Representation of the Internal World in Catatonic Schizophrenia

David Read Johnson

CATATONIA, which until 1874 was called atonic melancholia, has remained a relative mystery despite many advances in the understanding of schizophrenia. Its typical symptoms are certainly distinctive: a motionless stupor, bizarre posturing, waxy flexibility, religious delusions, stereotyped movements, negativism, loss of will, confusion, and recurrent frenzy (Kahlbaum 1874). The processes which motivate this particular derailment of self and body have been sought in various organic etiologies, with little success. Arieti (1974) proposes several reasons for the paucity of case studies of the treatment of catatonic schizophrenia. First, catatonic schizophrenia has been declining in occurrence. Second, the symptoms themselves, such as mutism and excitement, make verbal therapy extremely difficult. Finally, catatonics often have no memory of their psychotic experiences. Psychotherapists have therefore had to rely on highly personal intuitions of their patients’ crisis-in-being. Despite therapists’ attention to nonverbal behavior, mutism and stupor are particularly effective hindrances to communication in psychotherapy. Psychotherapy is often not begun until the patient’s symptoms ameliorate through chemotherapy and milieu support. The centrality of the verbal medium of communication in psychotherapy suggests that other approaches, using nonverbal media, may be indicated in the study of catatonia. This paper describes a treatment of a catatonic schizophrenic man which utilized movement and drama therapy. These methods were successful in evoking representations of the patient’s inner life.

Drama therapy is a psychotherapeutic treatment utilizing the nonlexical media of movement, symbolic gesture, and improvisational role-playing, in addition to verbalization, to provide avenues for expression of unconscious conflicts, transferential relationships, and self and other-representations (Irwin 1977; Johnson 1982; Schattner and Courtney 1981). Drama therapy can be differentiated from psychodrama, which is a more highly structured method of role-playing developed by Moreno (1946). Drama therapy as it is used in the present treatment is more closely linked to the process of free association through improvisation, rather than specific enactments of problematic life events (Johnson 1981a). Because of its encouragement of sensorimotor and symbolic modes of representation, drama therapy has been found to be especially useful with severely disturbed and ego-impaired patients, such as those

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suffering from schizophrenia (Johnson 1981b).

After a review of previous psychotherapeutic treatments, a case study will be presented. The final section of the paper will describe the nature of the catatonic’s object relations and cognitive functioning from a developmental perspective, and then speculate on the effects of the verbal and non-verbal interventions in drama therapy.

TREATMENT OF CATATONIC SCHIZOPHRENIA

The eight case studies found in the literature, all by psychoanalysts, will be reviewed.

Nunberg (1920) reports a case of a 32-year-old obsessional man who attempted to rape his sister, fell into a catatonic excitement, and was hospitalized. He had always been hypochondriacal and had attempted to “perfect himself” through a stringent program of physical exercise. During his illness he believed that he was destined to die, impregnate himself, and be reborn in order to save mankind.

Nunberg notes the presence of omnipotent fantasies, ambivalence, and loss of ego boundaries. The catatonic attack is seen as resulting from a need to defend against an increase in homosexually-directed libido. His ego collapses into “narcissistic intoxication,” which is followed by an attempt to regain object relationships and rebuild the world. During the patient’s recovery he indulged in a voracious eating binge as a way to make contact with the world. As he slowly improved, he at first became more paranoid, having projected his omnipotent “power” into others, including the therapist. Gradually, the patient’s identification with his therapist became more prominent. Finally, he established a passive, idealized relationship with his therapist, though refusing to talk about his internal state. Nunberg concludes that the catatonic state consists of a regression to an intrauterine state in which an “end of the world” fantasy is followed by an omnipotent rebirth fantasy. Catatonic symptoms, he suggests, are a response to the emergence of primitive birth anxieties, and recovery is dependent upon the patient’s successful search for a dependable ego-ideal, which the therapist can attempt to provide.

Knight (1942) reports an impressive therapy with an intelligent adolescent male, who gradually withdrew into a catatonic stupor during his last year in high school. He was an exceptionally compliant, considerate boy, an Eagle Scout, who was perfectionistic, obsessional, and anxious whenever sexual topics were mentioned. His father was passive and showed discomfort with strong affect, while his mother was hostile and rejecting. His grandmother, an important figure in the home, was fanatically religious and strict.

Knight details the patient’s extremely low self-esteem, his self-deprecation, and his depressive state. Knight initially was a kind and motherly figure, even wiping the boy’s nose and putting him in bed. When the patient verbalized that he couldn’t respect the nurses or his parents because they were too kindly, Knight understood this to mean he had become afraid of his own impulses because of the inability of his father to treat him forthrightly as a man. Knight then began to treat him quite firmly, struggling physically with him (e.g., pushing him into his room if he refused to go), and interpreting his rigid stupor as defiance and suppressed anger. The patient began to improve and began to spend much time exercising (often with Knight) and trying to “improve himself.” After 2½ years, the patient returned to college and then enlisted in the Navy.

Knight stresses the unresolved conflict in catatonia between overly strict ego ideals and sexual and aggressive instincts, leading to a narcissistic reverie. Knight counsels the therapist to intrude into the reverie, showing firmness and an ability to protect the patient from his own impulses. Reassuring physical contact and an insistent voice are critical.

Rosen (1946) reports three dramatic cases of catatonic excitement which he resolved by purposefully enacting an omnipotent, protective role (even the role of
God) from the beginning of the treatment. Arieti (1961) describes the progressive breakdown of an intelligent, young adult man's obsessive defenses into catatonic stupor. The patient had been a very religious adolescent who had attempted to remove sex from his life. Working on a farm for young men, he became overwhelmed with obsessive doubts, indecision, and diffuse anxiety over the smallest actions. Soon he felt he had lost control over his actions, fearing he might commit crimes or even kill someone. Later he felt that if he made any physical movement he would produce a disaster for the whole farm. Posturing and stupor alternated with the desire to kill himself so as not to commit a crime. Once hospitalized, he tried to commit suicide numerous times. When a particular doctor took an interest in him, he began to eat voraciously and later gradually improved. After nearly a year, he was discharged and entered a professional school.

