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CHAPTER FIVE

Schizophrenia, Catatonic Form

BY PAUL E. MEEHL

L. W., a 45-year-old unmarried school teacher from a small middle-western town, was brought by relatives to a university hospital in December, 1945. Although not consistently resistive, she was confused and impossible to interview, so the "present complaints" are not those of the patient but of her family. The informants stated that the reasons for bringing her to the hospital were that she was overactive, assaultive, talked irrationally, acted peculiarly, and was generally "out of her head."

Present Illness

The present illness seems to have begun on a Wednesday, four days before her admission to the hospital. For about a week previous to that date, the patient had suffered a slight cold and complained of feeling very tired. She was also unduly worried about certain rather minor problems that had arisen in connection with her teaching duties. She taught a class of "backward" children who were difficult to handle, and she had apparently assumed a very great personal responsibility in her handling of the job. She later said that she had "worked her head off trying to take care of them." Just prior to the onset of her acute illness, an incident occurred which worried her considerably. The students in this special class were each supposed to bring about ten cents to buy presents for a class Christmas party. One of the boys in the class brought $14.00 instead, which caused her an excessive personal concern. She worried about where he could have obtained this money.

took the money to the school superintendent, and wrote a letter to the boy's mother about it. When the latter did not answer her letter, she became very much upset. Simultaneously with these difficulties, she was taking charge of the forthcoming Christmas play, and was worried about whether or not it would be successful. These conditions may have acted as precipitating factors, but at the same time her reactions to them were apparently rather abnormal *ab initio.*

During the afternoon she was busy directing preparations for the Christmas play, and began to show physical symptoms. She was very tired, and complained of having a "full feeling in the head" which turned into a severe headache. When the other teachers suggested that she go home and rest up, the patient went to her boardinghouse, and then suddenly decided to go to her parents' home in a nearby town. Although the people with whom she was boarding tried to dissuade her, she proceeded to pack *all* her belongings and took the trip to her parents. When she arrived there, her parents recognized that she was not well and persuaded her to go to bed. The local doctor was called on the following day (Thursday), and prescribed sulfa drugs and rest in bed.

On the following evening there was a sudden and dramatic change in her condition, with the first clear appearance of grossly psychotic behavior. Her family describes her as being irrational and hyperactive. She first began to mumble somewhat unclearly about having stolen or lost $100.00 from the school milk fund. The family went to the trouble of checking this with the school superintendent, who reported that there was no money missing. She would stand motionless for long periods merely staring vacantly into space; then would suddenly shift to a marked degree of activity. She talked vaguely about someone coming to take her away. At times she would creep around the floor on her knees with her hands outstretched, exclaiming repeatedly, "A child is born! A child is born!" (possibly a connection with the Christmas play she was directing). With considerable difficulty her parents managed to get her back into bed.

On Saturday she continued to behave peculiarly. She wandered aimlessly around the house, whined and cried a good deal, and said puzzling things. On one occasion she knelt before her mother and cried, "Mother, mother—come!" She still seemed to be under the impression that someone was coming to take her away. Various members of the

immediate family remained at her bedside all that night, which on the whole was reasonably peaceful. She was able to carry on a more or less lucid conversation with her sister, although she was not very voluble and still stared for extended intervals into space.

When she awoke Sunday morning, she had a very difficult time putting on her stockings. She ate a hearty breakfast, and then at her parents' suggestion lay down for a nap. Upon awakening from this nap, she called her parents into the library, saying that she had something important to talk to them about. However, when they had come to listen, she seemed to have some sort of blocking which kept the words from coming. After manifesting this difficulty in speech, she grasped her father's hand without saying anything and squeezed it so hard that he cried out in pain. When her mother asked her what was the matter with her, she said that her stomach hurt and that she wanted a hot water bottle for it. Upon being given the hot water bottle, the patient began to "tear it apart." Then she suddenly became "stiff and rigid." This phenomenon alarmed the mother, who ran to the telephone saying that she was going to call the physician, whereupon the patient again became active and fought to keep her mother from the telephone. When the physician arrived and decided to administer an intravenous sedative, it required the combined efforts of four people to hold the patient down. During the half hour or so before this injection took effect, the patient ran and rolled "all over the floor," bumping into furniture and grabbing at people so that it was necessary to keep objects clear of her to prevent her from injuring herself. Late that afternoon she was brought to the university hospital and admitted to the psychiatric ward.

