ED 499 HONORS THESIS
by
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Catatonic schizophrenia is an abnormal psychological state of affairs in the human being. Webster defines it as a severe type of mental illness characterized by negativism and incoherence and often by rigid fixation of the body with alternating periods of stupor and activity. One of the terms used in describing catatonia is egocentric overinclusiveness. These terms of the nature of the schizophrenic thought disorder serve to clarify formal characteristics of schizophrenic thinking but do not directly open the way for understanding the delusional and magical thinking of schizophrenics. Overinclusiveness is primarily egocentric (cognitive activity in contrast to narcissistic). The patient is unable to overcome adolescent type of egocentricity and regresses cognitively as well as emotionally to an earlier phase of cognitive development in which there is a reliance on the "omnipotence of thought." This leads to reemergence of magical thinking and failure to differentiate the word from what it signifies and even what is the self and what is the object and what derives from inside and outside the self. (A: 54)

Although it is not apparent in various formal tests utilized in the study of schizophrenic thinking, the patient believes that what others say and do centers on him even when they are totally extraneous to him. He may have, as ideas, delusions of reference and persecutory delusional systems or may believe that his thoughts have influence on others and even magically affects the inanimate universe. The schizophrenic patient believes he is the focal point of events that are actually fortuitous or coincidental to his life. The catatonic remains immobile because he is the fulcrum of the universe and any movement he makes can have devastating consequences to the world. The patient becomes manifestly psychotic when he begins to order his world in such egocentric ways and goes into remission when the egocentric overinclusiveness stops. The schizophrenic is also egocentric in a broader sense and tends to distort reality to his own needs and point of view as well as in his regression to preoperational thinking and belief in the omnipotence of thought. Category formation and conceptual thinking must remain limited and defective if the self intrudes into all groupings. (A: 55)
One of the basic characteristics of schizophrenic patients is that one or both parents are profoundly egocentric and in some respects, narcissistic. Here, narcissistic is used reluctantly because of divergent and even paradoxical usage in psychiatric literature. Freud used "narcissism" to mean a state in which the libido is completely cathexed in the self. "Primary" narcissism being the condition of the young infant and "secondary" narcissism due to a withdrawal of cathexes from objects. "Narcissistic love" is love of someone identified with the self or self projected in another. A narcissistic person is so self-sufficient and self-satisfied as to be invulnerable. However, "narcissistic" is commonly used to indicate a person who needs and constantly seeks love, admiration and adulation to bolster self-esteem and ward off feelings of depression or emptiness. In this latter meaning, the parents of schizophrenics are narcissistic. (p. 55)

A mother feels worthless without a son to live the life closed to her because she is a woman; or a mother requires her children to consider her perfect and excludes a child who does not; a father cannot function without the adulation of a wife or a daughter, and so on. In a way difficult to describe the family may be used primarily to give a parent the completion he needs to function and to allow him or her to be emotionally free from needs for anyone outside the family. (p. 55)

There is a need to consider the relationship between egocentric overinclusiveness of the schizophrenic's cognition and his parent's egocentricity, but first the relationship between language, ego functioning and schizophrenic disorders and between the disturbed family setting in which the patient grew up must be analyzed in order to understand his disorganized language and thought. (p. 56)

Common precursors of schizophrenic disorganizations are: separation from home, death of a parent, and a threat that the parents will separate. Although these are not unusual traumatic events but common episodes in a life cycle, it is something with which the patient cannot cope because developmental difficulties have left him vulnerable. (p. 57)
The more reactive-regressive the disorder, the more likely it is that time, chances in circumstances, and therapy can help reinstate previously achieved levels of functioning and may even strengthen the patient's integrative and adaptive capacities. Because the opinion that profound regression indicates strong early infantile fixations has often adversely influenced therapeutic efforts, the author wished to emphasize that the extent of regression has little prognostic value. Catatonic patients though most severely regressed, have probably had the best prognosis of all types of schizophrenic patients and patients with fixed paranoiac delusional systems though least regressed are very resistant to treatment. (: 27)