In all three cases the patients slowly stopped manifesting violent, disorganized, hallucinative panic and eventually recovered. Rosen understands catatonia to be built around the patient's fear of destruction at the hands of an infantile love object. Stuporous states are the patient's attempt to "run away" from the danger. Rosen notes that in the excited state the patient is much more available for contact with protective figures. In the stupor, he wards off even potential friends. Rosen characterizes his technique as an "ego transfusion" between the strong ego of the therapist and the weak one of the patient.

Rosenfeld (1952) analyzes the super-ego conflict in a young adult catatonic male who had been hospitalized for three years and had received over 90 shock treatments. He alternated between violent outbursts and stupor characterized by catalepsy and mutism. He spoke only in cryptic, delusional statements, though later in the therapy he also communicated through gesture and dramatization.

Following Melanie Klein's formulations, Rosenfeld asserts that the schizophrenic is beset by a severe, persecutory super-ego, formed out of the interaction with a hostile mother in the first year or two of life. The patient projects the persecutory objects into the external world, attempting to ward them off through negativism, refusal to eat, and other resistances. This process may then create guilt and anxiety over having turned good objects into bad, leading to a desire to appease or be punished by the persecutors—as in submissive catatonic stupor. Automatic obedience and waxy flexibility occur as a result of the patient's projection of the idealized self into external objects.

As the demands for independence and personal responsibility increase, Arieti states, the pre-catatonic develops an ever-increasing fear of willed action. Religiosity and obsessiveness may develop in adolescence, the rituals and rules allowing the person to act without guilt. If the rituals are unable to contain the anxiety, the person "shuts down" and becomes catatonic, returning to total compliance with the will of the other.

Otto Will (1973) reports a case of a 17-year-old girl who became depressed and then withdrawn in her last year of high school. Her mother was chronically depressed and had been fearful of handling her when she was an infant. Her father was
a businessman who placed value on intellect and prestige. She was very involved in sports, and suffered from numerous eating compulsions. During her hospitalization, she made self-destructive gestures and a suicide attempt. She berated herself for not being “perfect” enough. Will observes that she controlled herself and her environment through omnipotent fantasies and obsessional rituals. At other times she would go “rigid, and become solid like a block of ice” having no thoughts, feeling no fatigue.

Will suggests that the withdrawal behavior can be understood in part as an attempt to cope with a danger situation, controlling her thoughts, body boundaries, and aggressive impulses. The withdrawal also lessened her isolation by creating in fantasy a protective, gratifying environment. Will believes that his patient’s mother was experienced in contradictory ways: comforting, disapproving, and prohibiting growth and independence. The catatonic behavior, Will concludes, arose out of a desire to maintain relational bonds and avoid separation.

These eight case studies show remarkable similarities. Nearly all of the patients show rigid moral standards and persecutory super-egos deriving from relationships with overprotective but disapproving parents, usually the mother. Religiosity is very common, as are depression and suicidal behavior. Many have delusions of omnipotence, fearing their actions will have a destructive influence on others. The fear of aggression is a predominant theme. All show significant ambivalence and obsessive symptoms, especially in warding off the increasing anxiety. Many engage in physical exercising, and others use gestures or dramatization to communicate during their stupor. Most are young, intelligent, and eldest children. In some cases, delusional aspects predominate (Nunberg, Rosenfeld, Rosen) while in others depressive and obsessive elements are more noticeable (Arieti, Knight, Will). Anxiety over homosexual impulses and guilt over separation are often present. Most of the therapists conclude that the therapist is successful when he is attributed with the patient’s omnipotent or omniscient feelings. Strength and firmness in the therapist’s behavior are usually recommended.

CATATONIA AND MOVEMENT BEHAVIOR

Catatonic patients use physical activity as an outlet both prior to their decompensation and as a means of communication during their psychotic episodes. Several of the therapists were successful in engaging their catatonic patients through action (e.g., hikes, gesturing, feeding, touch).

Another study of catatonic behavior supports the specificity of this link between physical action and catatonia. In a fascinating report, Strauss and Griffith (1955) find that catatonic stupor can be disinhibited with “surprising regularity” by simply playing ball with the patient. Nearly every catatonic patient whom they interviewed and filmed was able to play catch with them without hesitation, though before and after they remained in deep stupors. In wrestling, they find a bizarre combination of passivity with resistance: “The patient resists, but never starts a counter movement. He thus allows himself to be pulled into an extreme position, while he manages to maintain his balance through contorting himself uncomfortably” (p. 684). Strauss and Griffith explain this by hypothesizing that playing ball is a communication at a distance without rules or aims, and therefore without consequences. They call this temporary disinhibition of the catatonic state “pseudoreversibility” and warn the reader “not to over-rate prognostically minor changes in the behavior of catatonic patients.” Nevertheless, the regularity of this phenomenon raises many questions concerning the psychological nature of catatonic stupor. Playing ball may be a ritualized activity which allows the catatonic to avoid responsibility—and thus guilt—for willed actions, which Arieti contends is the central dynamic in the disorder.

The following case study describes the treatment of a catatonic schizophrenic man in which physical action, symbolic gesturing, and dramatic improvisations were purposely used to facilitate the patient’s representation of his internal world; these
successive steps helped the patient to engage in a therapeutic relationship.

CASE REPORT

Initial Impressions

Daniel was admitted to the hospital on New Year’s Eve. He was a tall, lanky 18-year-old who stood rigidly upright in the hall, slowly rocking forward and backward from the waist. He periodically folded and unfolded his arms, or picked intensely at his severe facial acne. He had a wide-eyed, innocent stare, which seemed to take everyone in.

This was the first psychiatric hospitalization for Daniel. He had been brought to the hospital by his parents and younger sister, who were concerned with his progressive social isolation, inability to tend to his bodily needs, and bizarre posturing and mutism.

