanatic extent, in Ostwald's natural philosophy, which preaches that one should accomplish as much as possible with as little expenditure of energy as possible. This patient went to extremes in following this philosophy. At first he made exact plans for the day, allotting a definite time for every kind of bodily and mental activity. Later he felt that he ought not to perform any work at all except thinking. He requested that his relatives respect his absolute rest during his mental work. In his efforts to work "with the most favorable coefficients possible" he neglected the common tasks he was supposed to attend to. With the excuse of acting in the most economic way, he gave up acting altogether. Finally he lay inactive for hours in peculiar positions, which Ferenczi regarded as catatonic postures. We have in this case a progressive withdrawal from action, in the beginning rationalized with ideas taken from a philosophical system, then followed by compulsions and finally catatonic symptoms.

It is important to understand the symbolism of the obsessive-compulsive rituals that in many cases precede catatonic symptoms. In the case of Sally, the ritual about making sure that small pieces had not fallen down may be interpreted in various ways. At a superficial level it represents the compulsive necessity to obey her mother again.

Sally's mother was concerned about cleanliness to a punctilious degree. What a calamity if she were to discover some dust in a remote corner of the house! Only by making sure that she was complying with her mother's wishes could Sally move. On the other hand, those little bodies may represent parts of the bodies of the relatives for whom she had so much hostility. She wanted to reassure herself that the parts of bodies did not fall down. At an even deeper level the little pieces may mean the world that was falling down. She had come to the realization that she had given up everything; the world she expected to live in was going to pieces. She saw herself only as a shadow of her mother, as a desire of her mother. There is also an additional possibility: toward the end of the second year of treatment, she began to use the phrase, "feeling like falling to pieces" when she was confronted by a difficulty. At this time, however, she was able to overcome her difficulties. It could be that earlier in her illness her symptoms were only a concrete representation of her subjective feeling of falling apart, of disintegrating as a willing person. Only by lapsing into a catatonic stupor could she avoid this catastrophe.

Why did Sally and Richard become sick at the time they did? In the case of Sally, the interpretation is easier. By marrying Ben, she saw

herself as being compelled to give up her own individuality and to live as her mother wanted her to for the rest of her life. Ben was a symbolic mother who was able to reactivate the old anxiety at a time when the patient, after a series of disappointments, was least able to cope with it.

In the case of Richard we see a progression of events leading to the psychosis. He did not have a schizoid personality, but rather a stormy one, although not typical. He was very sensitive and tried to protect himself by escaping from action, withdrawing, and avoiding the guilt, the feeling of responsibility, and the anticipation of rebuff. On the other hand, he did not accept the withdrawal and made excursions into life that progressively increased his anxiety and his feeling of hopelessness. In the case of Sally, the marriage was the important culminating factor that precipitated the psychosis. In the case of Richard, no final precipitating factor could be found, but there was a long chain of causes and effects that progressively reactivated the childhood anxiety.

Before concluding this chapter we must mention that some of the psychodynamic mechanisms are related to sociocultural factors (see

Part Six).

At this point we shall only mention that Bastide (1965) has tried to correlate the concepts expressed in the first edition of this book (1955) with some of the findings by Sanua (1962). Bastide stresses that my findings indicate that catatonic patients were overprotected children, because they could not act sufficiently on their own and their parents had made all important decisions for them. Bastide feels that paranoid patients were not overprotected, but rather rejected. Sanua found that children were overprotected more frequently by Jewish parents and rejected more frequently by Protestant parents. These facts would explain, according to Bastide, why Sanua also found a greater incidence of catatonics among Jews and of paranoids among Protestants.

In my opinion overprotection alone is not sufficient to explain the psychodynamics of catatonia. However, overprotection that is not accompanied by permissiveness, but on the contrary, and in a self-contradictory way, is heightened by an extreme sense of responsibility for one's actions, may predispose a person to this type of schizophrenia.

Notes

[1] This case was originally reported in a separate publication (Arieti, 1961a).

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