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Catatonic Behavior in Schizophrenia

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INTRODUCTION TO SOMEONE BECOMING A PATIENT

SEVERAL YEARS AGO I was asked to see in consultation a seventeen-year-old girl who was a patient in the medical section of a general hospital.

For two or three months prior to hospitalization, the girl (Kay) had been noted by her parents to be increasingly preoccupied, withdrawn, and seemingly depressed. Although she insisted that there was "nothing wrong" with her, after much urging she did consent to meet with a school counselor. During the fourth interview with this man Kay became mute, sitting with her eyes closed, her muscles rigid, and saliva drooling from the corner of her mouth. She did not visibly respond to a physician or her parents, and after about four hours in this withdrawn state she was transferred to a hospital, where she was examined by a neurologist who found no evidence of organic disturbance other than a minor elevation of cerebrospinal fluid protein and a slight—and transient—weakness of the left arm and leg. Kay spoke on the third day of hospitalization, but it was reported that what she said "didn't make much sense." I visited Kay during the second week of her hospital stay.

Alone in the room, propped up in bed, was a small, blonde girl, a large toy stuffed animal held close to her by her right arm, three fingers of her left hand in her mouth, and her eyes tightly closed. She at first made no response to my presence. I

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told her a little about myself and the reasons for my coming, and she finally nodded her head when I asked if it was all right for me to be there. I remained for about two hours, piecing together the following abbreviated account from fragments of mumbled phrases interspersed among periods of silence lasting five to fifteen minuts. Asked what she thought of me she replied that she could see me without opening her eyes to look at me—and that her own fear subsided as she came to sense that I was not afraid.

Kay said that she pictured herself as a form of record player, that is, she had developed a special, and hitherto dependable, way of dealing with each important person in her life. Thus she had a "record"—a form of speech—suitable for father, another for mother, another for sister, and others for friends, teachers, and so on. Recently it had become evident that these records, or modes of behavior, were becoming unsatisfactory; they were worn, scratched, no longer conveyed meaning, and she was bored with them.

Kay also spoke of having several "selves"—an "intellectual" self, an "emotional" self, a "practical" self, and others. One self might be pleasing to father but not to mother, and it was increasingly difficult to present a self in circumstances appropriate for its display. The selves were not well organized, unity was lacking, and a self might appear, or a record be played, on occasions so unsuitable that the girl would be embarrassed and frightened at the evident and undeniable decrease in control of her own living. She thought of herself as dying, being empty, hollow, and only a producer of records, the significance and value of which were rapidly declining. She no longer trusted her ability to make sense with others, and attributed their apparent avoidance of her to a destructive, horrible evil deep within her.

For Kay life was getting too complicated for her accustomed ways of behaving, and she was unable to modify these to meet the demands being placed upon her. She couldn't go home or back to school because the records wouldn't work, and the selves were getting into increasing disorder. She also feared that her evilness might destroy someone. "Who?" "My mother, " she said. "I hate her."

I asked, "Who are you?" The answer was, "I don't know." She was to go to college in a few months, but was frightened

at the prospect. In a strange place the old records would not be acceptable, and she doubted her ability to make new ones. "What then?" I asked. "I'm afraid that I'd be in pieces. There wouldn't be any me." I thought that she was speaking of the fear of disintegration of the self in panic. She found a small degree of security in the simplified, stereotyped routine of the hospital, where she lay silent, holding her doll tightly, sucking her fingers, shutting her eyes, and keeping her muscles tensed, as if to hold herself together and build a protective barrier against the world.

It seemed to me that Kay had for the time being found life to be too much for her, and was attempting to shut herself off as best she could in an effort to retain some remnant of recognizable and dependable identity. More succinctly, in the fashion of a psychiatrist, I thought of her as schizophrenic, and of her current behavior as catatonic—at least a mild variant of what had in times past been seen so frequently in large "mental" institutions. At the termination of this meeting Kay was more at ease. She opened her eyes, removed her fingers from her mouth, and agreed to my proposal that she visit the small hospital in which I work and—if it then seemed suitable to her to do so—to engage in psychotherapy with me.

"What is therapy?" she asked.

"About what we've just been doing, " I said.

THE CONCEPT OF CATATONIA

Catatonia, commonly described as one of the types or forms of schizophrenia, is not seen so frequently now as in the past—at least in my experience. I recall the hospital demonstrations of various psychiatric marvels, outstanding among which was catatonia with its waxy flexibility, posturing, command negativism, mutism, echolalia, and so on—a treasure house of strange and threatening psychopathology—all to be put aside on occasion by tempestuous outbursts of excitement. The demonstrator would reveal through the patient these wonders to a class, often speaking as if the subject of his remarks was somehow not present, but lost behind an impermeable barrier of disease. If there is a lessening of these phenomena the reasons for this may include the use of ECT and ataractic drugs, the refinement of a

therapeutic milieu, and increased recognition of the interpersonal aspects of so-called "psychiatric" disorder. There also may have occurred a change in cultural styles, making such dramatic exhibitions no longer as socially acceptable as once they were.

The word *catatonia* refers to a lowering of tension, described by Kahlbaum in 1874 as a disease entity, and later by Kraepelin as a type of dementia praecox. Clinically the disorder consists of (a) stupor with marked rigidity or flexibility of the musculature, or (b) overactivity—an excitement **(Hinsie and Campbell, 1960)**.

Fenichel describes catatonia as a regression to earlier stages of the ego, a state in which the person feels as if an authority other than his own governs his acts, strange thoughts are put into his mind, and his words and gestures have great and unusual power. His posturings suggest the recurrence of impulses from intrauterine existence, and the muscular rigidity may reflect a conflict between the impulse to act and a defense against it. Very importantly, he notes that the automatic obedience, gestures, mannerisms, and peculiarities of speech are attempts designed to regain contact with objects **(Fenichel, 1945)**.