Daniel’s physical state was extremely poor. He was nearly 30 pounds underweight and disheveled, and he occasionally drooled. For the first month of his hospitalization, he was incontinent and often smelled of urine or feces.

Daniel was virtually mute, though occasionally he responded cryptically in one-word answers minutes after a question was asked. His movements were reminiscent of a poorly designed machine or puppet. He often took ten minutes to sit down in a chair, becoming caught in several bizarre postures on the way down. His intent facial expressions suggested severe internal tension. This state of seemingly unrelenting pain initially elicited sympathy, then irritation, and finally avoidance from others on the ward.

Developmental History

Daniel’s mother is an extremely shy, quiet, dependent woman who appears to have difficulty dealing openly with strong affect. Both parents died by the time she was five, and she grew up “on the periphery” of her aunt’s family, always feeling a bit “strange.” Daniel’s father is an extroverted Protestant minister who talks loudly and rapidly and has difficulty controlling his aggression. He describes himself as tied to his mother’s apron strings, and as having great trouble separating himself from her “strong influence.” He is seven years younger than his wife, to whom he was attracted because she was “a yummy—somebody you’d like to screw.” She was attracted to him because he was forceful and strong.

Daniel was the result of a full-term, uncomplicated pregnancy. He was the second child. The first, a son, died several days after birth from a misdiagnosed intestinal atresia. His mother remembers Daniel as a passive, compliant boy with no eating difficulties or temper tantrums. Probably because of her anxiety over the death of her first son, she rigidly adhered to a feeding schedule established by her pediatrician rather than following a demand schedule. There were no problems with weaning, and Daniel’s developmental milestones occurred on time.

Throughout his childhood, Daniel had difficulty finding children to play with; he did not seem to fit into any group and was always “the odd man out.” His mother, anxious about his safety, watched closely whenever Daniel played outside the house. She felt that the neighborhood children belonged to a lower social class and were too rough for Daniel. After a move to another state, Daniel continued to be a quiet boy, never expressing much affect. He preferred to play board games in the house, whereas most of his friends wanted to play sports outside. He became more and more isolated, compensating by studying hard. In ninth grade, his family moved again, and his parents began talking about divorce. The mother finished her college degree and obtained teacher certification as “a way out.” They also started marital counseling several times but made little progress.

History of Illness

Daniel’s parents first observed his difficulties during the summer before his last year of high school. At that time, Daniel
had no male or female friends, and spent a great deal of time alone in his room. He was almost immobilized when faced with a decision. When dressing in the morning he could not decide what to wear. He did not use the family car because he was unable to decide where to go. Daniel became increasingly less able to communicate verbally and began to lose weight. He sat for long periods of time at the dinner table without eating, and kept food in his mouth without swallowing. There were several incidents in which Daniel behaved bizarrely with girls at school. For example, once he suddenly grabbed a girl’s arm and then became immobilized. Another time he followed a girl home from school, stood outside her window, and stared in at her. Despite Daniel’s progressive difficulties, his intellectual functioning at school remained satisfactory, and he was accepted at three colleges.

However, at his parent’s suggestion he took postgraduate courses in a Catholic high school instead of starting college in the fall. He became less and less communicative, and by December he was being almost totally cared for by his mother, who got him out of bed, dressed and fed him, and helped him change his clothes when he was incontinent.

Course of Treatment

I was Daniel’s drama therapist and a member of his treatment team. Daniel attended two drama therapy groups (3 hours per week) and one dance therapy group in which I was a co-leader (2 hours per week). These were part of the activities therapy program. In addition, he received 3 hours per week of group therapy, 2 half hours of individual psychotherapy, and moderate doses of psychotropic medication (Trilafon).

Phase 1 (January–April)

During the first month, Daniel was mute and disorganized on the ward. With some hesitation, he came to a ward dance therapy group which encouraged spontaneous expressions of feelings in movements and images. In his first session, Daniel immediately entered the circle and began to move with other members of the group, kicking his feet and shaking his arms. A broad smile erupted on his usually tense face. This was literally his first significant physical activity since admission. For the next three weeks, he attended many dance therapy sessions, where he consistently and energetically moved his body in unison with others.

In the third week, the group divided into partners who were to push lightly against each other’s hands. I was Daniel’s partner and when I pushed against his hands, he did not push back; neither did he withdraw his hands. Instead, he slowly leaned back so that a constant light touch was maintained. As I continued pushing, he began to contort himself in a strange way in order to maintain his balance (exactly as observed by Straus and Griffith). He neither moved his feet nor leaned on me. Rather, he seemed to be maintaining an internal, physical equilibrium while molding himself to my external influence. I repeated this exercise with him several times in dance therapy and later in drama therapy. By the fifth week, he began to push back, at first tentatively, then firmly, just enough to hold his position, never to push me back. In the sixth week, he and I actually balanced ourselves by holding hands and leaning against each other, which required him to exert a great deal of energy to support me. I suggested that we add sounds (e.g., grunts) as we pushed against each other, which he was able to do. After this session, Daniel became very eager to do this kind of exercise. In a session during the next week, I suggested as we were pushing that the sounds be “Yes!” and “No!” With great delight and energy, he shouted “No!” after each time I shouted “Yes!” When we attempted this without pushing, Daniel was mute and seemed anxious. Again when pushing was initiated, he cried out “No!” on cue.

In the tenth week, Daniel participated in improvisations in the drama therapy group.
He had a great deal of difficulty when the improvisations involved conversations between people. He delayed many minutes before responding and at times made confused statements indicating a loss of boundaries between himself and the role he was playing. As a “person” who had to “speak,” he was inhibited and silent.

I suggested that he and another patient do an improvisation in which they were animals. The other patient decided to be a lion.

Th: What animal would you like to be, Dan? (Silence; he opened his mouth, closed it. He jerked forward slightly, then as if deciding against it, straightened up.)