There is a tendency among organically minded theorists to analogize between catatonic phenomena and various neurological or chemical induced states in animals. But, Bleuler's masterly Theory of schizophrenic negativism (1912) shows how the whole range of catatonic behavior including diametrically opposite modes of relating to the interpersonal environment can be satisfactorily explained as instrumental acts. Even a convinced organicist must recognize that the causal linkage between a biochemical defect (as specific etiology) and catatonia is indirect. (: 24)

The catatonic has a primitive system of control and organization. The weakness of internal structure of a schizophrenia-vulnerable person is further manifest in the unstable nature of his control systems. His systems are poorly differentiated and are marked by archaic super ego qualities. They are arbitrary, peremptory, automatic and involuntary. The control system also follows inflexible rules which are applied indiscriminately and without regard to particular situations. Impulses trigger abrupt controls, thereby, not giving time for thoughtful delay. The primitive nature of the schizophrenia-vulnerable person's control system shows a desperate struggle to quell internal disorder which, since he lacks adequate flexible controls, threatens constantly. His strict controls show such behavioral restrictions as autism, immobility, refusing to eat, and perceptual-cognitive restrictions as blocking and impoverishment of thought. The person has incomplete differentiation fro
early heteronomous controls and sources of authority. He may show blind obedience or blind negativism toward dictates he has internalized. He cannot subject these dictates to critical evaluation or distinguish between authoritarian sources of opinion and the merit of opinion itself. This rigidity seriously limits the capacity to adapt flexibly. (C: 27)

Note's behavior gradually became predominantly catatonic. He ate little, lost weight and frequently was mute and unresponsive for hours at a time. Often he refused to wear clothing and presented a most unkempt, pathetic appearance. Several persons described him as the picture of a weak helpless, chronic invalid. Intermittently he lashed out in bursts of fury at persons who came into his room. (C: 347)

Catatonic schizophrenia, more than any other type, presents characteristics of its own. After a certain period of excitement, (which may be absent in many cases) characterized by agitated apparently aimless behavior, the patient slows down and reaches complete immobility. He is unable to move and care for his physical needs and is put in bed (catatonic stater). He can't dress or undress, feed or talk in the presence of others even if asked questions. He seems paralyzed. Sometimes the patient is not so bad but activities are still reduced. The patient is not really paralyzed, but just has a disturbed faculty of will. He can not will or will to move. He is very obedient and suggestible and follows another's will. The examiner may put the body of a catatonic into an awkward position, and the patient will hold this position for hours. This is called flexibilitas cerea or waxy flexibility. The patient may put himself in this awkward position and remain like that until put to bed and then may do the same thing the next day. (C: 39)

Negativism is related to this suggestibility. In this, the subject does the opposite of the examiner's request. In many cases, a few activities remain but are carried out in a routine manner. Any spontaneous activity is abolished. There may be some striking exceptions as when the patient is not immobile but repeats over and over some action that has special meaning to him. The patient interrupted his immobility to attempt suicide. Another, a 22 year
old girl would periodically completely undress herself irrespective of persons around her. Delusions and hallucinations are present but are not elicitable because of noncommunication. Often these are cosmic and general, "The world is being destroyed." Attempts to talk with the patient may elicit other symptoms. The patient may repeat the question instead of answering it (echolalia). Answers may be nonsensical, neologisms are numerous, and handwriting is more peculiar in style than in other schizophrenic types. Their general behavior is characterized by mannerisms, grimaces, and bizarre acts. (p. 39)

In catatonic stupor there is no overt depression and no history of it. In the past, catatonics were quite numerous, but now they are rare. In many cases of catatonia, the stupor is not complete; immobility is stopped when acting in the will of others or in the action that has meaning to the patient. "This selectivity for certain actions should be convincing proof that catatonia is a functional condition not an organic disease. It is a disorder of the will, not of the motor apparatus." (p. 161)

Overprotection alone is not sufficient to explain the psychodynamics of the catatonic. But, overprotection that is not accompanied by permissiveness but on the contrary is heightened by extreme sense of responsibility for one's actions, may predispose a person to this type of schizophrenia. (p. 164)