Arieti speaks of the catatonic person as one who exhibits a disturbance of the faculty to will. He says: "Catatonia is a removal of action in order to remove the panic connected with the willed action." **(Arieti, 1959)**. Arieti suggests that the child, who is to become in some instances catatonic, has been prevented in his upbringing from developing the capacity to will—to act in accord with his own wishes. For such a person to act is to experience anxiety and guilt—relieved in part by the compulsive and obsessive behavior that characterizes in increasing amounts the period immediately preceding the open display of schizophrenic disorganization **(Arieti, 1955)**. The failure of these ritualistic defensive devices to limit the accession of anxiety may lead to the resort to the catatonic mode, whereby discomfort is reduced as action is, for the time being, prevented. In such instances volition seems to be associated with a sense of great responsibility, as if any act brought with it the threat of unknown but dangerous consequences. As described by Arieti **(1961)** the catatonic person is not in a state of peacefulness, but is caught up in a turmoil of intense emotion, the very fluidity of which contributes to his therapeutic accessibility.

Sullivan considered the catatonic experience to be the essential

schizophrenic state—one marked by a sense of great need for early resolution, and, accordingly, by a quality of transience. He said that catatonic behavior "is of *a genetically more primitive nature* than ever appears in a remembered dream." **(Sullivan, 1962**p. 19). The conservative nature of this phenomenon lay in its " *attempts to regression* to genetically older

thought processes—to infantile or even prenatal functions— *successfully to reintegrate masses of life experience* which had failed of structuralization into a functional unity." **(Sullivan, 1962**p. 21).

The catatonic behavior described in this commentary appears in chronological adolescence or early adult life, there having been a previous consolidation of experience in which the need for intimacy and the rewards to be derived from it had been to some extent recognized and accepted. As the person concerned attempts to deal with the interpersonal-social-cultural requirements of adolescence—as in the search for an increase of intimacy with another human being—aspects of his earlier living (affects and ideas—sentiments)—hitherto dissociated, fragmentary, and not clearly recognized as part of the self, now must be acknowledged, if there are to be integrated and elaborated relationships that will not be simply superficial or transient. The pursuit of human closeness-initiated in infancy and intensified in adolescence—requires increasing self-revelation; as a consequence major systems of experience and value (if dissociated) are disturbed and revealed, leading to the entrance into awareness of referential processes lacking in definition and refinement, not readily connected with the remembered past, and not part of the self as known to the person or his associates. In brief, such an individual is faced by a complicated task: the search for closeness, friendship, and affection demands exposure of what one is. Such uncovering may bring to light unknown and possibly unsavory—if not intolerable—aspects of the person, that will alter the self concept and threaten or perhaps destroy the sought-for relationship. In attempting to gain greater intimacy and at the same time maintain a major dissociation of past events and their implications, one or the other goal must be modified or abandoned. If the former is pursued the contents of awareness will not be readily governed, with the resulting intrusion into them of fragments of experience felt to be foreign, frightening and nightmarish. Such a condition requires rapid

resolution. In this unhappy situation the individual must maintain some minimal form of the needed human contact, keep anxiety within tolerable bounds, control the contents of awareness, communicate with others in a conventional mode, and not act so crazy that he might be attacked, abandoned, or driven out of society entirely. The resultant behavior may not appear so incomprehensible or mad, if it is understood that it represents an attempt to solve in haste a problem as yet undefined, without the public exposure of grave personal disorder and deviancy.

Having referred to nightmares, a few words on this subject may be appropriate at this juncture. The schizophrenic state of panic has elements in common with the nightmare, a fundamental difference being the continuation of terror and its accompaniments beyond the sleeping state and the period of arousal. The following quotations are from "Nightmares and Human Conflict" **(Mack, 1970)**:

> From the point of view of the dreamer or of the psychotic, the overwhelming character of the terror in the two states is very similar. In each instance, the individual feels himself to be weak, helpless, and profoundly vulnerable in the face of powerful external forces or being that he believes will attack or destroy him. P. 164.
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> The adult's nightmare and the acute psychosis may both be regarded as responses to a threatening or painful experience in the outside world, a current reality that has had a profound internal psychological impact. This reality is most often an actual assault or a threat of attack, an intense thwarting of libidinal or object need such as a disappointment in a love relationship, or the loss of an important person upon whom the individual is dependent. These precipitating factors are made painful not merely because of any intrinsically traumatic qualities that they possess. They have the potential for provoking a regressive response because of their association with persistent internal conflicts and traumatic experiences and situations in the individual's past, especially those of childhood … In both the nightmare and the acute psychosis, the ego has been unable to limit the intensity of the anxiety, and it has become overwhelming with the result that primitive projective and distortion mechanisms have come to predominate, and reality-testing has been severely impaired. P. 172.
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> Finally in both the psychosis and the nightmare, especially in children, the comforting, protective presence of another person is

> of vital importance in restoring equilibrium to the personality. P. 165.

This last sentence fits well with the recommendation—which I strongly support—that the person involved in schizophrenic panic have close contact with another person (nurse, therapist, perhaps patient) who can be a stable, well-defined, supportive figure, and effective in helping the victim to distinguish "reality" from psychosis, and to "wake up" and find other ways to identify and deal with his difficulties.

Of particular importance in this concept is the idea that the patient has, in his earlier life, formed the need for attachment to other human beings—painful though that often turns out to be. Without such a need—frequently denied or not recognized—the therapeutic task is greatly complicated, if not made, for all practical purposes, impossible. That is, for a favorable outcome there have been "positive" as well as "negative" influences in the patient's development—and the past has not been all inimical to growth and understanding. The difficult to comprehend mixtures of behaviors—those that increase and others that decrease anxiety, favor or interfere with communication, lead to the self-concept being clear or otherwise, and so on—may have more to do with later psychotic confusion and fear than any single pattern of behavior labeled destructive, but having the virtue of being at least identifiable and verifiable with other people.

The psychotic performance, bizarre as it may be, reflects conflict, is problem-solving, and is goal-directed. Psychotherapeutic intervention is most likely to be useful at the earlier stages of disorder—stages marked by confusion and attempts to deal with panic—prior to the consolidation of experience in a manner that may reduce anxiety, but at the same time will permit only stereotyped and superficial human contact with resulting limitation of further personal development. The need for early human presence is to be emphasized—without a quick resort to ataractic drugs or ECT. The problem is very largely an interpersonal one—both in terms of origins and current events—and the human relationship can be the primary and vital agent in furthering change in a favorable direction. By favorable I do not mean simply a reduction in, or elimination

of, disordered behavior, or a return to a state (if that were possible) that existed prior to the appearance of the nightmare. Hopefully there will be obtained an alteration in personality structure that will favor the inclusion in the self-concept of important aspects of previously dissociated experience, with the possibility of a concomitant increase of satisfactions in interpersonal relationships (as opportunity allows) and an opening up to further learning **(Sullivan, 1956)**.