Th: Why don’t you mime for us how the animal moves? (He then leaned forward and walked around scratching an armpit in a clearly gorilla-like manner. Someone said, “That’s an ape!” He smiled, and began to straighten up.)

Th: Add a sound to the movement, Dan. What does an ape sound like?

He then began to grunt and beat his chest as he moved, sometimes breaking momentarily into a smile, then returning to his action. When the other patient entered the scene, Daniel gave a loud scream and pretended to pounce on the other patient, who was also roaring. The other patients applauded. Using mime and then adding sounds to animal characters, Daniel’s level of vocalization dramatically increased.

In the 15th week, Daniel participated in an exercise in which the room was marked off into three distinct areas, “Happiness,” “Sadness,” and “Anger.” Each patient was expected to walk through the room expressing the feeling appropriate to the particular area. After several others had tried it, I asked Daniel to go to the area where he felt the most comfortable. He walked to the Happiness area.

Th: What people do you think about when you are happy?
D: My parents.
Th: OK, begin talking with a happy feeling about your parents, and then feel free to move to the other areas and show us sadness and anger.

D: My parents are a loving couple. . . We have gone on trips. . . They are concerned. (He moves into Sadness. Silence.)
D: I feel sad. . . I am a disappointment to them. . . They only visit. . . once a month. (He now moved into the Anger area. Long silence. He moved back and forth, seeming quite anxious.)
Th: Take a deep breath and let out a sound.
D: (Quietly) ooooooo. . . I. . . (loudly) hate them!! Those . . . damn mosquitoes! (He looked up and smiled as other group members reacted with surprise to his exclamation. He began to swat make-believe mosquitoes, and I encouraged him to make angry noises.)
Th: What do you hate about those mosquitoes?
D: They buzz. . . they bother me! (I then asked two patients to pretend to be mosquitoes and “buzz” around him. Daniel tried to ward them off. After each angry sound, he smiled briefly and looked up at me.)
Th: Why else do they bother you?
D: They never let me alone.
Th: Tell them that. “Leave me alone.”
D: Leave me alone. LEAVE ME ALONE!!!! (Angrily swatting at them.)

This expression of hostility was an important step for Daniel, though he accomplished it only by transforming the real objects of his anger, his parents, into mosquitoes. Mosquitoes are both more degraded and less harmful objects.

Phase 2 (May–August)

By this point it had become clear that Daniel was making use of the structured and nonverbal elements of drama therapy to mobilize himself and explore his aggression on a physical level. I then began sessions involving him and another male schizophrenic patient, Alex, with whom I had also been working.

In our second session, Daniel was silent for many minutes, even after Alex and I had asked him questions. I asked if he could offer an image for what it felt like inside when someone expected a reply. He said, “Winding tighter and tighter. When I asked if he could show how that winding tighter and tighter felt in his body, he stood straight up, clenched his fists, and slowly raised his shoulders, bringing his arms close.
to his body. I asked him to add a sound: “Errrr....”

Th: What feeling does this remind you of?
D: Anger.
Th: At anybody in particular?
D: My father.
Th: You get angry at your father and other people who are impatient with you?
D: (He nods.)
Th: I will play your father—you can say or do whatever you wish to me.

He then picked up one of the large foam bats available in the room, and while I voiced impatience, he hit me several times. I then switched roles with him, and as Daniel, gently hit him, as the father. In this exercise, he had successfully connected a feeling with a person, and had expressed aggression without being immobilized by guilt.

In our next session, Daniel again was mute during the attempted verbal conversation between us. As in previous sessions, I asked him to show me with his body what it felt like inside. He began to sway back and forth from one side to another. He seemed to be obsessing over possible answers to my questions. I asked him to give me an image of his internal state at the time. He said, “Zigzag.” I inquired, “Do you mean you zigzag between different thoughts?” “Endlessly. Either way.” I asked him to show me with his body what he zigzagged between. He stood and assumed a posture not unlike the one he had shown in our sessions previously—fists clenched, body tight—and added an “err” sound. I asked for a word that would describe this state: “Tightly controlled.” The next position was remarkable in contrast: loose, he let his arms go, his body went slack. He made a wooshing sound by letting his breath go. I had never seen him so relaxed. The word he assigned to this was “Blah.” He then practiced alternating between the “tightly controlled” self and the “blah” self, while moving around the room. I asked him of whom each of these selves reminded him: “The tightly controlled self reminds me of my father, and the blah self reminds me of my mother.” We then role-played several scenes in which I played Daniel and he played his father, and then his mother. He went on to describe how tense his father made him feel, and how unmanly his mother made him feel.

The next session occurred after a hospital-wide case conference in which Daniel had been interviewed.

D: I had my case conference.
Th: What was it like for you?
D: I felt nervous. I had to be careful about what I said.
Th: Because you might make a mistake?
D: Yes.
Th: What would happen if you did. (Long pause.) Something terrible would happen?
D: (Nods but stays silent.)
Th: Shall we role-play your case conference? (He nodded.) If you want to, you can see what would happen if you said the wrong thing.

I then role-played the interviewer and introduced myself to Daniel. Suddenly, Daniel blurted out in a loud voice, “My father screws all the women in church!” I pretended to look horrified at what he had said, though my surprise at this irreverent but humorous statement must have shown. Daniel smiled, indicating his enjoyment of the image of his ministerial father engaged in a shameful activity. I then switched roles with him and asked him to show me what he expected would happen if he said something like that. He introduced me and I said, “My father screws all the women in church.” He stood up angrily with raised fist and glared at me.

Th: So you fear that you would be hurt physically if you said the wrong thing?
D: Yes.
Th: Would anything else occur?
D: They might close down the hospital.
Th: Why?
D: They would be horrified and angry.
Th: Who are they?
D: The senior doctors.
Th: Who would they be angry at?
D: The people who work with me—they’d be fired.
Th: So you have to stay quiet in order to protect your therapist?
(Nods.)