Personal History

As a child, L. W. was described as "very sickly," and her family had got into the habit of pampering her. As an adult, her health was fairly good. Besides the usual childhood diseases, she had been afflicted with erysipelas and Bright's disease. During these illnesses she was described as having been very irritable. Surgical operations included a tonsillectomy, removal of a fibroma of the cheek, and a hysterectomy and unilateral oöphorotomy. Cardiorespiratory, gastrointestinal, genitourinary, and venereal diseases were lacking in the history. There were no previous psychotic upsets, but the patient was given to severe temper

tantrums in childhood and had had several so-called "nervous spells" during her teaching career. About a week before the onset of her present illness she had fallen on the ice.

The patient was brought up in the small middle-western town in which her parents still live, and attended grade and high schools there. She was a moderately successful student and had no particular difficulties in the school situation. Upon graduation from high school she entered a state teachers' college, where she experienced considerable difficulty in making an adjustment. Her academic work was not wholly satisfactory, and she formed the strong impression that certain people at the school "had it in for her." She was forced to spend three extra months to make up work in which she had done poorly, and was told at this time that she would never be a good teacher.

Since that time she taught in various small schools throughout the state. She was several times forced to leave these jobs, for various reasons. At one school she had trouble with a school-board member whose child was in her class, and she felt that this was the reason for her being fired. At another school she "took on too much work" and was fired. School officials and other teachers have generally not liked her and seemed glad to get rid of her. Apparently she was quite tense and "nervous" most of the time. For a couple of summers she worked in a hardware store and seemed to enjoy this work.

Her social life was always rather meager, although when she was younger she "enjoyed going to dances." The family impression is that her social life even in youth was relatively minor and that the patient has tended to distort her recollection of this period. In later years her sole recreation consisted of reading and listening to the radio, and she had practically no social life.

As a child L. W. was cross and irritable, particularly around her mother. Her sister said that the patient had always been bored by people and had shown little real interest in them. However, she had spent considerable time in writing letters, and had sometimes sent people gifts for no apparent reason. During her youth she went out a little with boys, but they did not seem to like her very much. Her two sisters were both more attractive than the patient, and very popular with men. The patient was not. This unpopularity seems to have been due to a mixture of several factors—less physical attractiveness, a tendency not to get along with people in social relations gen-

erally, and a somewhat "choosy" attitude on her part. She claims to have had two offers of marriage, but turned them down because the suitors did not meet her standards. She rejected her first suitor because he was not very "sound financially," although she liked him. She said, "There ought to be a happy medium between love and ability to support." The second proposal came from a man she didn't like. After the recent war started she went out three times with a soldier she had met on a bus, and corresponded with him after he left for service. This correspondence soon died out, and while the patient insists that she didn't care much for him, her family believe that she was quite disappointed at the turn events took and that she seemed to have hoped that something more permanent would come of it. She did not care for sports or domestic activities such as sewing or cooking, and for many years her life had been quite narrow. She had chiefly been interested in her job, and was overly conscientious about it. She might seem to have maintained considerable professional and intellectual drive, as shown by her taking several "refresher" courses over the years and continuing to do a lot of reading. However, she had never really been able to enjoy her teaching and seemed mostly to have been driven by worry and the fear that she would not do the job well. Teaching seems never to have been a source of any particular positive satisfactions. It has been noted above that in spite of her efforts she had never really done very well at it. Her interest in "reading" was pretty much confined to *Collier's* and the *Saturday Evening Post.* She had not been very systematic in handling her financial affairs. She was religious only to an average degree. So far as is known, she had never had any heterosexual or homosexual experience.