It may be useful to review here selected, but common, aspects of the catatonic phenomenology without any claim that the events are being precisely "explained."

The person on the way to becoming openly schizophrenic is confronted by a variety of situations with which he must deal without being well equipped to do so. Characteristic of these situations are the following: (1) they require change in the person—implying growth, learning, and the alteration of concepts of self, others, and the universe; (2) they involve an increase of intimacy, with attendant demands for further revelation of the personality, aspects of which may have been denied, gone unrecognized, or been concealed from the self and others as unacceptable and not even considered as "part" of the person; and (3) they lead to forms of separation—from places, people, ideas and values, and from concepts of the self. To some extent these matters must be dealt with by each of us—strikingly in adolescence—but at other times also when we wish (or are forced) to evaluate the options available to us in living, and to make a choice among them.

This task is more difficult for those in whom the sense of personal security and identity has been maintained precariously. When important aspects of the personality are experienced as evil and disreputable—although poorly defined and understood and not translatable into communicable speech—they must be concealed from public view in order that a minimal sense of self-esteem be achieved and maintained. In such instances the feeling of security is so fragile that "portions" of the personality (an awkward locution) are not only kept private, but are also not available to awareness, except in occasional dreams. Unfortunately the need for security that requires this obscuring and limiting of self-knowledge interferes with the gaining of experience that could lead to useful change. Thus, vaguely defined

ideas of self as somehow evil and destructive, derived perhaps from infancy when the circumstances of their origin were not clear, were not corrected or validated in later periods, as they seemed too awful to be brought into the open; they continued as "unknowns, " or at best were dealt with autistically. The keeping from awareness of important aspects of the personality is a complicated task; to accomplish it there is much about the behavior of oneself and others that must be observed, evaluated as dangerous or not, and then accepted, or not noted, or dealt with in such a fashion that threatening personal implications are not developed.

In adolescence the situations referred to above arise with accompanying demands for response and change. Some young people respond to these demands by adopting pseudo-performances—behaviors that may be acceptable socially for a time, but are superficial, usually unsatisfying to those concerned, and detrimental to personal growth. There is formed a facade that outwardly seems to indicate change but acts to prevent change. I refer, for example, to the use of genital sexual performances to suggest affection while obscuring its lack.

For those people who become patients such devices eventually fail to ward off an increase of anxiety. As the need for change becomes more imperative, the inadequacy to accomplish the task becomes more apparent, and there develops a sense of impending failure. The person so involved must now guard against threats from the world "outside" and from

those representations of experience which previously had been dissociated. These matters can no longer be denied, rationalized, avoided through obsessional operations, or dealt with by sublimatory processes or selective inattention. In brief, the move toward intimacy with another human being requires a greater exposure of the personality than is satisfactory in more superficial, stereotyped encounters. This exposure includes not only the self as known to the person but will tend to bring into awareness any major systems of ideas and emotions that have been dissociated, but are now needed to further the interpersonal integration. Dissociated representations of experience, as the phrase is used here, are in the form of referential processes that lack the refinement (in terms of time, logical sequences, cause and effect, space, and identity of self and object) of the ordinary day-by-day forms

of thought, are not to be approximated in language, and are unsuitable as a means of communication with others—schizophrenic or otherwise.

The *spread of meaning*, in which everything seems to be involved somehow with one's existence and to have an undetermined but great significance, is a reflection of the decline in precision of referential processes, and the accompanying tendency to attend to phenomena that we have learned to disregard for the most part, or to accept as familiar aspects of living for which no explanation is required and to which no "meaning" need be ascribed. At such times there are in awareness fragmentary representations of past experience in which the distinction between me and you, sequential segmentations of time, and so on, are lacking, and the boundaries that we ordinarily (however vaguely) think of as separating the person from the "world" are less well defined. In this state the person may feel involved in some inchoate, universal design with the personal and impossible task of untangling the meanings of such matters as truth, love, trust, beauty, reality, and so on.

There is a feeling of *urgency* to find answers and take action in this strange and terrifying universe. On this subject Sullivan said: "… (T)he schizophrenic suffers an almost unceasing fear of becoming an exceedingly unpleasant form of nothingness by collapse of the self. … (T)he urgency is to get together again, to have the world remain, you might say, at peace instead of undergoing the unearthly intrusions and extrusions and divagations and one thing and another that the rest of us experience mostly in our nightmares. **(Sullivan, 1956**pp. 318-320).

The action taken in an attempt to resolve the unknown problem—to dispel the nightmare—usually miscarries, and the difficulties may then be complicated further by the public exposure of madness. Such embarrassment, or its threat, may lead the victim to eschew all major action for the time being, assuming an attitude of outward quietude marked by rigidity or stupor. The person involved in all of this may not feel responsible for what is happening, in contrast to an earlier feeling that he was responsible for "everything"—or at least for far too much. It may seem to him that an external power takes over, preventing activity and curtailing the exercise of that concept

by which he may have been bedeviled in the teachings of his earlier years—the "will power" which was supposedly devised to control himself, if not others, and which became one of the imprecise and ominous cultural prescriptions eventually controlling him. On occasion the power seems to invade the person and becomes, as it were, the self, whereupon attempts may be made to bring about changes in this mysterious universe through the demonstration of gestures and speech more aligned with magic than anything else. When one is caught up in the unknown he may seek to escape, or control, the situation by becoming a wizard and attempting to deal with magic by magic. From this point of view the behavior may be seen as sensible rather than crazy, akin, perhaps, to the dreamer's attempt to resolve or find a way out of the nightmare. If the resort to wizardry involves rapid bodily movement, violence, and verbal accompaniment the term excitement may be applied.