We then role-played the situation where Daniel, as the senior doctor, closed down
the hospital and fired me. This was a clear demonstration of a catatonic patient's omnipotent fear of his own potential destructiveness.

Daniel was increasingly more able to enact aspects of his persecutory super-ego. Switching back and forth between punishing figure and victim was helpful in delimiting the extent of destructive power maintained in his fantasy. It may also have helped to clarify and solidify the boundaries between inside and outside. These dynamics were being explored by linking them to his parents, and not to me as his therapist. Overt references to our relationship were at this point still rare.

Two weeks later, Daniel utilized a nonverbal exercise to portray his feelings about Alex and me. He had been talking via a foam ball game about how people in the hospital had seemed apathetic toward him since the case conference. Alex asked him how he felt about us. He became silent. I suggested he show us how he felt about our three-person group by creating a sculpture with us. He then quickly had everyone hold hands, having Alex and me look at him while he stepped in and out, toward us and away. I interpreted that he seemed to want to be with us and yet be separate from us, but that he was unsure if he would be safe if he did leave us. Would I still like him if he did? Daniel smiled, but remained quiet.

In August, eight months after his admission, Daniel came into our session and was very quiet. Asked how he felt, he said, "Disappointed." "In whom?" "Myself." He had been working very hard in patient government, and had become the co-editor of the newspaper and the chairman of the patient job committee. He had been doing so much better in the hospital that staff expectations had clearly risen. He had just been told at a planning meeting that his treatment team had set a date for his discharge.

I suggested that he had often felt that he would hurt or disappoint people if he didn't do the right thing. He imagined the staff saying to him, "You're not ready. We're disappointed in you, Daniel." I asked him to role-play what this was like. He played his ward administrator, who was in charge of his discharge planning. He sat down, put one hand behind his back, placed the other hand in a tight fist under his chin, and leaned forward with his eyes glaring! I described how he looked, saying that he was indeed a frightening sight. I asked him if he was afraid of saying the wrong thing or of being attacked. He nodded. I suggested he pretend to attack me in such a way in the role-playing. He stood up, with raised fist and said, "Damn you, Daniel! You're not ready! Why don't you say something!" We then switched roles; I portrayed his ward administrator and asked him to respond to me with an example of something bad to say. After a long, tense pause, he whispered, "Your wife masturbates with the crucifix!" I was impressed by the strength of the desire to mock and "put down," which his statement expressed.

In the next session, I asked Daniel how he calmed himself down when he felt anxious or pressured. He indicated nonverbally that he masturbated as a way to soothe himself. I asked what he thought about when he masturbated.

D: I think about provocative things, like uplifting the skirts of a ballerina. . . . I wonder sometimes whether masturbation isn't a masculine thing to do. It's like making love to your mother. I don't think I feel guilty about it.

Th: In what way is it like making love to your mother?

D: It's like going back to being a child, being with someone who will protect you, like your mother. Not giving in to that feeling is being more masculine, I guess.

The next week, after several exercises in which we maintained close physical contact, Daniel related this memory of an incident when he had been caught masturbating.

D: I was only caught once. I was in the attic, sitting on the bed. . . . with my pants down. . . . My mother was downstairs and she wondered why I was so quiet. She looked all around for me and then came up the attic stairs and into the room. She saw me, was satisfied, and left without a word.

Th: How did you feel when she came in?

D: I was embarrassed, even frightened.

Th: What was she satisfied about?

D: She knew why I was so quiet.
He later described his mother as a "pretty and gentle" woman, with whom he felt most comfortable. He clearly associated comfort, calm, the "blah" state, and masturbation with his mother, and punishment, control, and intrusion with his father. He felt caught between these two poles of his object relationships.

Four days later, Daniel was late to the session with Alex and me. As he walked in, he stopped to take off his shoes, which he had never done before. As he gave me an odd glance, he said, "In Japan, taking off your shoes is a sign of respect." I was caught off guard, and I merely looked back at him expectantly.

D: In Japan, taking off your shoes shows that you trust your host.

Th: Do you trust your host?

D: Yes.

Thus, as the summer came to a close, we had established a strong working alliance in which transference issues were beginning to emerge more forcefully. These were centered around his concerns about whether I would continue to love and protect him as he explored separation, and whether he would cause me to be hurt and disappointed if he didn’t improve.

Phase 3 (September–December)

In the beginning of September, Daniel’s roommate, Jack, impulsively attacked a nurse, who screamed with fright. This occurred outside their room, in Daniel’s presence.

In our next session, Daniel was more inhibited than usual, cutting off his words in mid-sentence and posturing. He said he felt down deep he had a rage which “might get out of control.”

I attempted to pursue Daniel’s feelings toward Jack, in relation to his fear of his own rage. He said he was angry at Jack for having frightened him, though he was inhibited when he tried to strike the foam bat against a post that represented Jack. Even after I modeled it for him, he swung the bat hard but at the last moment stopped it just in front of the post. When I asked if he felt frightened by the exercise, he did not respond. I then suggested that he was scared about the expression of his anger but that he kept trying because he also didn’t want to disappoint me, which he was now afraid he had done. I acknowledged that perhaps I was being too impatient on such a critical issue for him, and that we needed more time to understand it.

In our next meeting, I asked Daniel if he had anything to say about the last session. He rocked back and forth anxiously as if to formulate an answer, then suddenly stopped. After a minute, I asked him:

Th: Are you going to answer my question?

D: No. (This was the first time he had actually defied me).

Th: Why not?

D: (Pause.) Because it will start a conflict.

Th: What kind? (No answer). Between you and me or within yourself?

D: Between you and me.

Th: Ok, you and I will have a conflict about what?

(Long, long pause, during which I felt both intensely hopeful and irritated.)