In early childhood, the catatonic does not develop a normal capacity to choose, to wish, and to will what they wish. If an event happens in their life that increases anxiety, particularly anxiety related to tasks and choices, they may become catatonic. They may go through periods of inactivity in life that may be typical of later catatonic periods. These early (prodromal) signs of catatonics may be diagnosed wrongly as hysteria. (p. 166)

There are stages in the longitudinal view of schizophrenia. The first is a period of intense anxiety and panic; next is the stage of confusion when everything is mixed up and crazed; the third is a period of psychotic insight when the external world is seen according to the patient's new way of thinking. This new pattern
of thought follows the motivational needs of the patient. In catatonia, the insight period is substituted for by the catatonic state. The usual symptoms of schizophrenia show that the person has lost the power of his logical thinking. Hallucinations, ideas of reference, delusions, and catatonic posture may show. The catatonic pattern appears when the patient is overtly by fear of his actions. Heboparaphrenia are controlled by unconscious power and cause him to use pal- chloride or ancient thinking, an. the paranoid may use his remaining logical and conscious strengths to support his unconscious. A patient in the beginning of a psychosis may show symptoms of paranoid and then may go into a catatonic state. He may be decatatized later only to become paranoid again. This indicates that the patient is searching for any way of action. That will relieve the anxiety he feels, and unless something happens for the good, these transactions may not be a good sign. (p: 391)

In the second or advanced stage of the schizophrenia, the catatonics are a little more active. Inactivity or waxiness is replaced with minimal stereotyped behavior. The patient allows himself a little more movement and becomes less rigid. In his state, the four classic types of schizophrenia (simple, manic, hebephrenic, and catatonic) usually acquire similar symptoms making it difficult at times to distinguish them apart. (p: 404)

Neither severity of the dementia nor the duration of the illness is the necessary characteristic of chronic schizophrenia. Only the quality of the symptoms need to be considered. A patient in a catatonic stupor for several months is not necessarily a chronic schizophrenic. He may not have recovered from the initial first stage, and even experienced therapists are sometimes not clear on this. Ferreira (1959) had successful treatment of two "severely regressed schizophrenics" he called chronic catatonics. Ferreira was given credit for helping these two. He accepted one, as much as he could, satisfied the patients' needs however unrealistic they were. As improvement began, he encouraged them to use their reacquired ego functions more and more. They were in a severe catatonic state but were not chronic, but Ferreira's achievement is not diminished. (p: 540)
A mixture of obedience and disobedience often appears in the actions of a catatonic. If a patient is asked to close his eyes, he may do so but also turn his head at the same time. Bleuler compared this resisting negativistic attitude of the catatonic to sexual feelings, especially that of a woman who resists sexual advances. The negativism of the catatonic may have sexual connotations. The author days that he might not agree with this, but says that they might be similar in motivation. This is fear of guilt arising against a desire to act. In this case, sex gratification is connected with guilt; therefore, the woman resists and does not act because of guilt feelings. She wants to yield and get satisfaction. She alternates resistance and acceptance and puts on an act to convince herself and her partner that she is free of responsibility when she resists. He says that many women dream of being raped. If this happens, they get the satisfaction without the guilt feelings. (p:32)

Some catatonic patients seem to be suspended in time. When they recover, they can remember things what happened around them but not in the order in which they happened. Time is normally sequential: "today" follows "yesterday" and is before "tomorrow." It can be disturbing if the flow of time is reversed. These changes may be of short duration. The patient may sit for hours and "come to" thinking that only a few minutes have passed. Schizophrenics alternate between time passing slowly and quickly. When time is slow, they are depressed, and when time is fast, they get excited. It is usually believed that mood sets the time sense, but it could be reversed. (p: 36)

In fact, in hypnotic experiments which we will describe later, the mood was exactly correlated with the change in time passing. The slowing down of time movement produced depressed emotions. The speeding up of time produced euphoria, cheerfulness and even mania. When time was stopped, catatonia was produced. (p: 36)