The urgency that marks this acute schizophrenic condition demands an early resolution. The outcomes of panic include the following: (a) death through physical exhaustion; (b) suicide by misadventure or as the result of an attempt to magically change the situation by death supposedly to be followed by rebirth; (c) paranoid reformulation of experience in a manner difficult to modify therapeutically because of its effectiveness in reducing anxiety through the use of a pseudo-solution for pseudo-problems; (d) hebephrenic giving up of interpersonal involvements for the disastrous safety of preoccupation with the body and fragmentary minutiae of existence; (e) recovery of a superficially conventional but now more guarded way of life through the reinstitution of dissociation and other defensive processes—usually a retreat from further attempts at intimate human relationships for fear of the recurrence of the dreaded panic; and (f) inclusion of aspects of formerly dissociated experience in the self with a resulting increased tolerance for the total personality—and an improved ability to engage in new experience, to dare to learn and to grow.

The urgency, the involvement in uncertainty, the seeking for solutions, and the lack of resolution of this acute stage of disorder make it the most promising time for psychotherapeutic intervention. If at this juncture the beginnings can be

made of a clear-cut, trusting, honest human relationship the more grave of the

schizophrenic resolutions may be avoided and the prognosis need not be bad, which is not to suggest that the difficulty can be taken lightly.

COURSE IN THE HOSPITAL

Kay was in treatment in an open psychiatric hospital for two years and then lived as an outpatient for about five months. There were five sixty-minute (or longer) sessions with the therapist each week plus additional meetings as indicated—a total of 550 sessions. Most of the meetings were held in the office, but sometimes we met in her room, rode in the car, or walked about the grounds—the choice depending largely on Kay's level of anxiety. Detailed (not recorded) records were kept of the interviews in an effort to trace the course of patterns of behavior.

At first Kay was suspicious, withdrawn, and frightened; she wanted nothing to do with psychiatrists and their practices, belittling our efforts and insisting that nothing troubled her, or that she was too disordered to receive help, or that her being at the hospital was a mistake or some sort of a fantastic joke. The detachment and muscular rigidity were repeatedly exhibited during the first six months, being witnessed by me (the therapist) on ten occasions. This behavior was present in partial and transient form twice thereafter, the last being a few months before the termination of therapy—as if this were a way of saying farewell, for the time, at least, to a once familiar and useful way of acting. The subject of withdrawal—specifically as catatonia and in more general terms—was discussed in seventy-five sessions, being last mentioned specifically about seven months before the end.

In the third month of hospitalization Kay began cutting herself—on feet, arms, and face—a phenomenon that continued over a period of seven months. During this time she also injured herself by burning with cigarettes, biting, beating, and involvement in a series of "accidents." With these events there was developed an account of her longstanding feeling that she was somehow inferior, that she must be "perfect, " and that she should punish herself for any imperfection. In the tenth month anxiety increased markedly, she became preoccupied with an urge to kill a nurse to whom she had been closely attached and who now seemed

to resemble the younger sister, and she made a suicidal attempt. For two months small amounts of ataractic drugs were used to reduce the intensity of emotion although Kay protested at this, saying that the medication seemed to build a barrier between her and others. In a less open institution the drugs would not have been used, greater reliance being placed on the human relationship.

Although the course of therapy cannot be divided accurately into segments, in a crude sense the following periods were noted:

1. Kay has very little feeling, or none at all; she is self-contained, seems to need no one, and rejects human contact, often being preoccupied with fantasy.
2. Emotion is then more openly expressed but is directed at her self and her body as objects. She injures her body and berates herself.
3. Her feelings were then directed more persistently toward the therapist and other members of the staff. She attacked the therapist (no harm done) and went through a period of "transference psychosis, " making a suicidal attempt as her hostility toward, and dependency on, her family became more evident.
4. As affectionate and trusting attitudes toward the staff grew there was an open expression of anger and hurt related to her family.

The above elements were most dramatically displayed during the first year. Thereafter, the destructive activity subsided, ambivalence was reduced and better understood, and Kay became involved in work and recreation in and out of the hospital. In making a condensed statement about this matter we can say that the major difficulties dealt with were related to distress about attachment and separation. The patient is now in college and not in treatment.

The psychological test diagnosis at the beginning of therapy was of an acute schizophrenic reaction with catatonic features.

SUMMARY OF KAY'S DEVELOPMENT

This summary is brief and is not presented as an explanation of the behavior described. We are interested in the course of

development that preceded—if it did not "cause"—the openly displayed disturbance in adolescence.

Kay is the older of two sisters. She was born prematurely and spent the first six weeks of her life in a hospital incubator. Thereafter her mother was fearful of handling her as she was thought to be "fragile." The father is a quiet but successful businessman who places great value on intellect and professional prestige. The mother is more open in display of emotion and does not have the intellectual "toughness" that her husband admires; she tends to be offended easily, is chronically depressed, and is self-critical to an extent that distresses others who feel blamed and at fault. Kay identified more closely with her father than her mother; she was known as a tomboy who devoted herself to athletics, hunting, and vigorous sports, affected masculine dress, and scorned female "frippery."

At the age of four years Kay bled heavily after a tonsillectomy and thereafter began to withdraw from her mother, who had been present, but, from the child's point of view, not helpful. She stayed more by herself. Frequently she secluded herself in a closet in the house, sitting on the floor with the light off, holding her blanket or doll, listening to the faint sounds of household movement, and feeling comforted. She sought the closet when puzzled or frightened—as by family quarrels.

At about five years there was developed the concept of the *Well* —something like a cylindrical, deep hole with glass-like black walls streaked with yellow. At the top was an opening toward which one could climb by a ladder attached to the wall. As the top was reached the light began to replace darkness, and her mother would appear to push her down. Although she then fell, the yellow caught and held her, preventing serious harm. In seeking to climb out of the Well, Kay found both the light and the anxiety associated with mother; in falling she was sustained by the warmth of her father—the yellow of the sun. Although being in the Well was frightening, it was also a refuge and protection from the panic of separation—as was her family.

At seven years came nightmares; these were of pursuits by Indians, wolves, and gunmen, with no refuge to be found, and awakenings in terror just before she was to be killed. Mother was now busy with her own career, and Kay turned from her, no longer asking directly for tenderness, but showing her need

for it by a display of malice (Sullivan's concept of "malevolent transformation"). The girl now used herself as an object, playing the roles of both mother and child, hugging herself and being hugged as she withdrew from acknowledging the need for the parent.