Th: Dan, by your silence you fill up other people with anger, your anger, which probably scares you even more. My guess is that you might be afraid of how I will react when you tell me about the conflict: that I’ll get angry at you, hit you, or even end these sessions in despair. I would like to work this out with you, either through talking, or nonverbally, by pushing against each other as we have done before. (He seemed alert to what I said—we were standing only a foot or two apart—he was changing positions, at times trying to swing his arms, looking as if he was trying to formulate a response.) I have to be direct with you, Dan. In order for you to be discharged to the halfway house, you have to be able to talk and communicate about your conflicts. They simply won’t accept somebody who won’t. In order for me to help you, you have to communicate with me.

D: It’s just that you’re good and bad at the same time.

Th: That is a helpful comment, Dan. You have two kinds of feelings about me? How am I bad? (He paused.) Out with it!

D: When I was a child, I used to lie in the attic naked!

Th: OK. (He smiled; I smiled back. He was
fusing his representations of me-as-bad with himself-as-bad.) How am I good?
D: You stick with me even though I tell you unpleasant things.
Th: Yes, that’s true, and I’m sure we will be able to talk more about some of those unpleasant things. But I want to give you a chance to tell me what you don’t like about me.
D: (Pause.) Your eyes are in-set. (Appeared distressed.)
Th: Anything else, Dan?
D: Not right now.
Th: That must have been hard for you to say. I’m still here, aren’t I?
D: Yes. (He visibly relaxes.)

This session provided evidence that Daniel was struggling to integrate the gratifying and frustrating aspects of his representation of me. That he felt I could tolerate his negative feelings to this extent was encouraging.

In our next session, both patients mentioned important transitions: Daniel’s move to the halfway house and Alex’s attempt to get a job. Then I set up two large mats separated by about six feet. We all stood on one, which was to represent the Present in the hospital. The other was the Future: the job for Alex, the halfway house for Daniel.

Th: What do you see over there?
D: It doesn’t involve talking.
Th: Anything else?
D: A challenge.
Th: What lies in between here and there?
D: Anxiety. Despair.
Th: Do you want to make it across?
D: I want to.
Th: Take a step off the mat and pretend to feel the anxiety and despair. (He did this tentatively, shuddering as he placed one foot off the mat.) How will you get across? (Silence.) Okay, I’ll make you a deal. Either you can go across by yourself, through the anxiety and despair, or if you wish, I will carry you across, and you just have to hold onto me. Which will it be?

Alex unhesitatingly asked me to carry him across, which I did. I came back to the mat and asked Daniel what his decision was. He hesitated, and then asked me to carry him also. I found myself intensely disappointed with his choice; nevertheless, I carried him across. In retrospect, I realized that I gave him two disparate choices: total self-sufficiency, or dependency. A third alternative would have been to offer to go with him—e.g., hand in hand. I may thus have inadvertently reawakened in him the fear that separation involves total loss and abandonment by mother. My choice may have been fueled both by my omnipotent fantasy that I could cure him—e.g., make him independent—and by my unconscious wish to be rid of him. Nevertheless, I was prepared to carry him, and may have been gratified, like his mother, by his continued dependency upon me.

The next week, on the day that we met, Daniel was rejected by the halfway house. He had made a valiant effort, but, as he said to himself when he met with me, “You just didn’t talk enough.”

Plans were made for Daniel to return to his home state, to a more structured halfway house. Our sessions consisted of saying goodbye, moving to music, and mirroring. This mourning of our relationship, and gradual “letting go” of it, allowed me, and I assume Daniel, to integrate some of the positive and negative aspects of our treatment relationship and face the reality of his limited improvement.

In my last meeting with Daniel, he chose to play a John Lennon album. We stood in a circle holding hands, swaying, stamping our feet, often moving closer and then letting go. I asked him for his memories of the hospital. He mentioned the time a female patient had bitten his hand, and the physical exam at his admission, both characterized by intrusions of his body boundaries.

D: I was frightened that there wasn’t a urinal. Only toilets.
Th: How did this frighten you?
D: I was scared they would put in a hypodermic needle and draw my blood again.
Th: Dan, I don’t see the connection between being afraid of toilets and the hypodermic needle.
D: I don’t feel safe when anything leaves my body.

I suggested that this might apply to his
words as well. Alex put on the record “Exodus,” and began to gesticulate dramatically, singing, “This land, this land, this land is yours and mine. This land is yours, Daniel, this land is yours, Daniel.” I asked him if he wanted to dance a goodbye dance to Daniel. This he did, with graceful gesturing and singing. Then, uplifted by Alex’s mood, I too performed a dance for Daniel. Finally, Daniel said he wanted to dance for us. He moved about the room, turning and waving his arms. At the end of the music, he slowly squatted down and bowed his head to us. I was moved. We then held hands in the circle and I asked him, “Any last comments?” He replied, “No last comments.”

He was discharged to a structured aftercare program near the family’s home town. There he received psychotherapy, drama therapy and other rehabilitative services. A year later his parents divorced. He continued to improve slowly until his drama therapist left, when he regressed again. His psychotherapist hospitalized him for a series of shock treatments, after which he returned to the halfway house, where he now works in a volunteer job and writes for the house newspaper.

**DISCUSSION**

Daniel’s case is in many ways consistent with the other case studies of catatonic patients. A compliant, obsessive child, he gradually became depressed and withdrawn. Daniel’s mother was overprotective and demanding. She had difficulty accepting Daniel’s attempts to separate from her, becoming more anxious when he began to venture from her in his second year. He maintained an idyllic picture of her, associating her with a protected, undifferentiated “blah” state which he recreated through masturbation and fantasy. His father was intrusive and disapproving, and much of Daniel’s hostile feeling was centered on the father-image. Depressive features such as his self-deprecation seemed related to the perception of his parents’ disapproval and disappointment in him (e.g., “Don’t ever let them know that I am not good enough to make the grade”). Yet hostile impulses against them were arduously controlled and associated with the fantasy that he was protecting his loved ones from disaster. He became more fearful that the loved figures would be destroyed by his hostility. This attempt to control his aggression was played out on a bodily level by his need to maintain an internal balance and not exert (or assert) himself outward. His mutism, too, served to prevent the expression of aggressive or destructive thoughts. Sexual conflicts were apparent and were closely tied to religious themes (“My father screws all the women in church”; “Your wife masturbates with the crucifix”).