Family History

The family history is substantially negative. There is no history of neurotic or psychotic behavior. The patient's parents are both over 70 years of age and in good health. The father is a successful lawyer and the mother is also a college graduate. Both parents were native-born. There are two sisters who are living and well, and both are happily married. From the environmental point of view, the intra-family relationships were never grossly discordant, although the patient's childhood hostility toward her mother has been noted. The mother was a very complacent, easy-going woman who did not react

to these manifestations particularly. The informant's view was that the family circle had been a very happy and comfortable one. The parents showed more than average kindness to the three children, at least in the obvious respects. It has been mentioned that the patient was treated rather specially as a child because of her sickly condition. Concerning the more intimate and dynamically important relations within the early family constellation, no information could be elicited.

Psychiatric Findings

Routine physical and neurological examinations were essentially negative, as were routine blood and urine studies. Spinal tap revealed an elevated protein level (not maintained on two later taps) and positive Nonne test. On admission there was some leucocytosis and fever, which the medical staff attributed to the marked dehydration resulting from lowered fluid intake. The spinal tap showing elevated protein was taken after several shock treatments and may have been attributable to the latter.

Upon admission it was difficult to determine the nature of the patient's mental content. She was almost inaccessible and would answer few questions except those needed to determine orientation. She also murmured about having stolen the sum of money previously mentioned, a belief which can presumably be classed as delusional. There was no evidence of hallucinations or illusions. (After recovery she was amnesic for the acute phase and could give no information as to what her content had been at that time.)

Because of the patient's catatonic and almost mute condition upon admission (see below), an adequate study of sensorium and intellect by, for example, tests in the Wells and Ruesch *Handbook* was not done. Psychometric studies were also delayed until she was recovered sufficiently to cooperate more fully. She was at all times oriented for time, place, and person, so far as could be elicited by listening to her and questioning her. During the acute phase, the other aspects of the sensorium and intellect could not be examined. Psychometric findings gathered after marked improvement are reported below.

During the first few days after her admission to the hospital, L. W. showed more distinctly catatonic features than previously. She was admitted in a wheel chair and presented a picture of cataleptic rigidity. During the first few days the upper extremities were maintained

in flexor contraction for many hours at a time. She was both actively and passively negativistic. If asked to perform a certain movement, she would do the opposite. When the nurse wished to take her temperature, she would close her mouth tightly. On a few occasions she presented the classical "waxy flexibility" of catatonia. Sometimes when being bathed by the nurse, she would not actively refuse to cooperate and yet her extremities showed a resistance against movement. At other times she violently fought all efforts to move her and care for her. Sometimes this motor resistance was associated with facial and verbal signs of hostility, but more often not. At times she would allow food to be put in her mouth, and then she would spit it out. It was necessary to catheterize her because of urinary retention. There was some stereotypy of verbal behavior, such as replying "No, no, no" to all questions and saying repeatedly, "Mother, forgive me." On several occasions she called to the nurse as though wanting her for something, but upon the nurse's appearance seemed unable to say anything. Changes in behavior sometimes occurred quite rapidly. She would be fairly quiet and free of tension, able to speak easily; but within the hour she would become tense, hold her arms rigid, and two hours later have to be put in restraints because of violent activity and assaultiveness. Sometimes, within a short time, she would pass from a very violent, assaultive state to one of lying quietly and mute upon her bed, often with eyes open. Once when being neurologically examined she struck one of the physicians violently in the mouth. In her excited state there was sometimes an expression of extreme anguish upon her face.

So far as emotional tone could be assessed, the predominant affect seemed to be one of acute anxiety. On occasion she would pull at the bedclothes or wring her hands in a manner most suggestive of an agitated depression. She sometimes moaned and wept, but on other occasions would lie with a placid, almost euphoric expression on her face. There was associated with the prevailing anxiety considerable guilt which was displaced to the delusional content concerning the "stolen" money. The other noticeable affect was rage in some of her more assaultive states, but sometimes even her aggressive behavior did not seem to be colored as much by hostility toward others as by generalized tension and anxiety.