The idea of the *Island* was formed at about nine years. This was a beautiful place to which one could go when in trouble. On the Island were people who spoke her own private language, who welcomed her, who did not find her strange, and who would protect her when the need arose.

During the years nine to thirteen Kay gained an excess of weight and thought of herself as repulsive and ugly. There was nothing about her body that she liked. The family moved to a different part of town and the separation from familiar objects added to the girl's growing sense of disorientation, dislocation, estrangement, and uncertainty about her own identity. The Well and the Island were no longer so readily available as they had been; as the complexity of social demands increased anxiety grew and the old methods of reducing it were proving inadequate. She was depressed.

By fourteen Kay felt that she was walled off from other people by a cylinder of glass, and that none were aware of her isolation. Should the wall be broken, by accident or intent, it seemed to her that she herself would shatter. In an effort to feel a little more at ease she drank, smoked marijuana, tried amphetamines, and had sexual affairs during which the aloneness was briefly driven back. She lost weight and her body, at least, was for a time more acceptable.

At fifteen Kay was less tolerant of groups, was often confused and unable to concentrate, and was apprehensive at the possibility of losing another source of her failing self-esteem—her excellent academic performance. As the demands increased to identify herself as female, adult woman, person separate from family, and so on, she found that she had no one, coherent identity. She thought of herself as only a collection of records which were no longer popular or useful, and for which no replacements were available.

Increasingly Kay felt that she must control "everything"—thoughts, body, feelings, environment—in an effort to make life knowable, simplified, and predictable. Being intolerant of

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[1] In this operational description the concepts of ego, punitive superego, incorporation, etc., are not used.

uncertainty, she sought to be omnipotent. She would be made of steel, be a robot, have no contact with human beings, be free of emotion and desire, and be invulnerable to all human experience. She cut herself, burned herself, was injured in sports, endangered her life while driving a car—and let no one know about all of these happenings. To herself she said that she was stupid, ugly, weak, destructive, and bad; she should be punished by beating, burning, humiliation, derogation, and abandonment. She acted as if she were a cruel parent determined to castigate a wicked child; earlier she had acted as both the comforting parent and the comforted child. The real parents were being excluded from the person she felt herself to be;[1] in this way she avoided recognition of her perception of her parents—as demanding, unsympathetic, critical, and punitive. To accept this aspect of family life at this juncture would have brought her to face the possibility of leaving home; this she could not tolerate. Kay did give some evidences of trouble by wearing ragged clothes, dressing like a boy, eating compulsively, exploding in tantrums of temper or withdrawing into silence—but the message was not received clearly by others. When help was offered she rejected it, saying that she needed no one; she was so threatening in her insistence that she be left alone that she was left alone. She had fantasies of being severely injured—as in an automobile wreck—and being taken to a hospital where she would be cared for by a loving woman.

The period before the final collapse was marked by a series of losses—actual or impending. The Well, the Island, and the toy animals were no longer so available or satisfactory. The records were failing. Her lover left her, and a young woman whom she had known for years—and liked—went away. She was unhappy at home, yet bound to it. She was ashamed of her fear to to to college. Now she was convinced that she could not meet the expectations of her parents or others, and that she would be deserted. Nightmares were more frequent and often Kay did not know if she were awake or dreaming. There were periods of confusion, perception of other people was blurred, and she scornfully insisted that she had no human needs while she covertly considered suicide.

When Kay finally came to the office of the counselor she was unable to talk with him, being convinced that he would loathe her and cast her out when he learned more about her. She then was catatonic. The rigid state appeared publicly at the time when object contact was being lost and the demand for it was increasing.

CATATONIC BEHAVIOR AS OBSERVED BY THERAPIST

There follows a brief description of a meeting with Kay during which she displayed catatonic behavior.

In the fourth month of the patient's hospitalization I was called by the nurse at eleven at night to visit the patient who was said to be unresponsive. Kay was lying on her back in bed. Her right arm was extended in front of her, the left being held tightly at her side. Her eyes were closed and the visible musculature was tensed. She held her breath for what seemed like long periods of time and made no obvious response to my presence. I sat down beside her, lightly rubbed the tightly clenched fist of her left hand, and commented on her present state and my puzzlement at it. I don't know exactly what I said, but I did not attempt to "interpret" what she was doing. I simply said what was so—namely, that I didn't know what the behavior meant in terms of current events and our relationship. After a few minutes—perhaps ten—she spoke in an explosive, disjointed, shaky manner with little regard for sentence structure. "… think … shouldn't … perhaps … intellectual me … governor … no me … no govern … all right maybe."

After a few minutes of that sort of performance Kay became more relaxed, opened her eyes, sat up, and then spoke more clearly. She said that she seemed to be changing, in that during the past several days she had been flooded by emotions that she had not experienced for years. She was becoming attached to me and members of the nursing staff and found this development frightening. People, she said, are not as reliable, predictable, and manageable as the toy animals or the fantasies of Well and the Island. Her renewed involvement in the interpersonal world increased her anxiety; there was more uncertainty in this world and greater risk of loss. It could not be controlled to the extent that she felt she required. Kay was angry at me, as I was "taking

away" the refuge that she had constructed and offered little in return. She wanted to go back to the Island, to Well, to the closet in the old home; she said that I was attacking her very life and seemed set on destroying her. I replied that I had no quarrel with her possessions—fantasies or otherwise—and wasn't trying to advocate some "good" life in contrast to a supposedly "bad" one. I added that when one dared to care about someone else he did face the inevitabilities of change and loss, and I knew that the prospect could be frightening. After a time Kay smiled and said that she thought she could go to sleep. I sat by her bed, and shortly she slept—whereupon I left.

PHENOMENOLOGY AS DESCRIBED BY KAY

In an account of events such as are outlined here one recognizes that there may be little correlation between what is said and what was experienced. The report of a dream, for example, is not the dream itself or the experience of it—only a translation from one mode of living to another. The giving of an "explanation" need not explain, as the purpose may be to terminate investigation and reduce anxiety rather than to seek illumination. In addition, what is presented may be tailored to what the listener supposedly wishes to hear—the therapist, for example, who seeks information about the drama of schizophrenia. Thus it is that we are denied the luxury of being believers or disbelievers, but must be, as best we can, observers.

Although we shall not consider dreams in detail here, their role in Kay's life was important. Since the age of about seven years she had had frequent terrifying dreams. In the sixth session she reported the following dream.