In the initial phase of treatment, Daniel responded to movement therapy with immediate involvement and showed a progressive increase in his ability to assert himself. This corresponded with a clear improvement in his physical and clinical condition. As Daniel became more verbal in drama therapy, he was able to provide information concerning his internal state (e.g., winding tighter and tighter, zigzag) and his feelings about his parents. He was able to demonstrate his trust in me as his therapist and to express himself without overwhelming anxiety. We had managed to create a mutually gratifying, symbiotic-like tie. During the summer, Daniel was able to discuss both sexual and aggressive issues (e.g., masturbation, punishment). Progressively, these topics had more relevance to our relationship and transference-countertransference issues became more differentiated from other aspects of the treatment. Aggressive impulses were no longer safely directed toward his parents via role-playing; they were being evoked and experienced directly in relation to me. Our interactions in the third phase became more troubled as issues of separation became delineated. The setting of Daniel’s discharge date by the treatment team intensified this process. It is not uncommon for schizophrenic patients to regress in the face of discharge from the hospital and the tre-
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mendous stress which such a separation entails. Daniel clearly required a psychotherapeutic commitment of many years, during which his fear of abandonment at separation and his inability to tolerate aggression might slowly ameliorate. Nevertheless, his responsiveness to the physical and symbolic medium provided by drama therapy, within which our interpersonal relationship developed, was encouraging and made me hopeful about his future.

Countertransference

The feelings evoked in me by Daniel’s struggle to manage our relationship are instructive of the nature of his, and perhaps other catatonic patients’, object relations. Throughout his treatment, Daniel’s behavior had elicited two desires in me: the desire to get into him, to discover what he was about, and the desire to force it out of him. I felt the former desire more strongly in the initial phases of treatment, when Daniel was less verbal. Through unison movement and touching, I became aware of symbiotic and motherly feelings. The homosexual component of these impulses gradually emerged in the course of treatment as the boundaries between Daniel and me seemed to become more differentiated and stable, and as loving feelings for his father were evoked by the physical intimacy of the sessions.

I then became aware of the desire to force ideas and feelings out of him, which I associated with the father image. When I asked him about bad feelings, my comment “Out with it!” reflected this desire, and could have been said by the frustrated parent of a constipated child. Knight has counseled therapists to be firm with catatonic, but here the great pressure on me for intrusiveness produced the danger of duplicating the father’s intrusiveness. Daniel specifically expressed his anxieties over these two issues: in being entered (e.g., when he was bitten by a female patient, and at the physical exam), and in feeling unsafe when anything left his body. A deficit in the stability of his body boundaries was implied by these concerns about the outside coming in and his insides going out. Possibly his physical rigidity served a defensive function by heightening awareness of body boundaries. If so, then one might say that the stuporous catatonic becomes the impenetrable boundary between inside and outside, which in turn stimulates the countertransference reactions described above.

The Object Relations of Catatonic Schizophrenics

Much evidence suggests that the object relations of catatonic schizophrenics are developmentally at a level between paranoid schizophrenia and the affective disorders. This is a higher level than that suggested by the view that they have regressed to intrauterine life. Catatonia seems closely allied with the affective disorders, with which it is often confused (Abrams and Taylor 1976; Hearst, Munoz, and Tuason 1971; Morrison 1973, 1974). Depression often accompanies or precedes catatonic symptoms. Superego issues are unmistakably present in the psychodynamics of catatonia: guilt, religiosity, and rigid moral standards are frequently mentioned in the case studies. The better prognosis and more acute onset in catatonia than in other forms of schizophrenia also suggest a higher developmental level.

While certain catatonic symptoms overlap with those of affective disorders, others seem to overlap with paranoid conditions. Rosenfeld, for example, notes the importance of projection in the symptoms of negativity. Paranoid delusions are common among more severely ill catatonics (e.g., Nunberg’s patient entered a paranoid state during his partial recovery). Similarly, Arici (1974) notes that in terminal phases, catatonic patients become indistinguishable from paranoid schizophrenics.

These considerations strongly suggest that catatonic schizophrenia is developmentally at a level between paranoid schizophrenia and the affective disorders. Klein (1975), Kernberg (1976), and others have conceptualized the relation between
paranoid and depressive object relations. In the paranoid conditions, bad objects are externalized and the ego is concerned with protecting itself from external intrusions. People in the environment are not experienced as "whole," that is, of having good and bad parts. Rather, objects are either all good or all bad. The "all bad" objects are experienced as being external to the self. In depressive conditions, these good and bad part-objects are brought together and the ego is concerned with the possibility that the bad parts of itself will hurt or destroy its good parts. Thus, in paranoia the threat is experienced as coming from the outside, and in depression from within.

I suggest that the catatonic is caught between these states of depressive and persecutory anxiety, and in fact alternates between them. Because he has advanced beyond a paranoid stance, aggressive feelings toward external objects create intense guilt over having destroyed the good, even idealized, provider. The catatonic fears that an action by him will result in horrible consequences for others. Thus Daniel was concerned about causing harm to the staff, his family, and me. To protect the external good object, the bad object is internalized and the aggression is directed against the self (e.g., Knight's patient felt he was a despicable person, and Daniel felt he was "no good"). However, not having consolidated a "whole" ego that can sustain a great deal of depressive anxiety, the self periodically protects itself by splitting good from bad and externalizing again the aggressively related bad object. Daniel's comment to me, "It's just that you are both good and bad," was a dramatic illustration of his struggle to integrate conflicting parts of an object.

The alternation between externally and internally directed aggression (or paranoid and depressive ideation, respectively), has been noted by several authors (Ferenczi 1950; Arieti 1974) and was also evident in Daniel's case. This alternation may have been expressed by his "zigzagging" between the "tightly controlled self," associated with external punishment from his father, and the "blah self," associated with a loose, empty feeling in relation to his mother. Furthermore, Daniel's "jerky" movements and verbalizations, in which a movement or a sentence was suddenly begun, then stopped abruptly, and then continued, are suggestive of a series of impulses toward the environment which are checked out of a fear of their consequences.