This change in time perception was produced by using a metronome with a loud regular beat. The metronome could be adjusted from zero to several hundred beats per minute. The subjects were
hypnotized and the beginning frequency was 60 beats/minute. The subjects were then given the suggestion, "When you come out of your trance, you will find the clock is beating sixty beats a minute." The subjects appeared little altered. When the frequency was decreased to 30 beats/minute without their knowledge, they were markedly slowed up. They thought and acted slowly, said that they were depressed and appeared that way. When the beat was stopped, the subjects became catatonic almost immediately. They literally stopped in their tracks even if they were walking rapidly or were active in other ways. One subject developed the typical waxy flexibility. When placed in any position, she seemed to be frozen into it indefinitely. The other developed a rigid negativistic catatonia from which she could not be moved. When the beat started again, they both resumed activity as if nothing had happened and denied vigorously that they had paused in any way. (Ell: 79)

When the beat exceeded 60 beats/minute, the subjects became more alert, friendly and active. They spoke more rapidly, stated that they felt wonderful and appeared hypomanic. This proved that when normal subjects were exposed to perceptual time changes and accepted them as real, their behavior was abnormal reproducing the varieties of schizophrenia seen clinically. (Ell: 79)

**Therapy**

In therapeutic encounters with patients, nonverbal, meaningful actions may be useful such as holding their hand or walking together. There may also be danger in this if a catatonic patient in a stupor is raised to a frightening catatonic excitement. Active intervention is called for in some cases, but some patients may see it as an attack or intrusion and may pull away and disintegrate even further. (Ell: 548)

There is a certain way to conduct a session with a mute catatonic. Do not force him to talk, but take the initiative and talk to him. It should be pleasant and neutral not arousing the anxiety of the patient. Since the catatonic generalizes his fears, this may be a little difficult. Don't hit too soon or accidentally on
a psychodynamic subject when the patient seems to be improving. A mentioning of a mother, brother, etc. may throw the recovering catatonic into another stupor. When the therapist is conversing with the patient on a neutral subject, the patient must feel that a sincere desire is being made to help him even if he is disinterested in the subject. There must be no demands made on him. These one-way talks may bother the patient at times if he feels they are just monologues and not real communications. "he patient may show his irritation by withdrawing. The therapist should respect the patient's need for silence and communicate no verbally if possible maybe interrupting at times with a gentle firm voice to make his presence felt. \(D: 549\)

The other half of mute withdrawn behavior is catatonic excitement which is similar to the manic of the manic-depressive. With the anger of the catatonic to others there are periods of explosiveness that alternate with paralyzed periods from his fear of aggression. One patient said that he had to be still from fear of heart attack. Cold wet sheet packs and the seclusion room have been used for these excited patients. The new residents and nurses sometimes regard this as a form of punishment and, therefore, hate to see it used on the patient. But, it is useful, sedative and restraining. Once it is used frequently of that patient, the patient may request it. It is also good when the therapist feels threatened in the presence of a patient. If the patient is restrained, the therapist can concentrate on helping the patient without fear of an attack. These wet sheets might have the same affects as that in the swaddling of infants. \(P: 213\)

The seclusion room decreases the amount of stimuli for the patient. This prevents the patient from inflicting self harm, from harming others and destroying property. Although a decrease in stimulus is needed, complete shutoff from human contact is not. Nurses should be allowed to visit and sit with him. Also, it is beneficial for disturbed patients to be around better integrated patients. In this hospital, they have removed the "disturbed halls", and the monthly average of seclusion room time decreased to less than one-tenth of what it had been. There is a need to interact
with less disturbed people in a civilized setting. This tells the patient that his disturbed behavior is expected to cease. Group pressure influences the patient to use whatever ego functioning he has left to control his behavior. Hall meetings are sometimes used to discuss the situation when others want to get rid of a certain person. This discussion can be constructive in getting the group to see how they can help this person become a part of them. (F: 213)