"I have always had this same sort of a dream. It used to be that Indians were chasing me … but more recently it's a couple of men. There is always some kind of a house in it, and I run to get in the house. The house is on the seashore—and also on a mountain. That's sort of strange—I guess the mountain is near the sea. I'm being chased—and I have to lock everything up so they can't get at me. I go all over the house, locking windows and doors as fast as I can. Outside are these two men. They are dressed all in black—black shoes, black pants, black trench coats. They have black hair and their faces are dark. Whenever I come to a window they are looking in …

They don't seem to be in a hurry … but no matter how hard I try I can't get everything locked up. I always do something wrong. I can't get a window locked, or I forget to lock it, or there isn't a lock on one of the doors. The men get into the house. They have knives—bright and shiny. They are going to kill me … I lie on the floor and they sort of crouch over me with the knives, and I keep struggling and try to wake up … Even in the dream I feel maybe it's a dream … And then I wake up before they kill me. I'm terrified—all covered with sweat." At this time the dream was not interpreted or dealt with in detail in view of the patient's marked anxiety that was roused whenever I attempted to add "meaning" to what she said.

In the early months of our work Kay was afraid to go to sleep at night, fearing the appearance of nightmares. Sometimes I—more often a nurse—sat with her until she was asleep. After waking from a nightmare there might be a period of several hours before she could distinguish between the dream and the waking state. In some sessions in my office her speech would become more fragmentary and obscure in meaning; as anxiety increased she would lose "contact" with me and drift off into the disorganization of psychosis—a caricature of disturbed sleep. Then I would raise my voice and sometimes shake her, saying, "Wake up! Don't go away. I'm here." Frequently, when approached in this way, she would withdraw, seem terrified, strike out, or be about to run. Such reactions usually were prevented if the intervention was made at the beginning of the withdrawal.

What follows are excerpts from Kay's description of her experiences in periods of withdrawal, given primarily during the first 200 hours (eight months) of therapy.

Kay knows that somehow people "make" her anxious. She then feels an external pressure, and thoughts that make no sense come into her mind from "nowhere." She tries to control these by making rhymes and thinking of metaphors, hoping to bring a semblance of order into a situation of increasing disorganization. She feels surrounded by an ill-defined threat, as if the air were filled with evil. Familiar objects become distorted, strange, and frightening. Often there is an indistinct murmur of voices. She wants help, but no one recognizes her difficulty, and she is unable to call to anyone. She wants to run, but fears that she

is so fragile that any movement may lead to her "coming to pieces."

As any action seems to increase the danger, Kay may become "rigid, " as she speaks of it. Then she feels hollow, encased in sand, or glass, or ice, in some instances seeming to become sand, or glass, or ice, herself. In this state, lasting an hour or more, she has no thoughts, feels no fatigue, and is but dimly aware of activity around her. There is relief from fear. This state was developed when Kay was about ten years old and offered more silence and detachment than the Well, which had begun to fail her.

There are times when Kay feels tense, notices a blurring of vision, and seems "to become solid like a block of ice." There is then a feeling of terror as a Power takes over the control of herself—and then relief at being no longer responsible for herself. The Power may become the essence of her being, replacing the self, so that she is no longer Kay, but something else. If someone touches her the feeling of isolation diminishes and she may regain her self. The Power—sometimes referred to as *It* —surrounds her, invades her, becomes a part of her, and then *is* herself as she surrenders and becomes one with it. This *It* resists her growth, "saying" that she must never change in any way, as to do so would lead to a great disaster for Kay—and *It*. It is as if a mother told her child that the world was too dangerous to live in, and that the

family—as well as the child—would be destroyed if development continued and separation occurred. A struggle developes between the forces of change and the need to avoid anxiety. *It* and the therapist are frequently placed in opposition to each other. Betterment from the therapist's point of view may be seen by the patient as destructive to self and family, and suicide may be seen as the only way out of avoiding the apparent disaster of change. Kay did equate *It* with a representation of her mother. A mother, vitally needed in a child's growing up, may control the child more than is required, and her presence may become both a necessity for existence and a hindrance to development. Thus it was, perhaps, that Kay both desired and feared *It;* she found it both good and evil, the introjection of an experience marked by great ambivalence and obscurity.

Prior to hospitalization Kay found it increasingly difficult to

"get into" a protective detached state when anxious. There were then devised rituals that for a time facilitated getting the desired result. For example, she would secretly cut the sole of her foot. The injury somehow enabled her to "get into" a withdrawn condition. There she would have the fantasy of being cared for, finding a comfort and peace that she later spoke of as being with a mother.

THE "MEANING" OF CATATONIC BEHAVIOR

It is difficult to ascribe meaning to the phenomena which we are now considering. One can combine all of the behavioral descriptions under one general heading—such as defense against anxiety—thus losing subtlety and variety in oversimplication; or one can resort to so many classifications that a central issue of importance is minimized or lost. During the first eighteen months Kay frequently spoke of the phenomena of withdrawal, and it was noted that her observations could be placed in several categories in terms of function. By function, I refer to the benefits that Kay seemed to gain from the behavior. This is not to say that in any simple sense the behavior is designed to produce specific results, or reach a certain goal. We are unable to say that the behavior is innate in contrast to being learned. That problem is beyond my competence. The human organism has the ability—as do many others—to withdraw, remain quiet, and maintain alertness in response to danger. To an extent such behavior can be taught—witness the American Indian infant who learns to refrain from whimpering when the enemy is near. Sullivan speaks of "somnolent detachment, " a sleep-like state to which an infant may retreat in the face of anxiety, to emerge later into what will hopefully be a more rewarding situation. One way of avoiding danger is to lie still, shut aspects of it out of awareness, and hope to go unnoticed. From this point of view catatonic behavior is a method of keeping out—or getting out—of trouble, when one can't understand the trouble, run away from it, or do away with it. Many of the decorations of the response—fanciful adornments—are learned and reflect the cultue, the times, and what may be acceptable locally.