This process of repetitive projection and introjection of the bad object into and from the environment results in a constant shifting of the boundaries between inside and outside. The loss of boundary integrity was reflected in Daniel's fear both of being entered (by the bad object) and of things leaving his body (i.e., the good objects). It was perhaps most clearly externalized in the exercise where Alex, Daniel, and I held hands and Daniel repeatedly stepped in and out of the circle.

**Stupor as a Defense**

The rapid alternation between these two untenable positions might lead to the defensive immobilization of the body and speech as the only means of stopping a seemingly uncontrollable process. The immobilization serves to keep the confusing and anxiety-producing array of thoughts and internal stimuli to a minimum, and to reestablish firm body boundaries. Klein writes that the immobilization of the body in catatonia is an attempt to "paralyse the introjected object and keep it immovable and so render it innocuous" (p. 144). One advantage of stupor, then, is in the actual elimination of painful ideation by a process of complete *embodiment*: Daniel expressed several times that when he became rigid he wasn't aware of any thoughts, only perceptions of the external world. Forceful intrusions by me (as in Knight's case) "keep my thoughts active." Will's patient also reported feeling "like a block of ice" in periods of stupor. The peculiar loss of memory for the events during stupor, noted by many observers, may be due to the elimination of conscious ideation during periods of physical immobilization.
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The catatonic, then, is in the hub of an intense conflict between his guilt over aggression and fear of his own annihilation. It is as if he were in the “eye of the storm,” where it is calm, but where a step in any direction elicits terrifying anxiety.

_Drama Therapy as a Psychotherapeutic Intervention_

I wish to discuss three points concerning drama therapy as an intervention. First, the regeneration of movement through dance and drama therapy seems to be associated with an increased access to and flow of images and words. This is consistent with the notion that physical immobilization is an attempt to eliminate certain ideational states. Second, the mobilization of the body seems to evoke awareness of internal states, which are raised to consciousness in a particular developmental progression, from purely sensorimotor, to imagistic, and then ideational forms. Finally, the structure of the dance and drama therapy experience provides a ritualized means of expression that helps bind the catatonic’s anxiety, allowing him to disinhibit his motoric responses.

The mode of Daniel’s representations began at a purely physical, sensorimotor level, progressed through sounds to imagistic, iconic representations, and then were articulated further into verbal form. This developmental progression in representational form is seen both in the overall treatment (beginning in dance therapy, followed by a focus on images, and then more on verbalization) and in each session, where Daniel did not usually speak until a movement or image was expressed in bodily terms.

This developmental framework is consistent with that proposed variously by Piaget (1951), Bruner (1964), and Werner and Kaplan (1964). Representation (thought) is conceptualized on a continuum from (1) purely physical movements and sounds to (2) images or iconic symbols, to (3) words and more autonomous linguistic forms. Child development is characterized by the development of increasingly more differentiated and hierarchically integrated symbol systems. While these authors have conceptualized a developmental process which takes many years, the same progression occurred within the course of a one-hour session with Daniel, indicating the applicability of their models to cognitive functioning in general.

Werner and Kaplan’s formulations offer support for the view that drama therapy activities stimulate the organismic connections between feeling state on the one hand and symbolic representation on the other. The initiation of physical movements sets off a flow of physiognomic sensations which are apt to stimulate a corresponding flow of primitive ideational states (such as diffuse imagery), which in turn lead to higher levels of symbolic thought.

The developmental progression in Daniel’s representations was encouraged by the medium of the drama therapy, which allowed communication to occur through touching, movements, images, role-playing, as well as verbalization (Johnson 1982). Purely verbal communication was difficult for Daniel throughout his hospitalization because it was beyond his cognitive capacity, except when supported by a structured physicalization of his internal states.

_Ritualization_

If the purpose of Daniel’s stupor was to prevent the awareness of painful ideation, then why was he able to participate so easily in dance and drama therapy sessions? Something in the structure or medium of these sessions alleviated his anxiety so that body movement was possible (as Straus and Griffith also found with ball-throwing).

Arieti noted that the catatonic stupor occurred when the patient was no longer able to contain his anxiety in rituals. Drama therapy may be effective in mobilizing the patient because it provides a ritual which binds anxiety. While the obsessive rituals used by patients are idiosyncratic and not integrated into a shared social fabric, drama therapy activities, by being con-
doned and supported by the authority and shared by the group, create a social context in which the catatonic patient is integrated. The ritual process (unison movement, structured sounds, roles, and interactions) involves the active concretization of feeling states (e.g., by dividing up the room into happy, sad, and angry, or by playing out part-selves). Such structuralization of ambiguous and fleeting states allows for a greater sense of control. The ritual process also simplifies complex emotional states and engages the patient on a concrete, physical level of cognition with which he is familiar (Johnson 1981b).

Drama therapy thus shares some of the properties of therapeutic rituals in African cultures (Collomb 1977) where the afflicted person is seen as having become alienated from his context. There, too, therapy involves a process of ritualization in which the person is reintegrated into the community through group dancing and the dramatic reenactment of ancestral spirits.

Thus the ritualization, involving the enactment of simplified and concretized feeling states, provided by the drama therapy sessions allowed Daniel to initiate movements. Once movement occurred, I encouraged him to report on his internal state through first imagistic and then verbal channels. Complex feeling states creating tremendous anxiety could thus be expressed and explored within a therapeutic relationship which slowly developed. Ultimately, it is through the development of a therapeutic relationship with the therapist that alterations in the catatonic’s psychic structure can occur, transforming the “pseudoreversibility” produced by the nonverbal interventions into more lasting changes. Yet, in this case at least, the nonverbal and imagistic properties of the drama therapy were crucial in allowing that important contact between therapist and patient to begin.

REFERENCES