Tranquilizers can be used on these excited patients. This terminates the disturbance or lessens the degree of the disturbance. It is used when the patient responds to nothing else, is a danger to himself, or draws near to exhaustion or self-destruction. More effective use of the tranquilizer is made if it is given in an earlier large dose. (F: 213)

The therapist (though rare) can use electroshock on them. This is used on fewer than 1 out of 300 patients annually. Because it results in a temporary memory loss, it makes it hard to develop a productive psychotherapeutic relationship. Some patients have had prolonged catatonic excitement that have ended in death. Before tranquilizers were used, catatonic excitement was ended when the patient became physically ill. This may have involved stress on the endocrine system or may have been a response to the increased attention from nurses attending the physical illness, or both. (F: 214)

There is a very contrasted interaction between the patient and the nonclinical employees such as porters, carpenters, plumbers, or dieticians. The patient treats these people as if they were "off limits" and do this with no specific instruction to this effect from the clinical personnel. They will not use a plumber's wrench or a carpenter's ladder but will move around these and grab a nurse's scissors to attack or mutilate themselves. A particular porter who mops the floor can sometimes get the patient to return to his seclusion room more effectively than a task force of nurses. (F: 214)

The catatonic uses projection and denial as his primitive defense mechanisms, and this can make it difficult on the staff who become targets of this projection. The patient may be right
in his projection (i.e. what he sees in the staff person may actually be present) though not to the degree in which he thinks it is there. The staff must allow and accept this in order to get the patient to integrate all of these dissociated aspects. When the angry catatonic attacks a staff member and makes him angry, the staff should not deny his anger but show the patient that he is angry also. This allows the catatonic to identify with the staff and accept his own projected anger. These patients can induce anger in a staff person. The staff should not deny the patients anger or tell him how good or kind he is. (F: 216)

CASE PRESENTATION

This was a single young man in his mid twenties who was admitted for the present treatment in a catatonic stupor. Two years before in college, he had had feelings of "tension" and worried about his feelings of sexual attraction for other men. He thought that things were emanated from others that influenced him and thought that things came from him that adversely affected others. He visited various psychiatrists including Wilhelm Reich. When returning from therapy one time, he began to pray in a railroad station and was taken to a psychiatrist and hospitalized. He went through a series of hospitals and was put in an open ward sanitarium. They thought that he might regress or explode in intensive psychotherapy, but he reacted well and was not moved to a closed ward. His catatonic episode was brought on by his becoming engaged to a female patient while in a hospital. He, his girl friend, and his mother met in a certain city. The mother discouraged her son in this endeavor disagreeing with his choice of fiancées. The man stopped eating and became withdrawn and mute. He took the train back to the sanitarium, did not get off in time, and arrived in the town where his therapist lived. He walked back to the sanitarium and got there in the middle of the night. The therapist was called in. The patient asked for a cigarette and asked the therapist to kiss him. The therapist kissed him on the hand, then the patient took the cigarette and burned the spot where the therapist kissed him. He said that he
was afraid of becoming dependent on the therapist. He was tube fed. He was the younger of two children and close to his father. His mother thought that they were too close to be healthy. She also thought that he was too close to other people. During her pregnancy, she had a complication and had to stay in bed after the delivery. The nursemaid cared for him. The mother thought they became too close and got rid of the nurse. The patient was always compliant, gentlemanly, known for his fairness, polite, and agreeable.

His sister was rebellious and caused the family much trouble in her early years especially when having her girl friends over. The family would go to their farm, and she would stay in the city. She did not care for her appearance, overate, and had arguments about this with her family. (F: 185)

The patient's relationship with his mother was one of polite consideration. They had no arguments until he was grown. In addition to the nursemaid and the patient's father, the mother disapproved of the patient's closeness with any of his girl friends. This theme was later to continue in the relationship to his therapist. When he began to work well in treatment. His mother suddenly began to suggest that someone else could be friendly with the patient, play the piano with him, or in other ways break up what she considered to be an excessively close relationship. (F: 186)