There follows a brief review of Kay's account of catatonic behavior in terms of its seeming usefulness in her life. Four

general categories of function have been derived from these reports which were given primarily during the first eighteen months of therapy. These phenomena were rarely mentioned or put into action after that period. It will be evident that the categories are artificial contrivances, and that one group is not clearly distinct from another. The withdrawal behavior—referred to here as catatonic—seemed to serve the following functions:

1. The exercise of *control* over—

a. the organization of the self;

b. the input from external stimuli;

c. the integrity of the body image;

d. the contents of awareness; and

e. destructive impulses.

2. The making of choices or *decisions* (as in the exercise of so-called will).

3. The attempt to lessen *isolation*.

4. The movement toward a *protective* environment.

The above outline is dealt with more fully in what follows.

1. Control

The greater number of references had to do with this topic (fourteen references in the first nine months, sessions No. 18 through No. 215; the fifteenth reference came a year later, No. 389).

(a) The Organization of the Self

In Kay's growing up emphasis had been placed on her being controlled, stoical, successful, and responsible for all that happened to her; she was to be impervious to pain and was to approach perfection in all that she did. Any failure to seek for—approach—a perfectionistic ideal was looked upon as evidence of personal defect or weakness. Prior to hospitalization there were years of insecurity in the home, and Kay grew to feel personally inadequate without knowing what her fault might be. She used various devices in efforts to reduce anxiety and shore-up failing self-esteem. A number of these have been discussed.

There was a lack of integration of the self, and attempts were made to reinforce organization even as it was falling apart. The

concept of I was inconstant; it seemed to be composed of irreconcilable attributes—male and female, mother and father, "hippy" and conservative scholar, good child and hateful beast. In the attempts to hold herself together she would say repeatedly, "I am I, " and as this magical reminder failed she might become rigid—catatonic—thus reducing conflict as well as perception, affect, and awareness of the incompatible "parts" of herself. The field of attention was restricted to the exclusion of some of its more troublesome aspects.

(b) The Input from External Stimuli

The input from external stimuli often threatened to become overwhelming. There were too many demands, ideas, requests, suggestions, voices, and so on, and Kay withdrew from these to attend to what went on "in the mind." The hospital often mimicked the home—crowded with people, movement, ringing telephones, quarrels, conflicting ideas, inexplicable disturbances—a constant turmoil from which she sought escape. These intrusions from "outside" were experienced as replacing Kay's own ideas, as if the sights and sounds became tangible objects that would enter into her body. The result might be that she would be filled with foreign stuff that would replace her own self—a form of death.

(c) The Integrity of the Body Image

Kay's image of her own body was usually derogatory and often fragmented. In early adolescence she was overweight and compared herself unfavorably with her slender young sister. She felt that her breasts were too small, her hair ugly, and her face a disaster; she made no attempt to appear more attractive, using no make-up, wearing torn and worn clothes, and often refusing to bathe. "Inside" there seemed to reside something evil, which some people noticed without daring to mention what they saw, and which others turned from in disgust. Sometimes she felt as if her hands and feet were not attached to the rest of her body and as if she were empty inside. In the rigid state the fragmentation of the body could be halted, and for a time the pieces pulled together into a fragile unity, and the emptiness filled.

(d) The Contents of Awareness

A few months before she became a patient Kay found that she was no longer able to focus her thinking. In the past she had been able to wake up from the nightmares. The distinction between waking and dreaming became indistinct. There were many feelings and thoughts—sentiments—that were unfamiliar to her, and did not seem to be a part of herself. No longer could she control the contents of her awareness. The withdrawal with its concomitant limitations or absence of thoughts served to reduce for a time this "internal" invasion of consciousness. The stimuli from in and out were being held temporarily in check.

(e) Destructive Impulses

Kay feared her own destructiveness—particularly to those people who were close to her and needed by her. It seemed to her that some poorly comprehended—but strangely evident and powerful—core of evil within herself would hurt anyone who related to her—driving him to madness, sickness, or suicide, or to abandoning her. She attempted to cope with her aggression by running away from the object, by injuring herself, and by becoming immobile and thus preventing action.

In a sense Kay did not simply exert control; control became a part of her—an embodiment of Power or It. She felt governed by "fate" and was terrified at the possibility of making "foolish errors, " or forgetting events supposedly easy to remember. Such errors were taken to be reminders of It's power over her, as if It said: "Remember that you belong to me. I shall not let you go into what they call the real world. Whenever you begin to feel competent I shall remind you how bound you are to me—by showing you your incompetence."

Control had to do with maintaining a personal integrity. In order to accomplish this task the external and internal inputs had to be reduced, and destructive action restricted or diverted. The self-organization and the image of the body were closely related to the above. For the patient the tasks are too many and too great, the preparation for them is inadequate, failure is seen as a probability, there is too much to do, anxiety increases, and there is a decrease in the ability to sort out what is relevant

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from those factors that simply aren't worthy of attention. Action is required, but there is uncertainty as to what act is appropriate or possible. At this juncture stopping for a time may be an excellent solution.

2. Decisions

In the earlier days of therapy Kay often spoke with obvious apprehension of "collision decisions." She was afraid to assert herself in making a choice. In the state of withdrawal this distress was temporarily eliminated. There she had no self or power, being controlled by something beside herself; she was freed of the guilt that might arise not only from making the "wrong" decision, but from daring to make any decision. In her home there had often seemed to be no "right" way. If Kay showed anger mother was hurt, whereas if she were silent mother was also hurt. She was supposed to seek perfection, and this being unattainable she was always subject to criticism and punishment. Life was more secure for the girl if she had no opinions, made no decisions, and let others run her life. To live without assertion—to express no will—may bring a measure of peace, but also foists on one a form of slavery, with the attendant need for denial and suppression—as well as the existential guilt that arises from engaging in a crippling of the self.

The "records" remarked upon in the first meeting seemed to represent attempts to simplify experience through the use of stereotypes. It was necessary for Kay to develop a dependable—albeit repetitive—record for each person in her life, thus fitting her expressions to the actual or fancied requirements of her associates, and furthering her own enslavement. In brief, she was unable to meet the demands of growth and new experience.

The concept of the will is difficult for me to grasp fully, if I attempt to look upon it as some sort of entity. We do find ourselves in circumstances in which we cannot do everything that might seem to be desirable, and thus we must make choices. It is helpful if we can have clarity about the possible consequences of the choices to be made, and about the options for action that are open to us. As I understand Kay's situation the options were often unclear, and the consequences of selecting one or the other uncertain or frightening.