He was good academically regarded as charming and lively. He failed two courses in college. One was harmony because his mother liked music. He didn't have the background for this, and the other was in science because he didn't do his laboratory work. He thought that it was silly. He was out of school for a year in which he worked as a lab assistant doing research on hypertension. His father had a stroke and was hospitalized in the same hospital that the research was being done in. The stroke happened after the patient and his father had argued at the breakfast table. The father was semi-invalid until his death 2 years later. When the father was ill, the patient displayed anger and impatience at his father's helplessness. (F: 186)

Sexually, the patient was very sensitive and tender to other boys. He abhorred homosexual encounters when approached by other young men. In college and in grad school there were attempts at
heterosexual intercourse, but he was impotent and could not achieve orgasm. The encounters ended unsatisfactorily. (F: 186)

In contrast with his sister, he underate. His parents tried to get him to finish his food. He had difficulty learning to read, while his sister read well. He could not remember facts, and his sister could. He was better behaved and did not like fighting with the kids in kindergarten. He was in competitive athletics. On his father's illness, he made bad remarks about him being useless and incapacitated but was happy at any improvement of his father. He went on to college, graduated, and went on to grad school. (F: 186)

His father died when the patient was in the open ward five months prior to the onset of his stupor. His mother said that the patient had not seen the reality of his father's death until 2 weeks before the onset of the stupor when the mother and her son had tried to do some business on the father's estate. Shortly before the onset he had broken with his fiancée, and just prior to it, he told the doctor that he did not want to become dependent on him. (F: 187)

During the first 19 months of the latest hospitalization, he worked with a woman therapist. He was a tall thin man who lied in his bed, looked at the ceiling, and was quite catatonic therefore not talking. He was incontinent of feces, did not eat, and was tube fed. He seemed like a big boy acting like a little boy to his therapist. She told him that she felt some despair since he had been in other hospitals before this. She said that she was interested in working with him but that he did not need to be under any pressure. She said that she would sit with him, and when he had things bothering him, she would like to hear them if he could tell her. She indicated that his incontinence (not holding feces) might have been his way of telling others that he needed help. She told him that there were nurses to help him when he couldn't help himself. (F: 187)

In her second interview, about the fourth day after his admission, he had a grand mal seizure as she came through the door into the hall for their appointment. He was tested for epilepsy. The
first words he said to her were, "I just resent having to take pills. I feel as though I ought not to have to." (F: 187) He resented the fact that he might have something wrong with him. She said that in addition to this epilepsy, he might have an emotional problem he wasn't discussing. When he spoke, he intellectualized on a high level, talked of cybernetics, neurophysiology, and so on. One day, she came into his room. He was nude and crawling on his hands and knees. He had piled up his books on the floor and was using his nose to push them out into the hall like a dog. "She commented, 'You feel like hell and I just feel a great deal of compassion for you in this situation.'" (F: 188) He came back into the room, got into bed, and spoke of cybernetics and what makes the brain tick. He said that he thought that he was sick because he was a homosexual. (F: 187)

Several psychological tests were given. The Wechsler-Bellevue Intelligence Scale measured his IQ at 121 which meant that he was superior in intelligence. The Rorschach classified him as a paranoid schizophrenic who is overly psychotic, confused, and not in touch with reality. He had a good intellect and imagination but could not integrate his intellectual functions. He used perseverative thinking, had automatic phrasing tendency, and did not shift his form of thinking. He saw his relationship with others as an unresolved struggle. He made enormous demands on others that they couldn't satisfy, and his overt expressions may be hostile or vulgar about this. Prognosis: He may have an organic component. This is not a favorable prognosis although he does have lively feelings and a need to contact others. The Wechsler Memory Scale form I showed the patient to have an extreme impairment of memory. The memory quotient was 73. This impairment was in all types of memory. He made an average score in visual and repeating digits sections. The impairment could have been a function of his psychosis or organic. (F: 189)

On the four pictures test, the patient could not tell a story about them but was stuck in his own experiences. He had a high degree of concreteness, did not shift from the present, and could
not integrate separate items. This indicated an organic defect and autistic preoccupation. The drawings that the patient made showed a marked regression to a primitive level which points to a probable organic factor in paranoid schizophrenia. (F: 189)

When a previous Rorschach was compared to the later one, it was found that the patient was worse than earlier. He was less productive, slower, and less communicative. His inner life was stereotyped and constricted. He was less emotional, creative, and original in imagination and was vague and confused in perceptions. He also showed more of a perseverative trend which suggests the organic component. (F: 189)

The therapist tried to respond to the "little boy" aspect of the patient while listening to his intellectual ideas. Since this one therapist seemed to be stuck, there was a change of therapists. When the patient heard that this new therapist came from the same geographical area as him, they had a lively talk about where he lived and went to school. They also talked something about his father's illness and death. This contrasted with his usual withdrawn state. The next day the patient was coughing and blowing his nose. The patient told of his sinus trouble and medical attention. From this, the therapist found out that his tonsillectomy was done by an otolaryngologist who was a classmate of his father in medical school. From there, the patient talked of his early illness which he spoke of as "tension states" in which he had a "fear of failure." He qualified some of his statements or replies to the therapist with, "I don't know exactly." He thought of his mother as a perfectionist. He said that he had a problem controlling his violence and felt that he might explode. In the fourth session, the therapist asked him why he had to take the initiative all the time. The patient said that he had none and was trying to repress and forget these unpleasantries. (F: 191)

The patient ate for a while and then started fasting again. The therapist said that the patient had had feeding trouble as a child. When he was 5-10 years old, his parents made him sit at the table until he had finished. The patient spoke of anger toward his parents, and the therapist was impressed that the patient was
holding back large amounts of hostility. The patient saw his parents as demanding perfection from him and anything outside of perfection would result in catastrophe. When he was asked a question, possibly 50 answers would fill his head and selecting one was crucial. He would not talk rather than to be mistaken. (F: 192)

The patient thought that when the therapist talked of his being withdrawn, he had to block it out. He thought that the therapist was making demands on him to be different than what he was. If the therapist spoke on the patient's feelings of failure or disappointment, the patient would discuss it. The patient wanted to leave the hospital and would badger other personnel members. The therapist said that if the patient went to another hospital, he'd have the same attacking feelings toward them also. (F: 193)

After 4 months, he was put on an open unit. Three months later his mother visited him on his birthday, and within 2 hours, he was in a cold wet sheet pack. He was returned to the open when she left. The patient was belligerent to the therapist.

About five months along in the treatment, the patient's mother consulted with an internationally famous psychiatrist about her son's case. As a result of his asking, "Is Frieda on the case?" I had a consultation with Dr. Fromm-Reichmann. She told me, "Don't be so easy with him. He knows that he has to talk about these things and so do you." This gave me encouragement to be more forward with him, but his response to this was to feel that I was like "steel." He felt that I was a precision machine and was smacking into things, and sometimes it felt like he was being hit over the head with a sledgehammer. (F: 194)

The patient attacked verbally not physically. He would take off his shoe and bang the floor to emphasize a point. His negativism and uncertainty was confusing to the nurses. He would get ready for a picnic and then would say that he wanted to stay. They found that if they were indifferent to him at the critical moment of participation, he would join the activity. He began expanding some of his activities, went to town, etc. His appearance improved, and he worked on constructive jobs. (F: 198)

The first 2 years of treatment contrasted with the latter 2 years. During the first 2 years, the patient showed change from
a withdrawn mute, catatonic state to one of social participation, talking in these sessions, and expressing anger. But, he still had a large reluctance in working through his psychological problems and conflicts. A consistent theme throughout his treatment, was his wanting to be an outpatient. He wanted more independence. The therapist thought that the entire course of the therapy might have been different if this would have been allowed. In the second years of treatment, the patient had increased feelings of anxiety when in contact with his mother. At times he would be active and dating and at other times withdrawn. He would be less verbal in the sessions after returning from home. Later, he voluntarily had himself transferred to the disturbed ward and stayed there for the remainder of his stay at the hospital. (p: 203)
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