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Increasing anxiety greatly complicated the matter, as its presence reduced the accuracy of perception and the exercise of judgment. I think that the major threat to Kay was that she was on the road to losing meaningful contact with human beings important to her, and that the loss of such contact meant finally the loss of self in panic. In this sense the self is looked upon as an interpersonal construct maintained through human relationships and associated fantasies. Kay attempted to hold on to herself, and took the action that was available to her—that is, to withdraw or become catatonic. In this sense she did make a decision, and she acted on it.

In Kay's family great emphasis was placed on will power. This device was helpful in exercising control over the child who was to use the power to control himself. Through the influence of parental teachings—converted into the will—the child adopts behavior acceptable to the family and society, and in many ways to himself, in that conformity may be both efficient and comforting. The child is often told to exert his will power to control activities that may demand expression—such as sexual feelings, "bad" thoughts, aggressivness, and so on. The route leading to the schizophrenic outburst is marked by a lessening of personality organization, with the frightening prospect of a disruption of those human and nonhuman contacts—real and fantasied—necessary to sustain a viable concept of the self. All means available are used to avoid that catastrophe; among these are the various psychological defensive operations. Also, attempts are made to enforce order through the exhibition of will power. The failure of this device is felt to be further evidence of personal deficiency; Kay berated herself for not being "strong enough" to hold everything together. The will which was to be used by her, now used her, and then became a "part" of her, and at times seemed to be "all" of her.

One way of looking at these phenomena is as follows: An aspect of what is called the will is derived from the examples and teachings of parents and others, and is included in the personality. There it assumes an identity separate from the teachings that gave rise to it; it is a power that is to be mobilized and used by the rational and conscious self. With the increase of anxiety and the decline in organization and rationality, this will power now seems to be external to the personality—an

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evidence of regression. The possible connection between this now external power and earlier family experiences is usually not made at this time, although the recognition of the relationship is one of the goals of psychotherapy. In the struggle to retain a semblance of order the power is at times again "internalized, " not this time as a part of the self, but as the entire self; that is, it "takes over, " as a desperate effort is made to gain stability, the voluntary quality of the operation as implied in the term "will" now gone.

3. The Attempt to Lessen Feelings of Isolation

As Kay felt less acceptable to others she turned to a world of fantasy which was largely predictable and subject to her control. On the Island, for example, she found relief from isolation and loneliness. She attempted to contain all experience within herself. She was the good child and the loving parent, the bad child and the punitive adult. She could, when withdrawn, manipulate events, even to the extent of reducing or cutting off her perception of them. Fortunately for Kay, however, the tie to human beings was too strong to permit her to find enduring or complete satisfaction with such figures of fantasy. The feeling of isolation was not done away with, and the conflict—on which therapeutic hopes to a large extent depend—continued.

4. Seeking Protection

The condition of withdrawal can be described as a seeking for protection as well as an effort to escape from isolation. These two functions are closely related and perhaps should not be dealt with separately.

As a small child Kay had sat in the dark closet, holding a doll, listening to the muffled sounds of family life, and experiencing the walls of the small room as being alive. Later she imagined being injured or sick as means of attracting and deserving the care of a mothering person. By that time her mother was no longer identified as the desired object. It was "as if" she might be held in a mother's arms, and be once again in the womb (an extension not reached with Kay, although the idea is always tempting). It seems that Kay's mother had been experienced by the child something as follows: (a) a comforting person, offering peace, quiet, and warmth; (b) a

disapproving person who might abandon one, built into the child's personality as a sense of inner evil that must be hidden; and (c) a prohibition against the child's growth and independence, as if these jeopardized the mother's own dependency on her daughter. When Kay had earaches in childhood her mother comforted her. When this disorder no longer recurred Kay injured her ears to get the desired care. Thus pain itself came to have a quality of pleasure, being equated with the possibility of being held—of regaining object contact, if you will.

As stated earlier, this account is in no sense a satisfactory explanation of withdrawn or so-called catatonic behavior. In terms of Kay's reports these states had to do with problems of control as related to external stimuli, the contents of awareness, the stability of the body image, and her destructiveness (greatly exaggerated). They were related also to anxiety regarding decision-making, the concept of will power, isolation, and the seeking for a mother. Of fundamental importance was Kay's lasting, although troubled and uncertain, attachment to other human beings. It was from this strength of attachment that we derived our expectations of a useful outcome in treatment. The catatonic behavior seemed to have as a primary function the maintenance of relational bonds and the avoidance of separation and loss. The fear associated with both attachment and separation led to the production of complicated and bizarre behavior, which was, nonetheless, purposive.

COMMENTS ON THERAPY

The phenomena described in the foregoing account appear to be, to a large extent, the outcome of years of interpersonal and social experience. Kay was seeking, in often obscure and devious ways, to maintain needed human relationships and to avoid the great distress associated with them. The catatonic behavior was the condensed expression of the culmination of a long struggle to resolve this problem satisfactorily. If the behavior is looked upon as simply pathological and thus to be eliminated as quickly as possible, resort may be had to such agents as ECT and ataractic drugs. In that case the patient and therapist may lose a valuable opportunity for learning and growth. I do not think that this view is popular or commonly

held. In addition to clinical and theoretical opinions, there are pressures of time, monetary costs, personnel shortages, and public need that influence our choices of therapeutic approaches.

I continue to favor the therapeutic use of the human relationship; it has not only healing, but educational and research values. In the therapist a quiet, patient, tolerant attitude—combined with a bit of confidence, humor, and endurance—can

be helpful. The therapist need not know "everything, " or seek to comprehend all that happens. He would do well to be interested in observing and learning—with compassion, and without sentimentality. Although he will set limits and will not be driven off by his patient's hostility or apparent disregard, he will not attempt to force change, or control all actions that he does not understand or that prove to be discomforting to him. The major task is to reawaken and develop the remnants of past relationships marked to some extent by confidence and trust.

Erving Goffman's comment on the human relationship is appropriate here: … "(T)here seems to be no agent more effective than another peson in bringing a world for oneself alive or, by a glance, a gesture, or a remark, shriveling up the reality in which one is lodged." **(Goffman, 1961)**.

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