As to the stream of thought, replies were rather inadequate and ir-

rational at times, but there was no genuine incoherence, "scattering," or clearly schizophasic speech. In the acute phase this area was of course difficult to evaluate. On occasion, when lying mute and quiet, the patient may have been in a mild ecstatic condition, but this is speculative.

The patient signed her own admission papers under some pressure, and seemed to realize that she was ill; but how adequately she assessed her psychological condition in the acute phase can only be guessed.

Course in the Hospital

During the first five or six days after admission the picture was that described above. Electroshock treatments were instituted on the second day, and a total of five shocks with grand mal seizures were administered over a 12-day period. On the second day she was given 2¾ gr. sodium amytal intravenously and she responded immediately by talking lucidly before going off to sleep. Although no particular material was elicited in the short time available, she afterwards asked for fluids and ate a normal meal, both of which she had previously refused. Staff note at this time was: "The change in the patient's condition from marked rigidity and inaccessibility to normality was dramatic." Following the first electroshock given the same day, she ate dinner and was lucid for an hour and a half, after which she again became rigid and made self-accusatory remarks. Five days after admission she was still very uncooperative, although she had begun making apologetic remarks about her behavior. About 45 minutes after the administration of 120 cc. of 50 per cent *spiritus frumenti* through a nasal tube, the patient said that she felt much better and her arms were taken out of restraints. A smile appeared on her face, she sat up and was very cooperative when moved to a chair. Asked how she felt, she responded quickly, "I feel much better—more relaxed—thank you." She ate a light lunch, then asked to lie down as she was tired but still "feeling fine." She then lay quietly in bed for a long time, smiling euphorically to herself. Following this episode there was no more violent or cataleptic behavior, but rather frequent crying and signs of anxiety and depression. She said to the nurse, "I am sorry I broke down a while ago. I want to get well and get back to work." Gradually her condition improved and by nine days after admission she was behaving almost normally. The delusion about stealing money

had vanished, and she claimed to have no recollection of having held such a belief nor any idea of how she could have come to hold such a foolish notion. She was amnesic for almost all the acute episode and referred to it as her "delirium." She became very conscientious about her ward behavior, was apologetic about her previous conduct when she was told about parts of it, and was obviously trying very hard to convince both the staff and herself that she was now wholly recovered. Examples of her verbal behavior during the recovering phase are: "I don't mean to be a nuisance—I wasn't brought up to be rude." "I'm sorry I was so rude to the doctor the other day. I didn't mean to hit him." "I have to go home soon. There is so much I have to do, and my mother needs me. She is the best mother in the world. She is such a good woman." "Do you think I can go home now—I've done everything I thought you wanted me to." "I want to make a good impression on the doctor tomorrow, I feel so awful about doing the things they say I did when I first came in." Finally she became even cheerful, and her relatives visited her and reported that she was acting and talking like her normal self. In the middle of January, about one month after the onset of the acute symptoms, she was discharged to return to work, apparently quite well.

Psychometric Findings

When tested on the Minnesota Multiphasic Personality Inventory eight days after admission, L. W. attained an entirely normal profile. The scores were as follows: ? (Cannot Say) 50, Lie 53, K (Validity) 46, F (Validity) 50, Hypochondriasis 39, Depression 51, Hysteria 45, Psychopathic Deviate 41, Masculinity-Femininity 52, Paranoia 53, Psychasthenia 46, Schizophrenia 40, Hypomania 55. These scores have already been mathematically corrected for the "K-factor," and therefore she seemed entirely normal at this time. In terms of the clinical picture presented on that date, as indicated by notes of staff, medical clerks, and nurses, the patient's behavior was not appreciably different from that of a normal person. On the other hand, the differentiation of schizophrenic cases by the MMPI is notoriously poor, especially in relatively integrated cases where the patients have recovered from acute episodes. We have noted that almost immediately upon the cessation of acute catatonic symptoms the patient began to be excessively proper, dignified, and "normal." There was a repression of

the whole psychotic episode, and a determination to leave the hospital and "go back to work" as soon as possible. It is highly probable that this reaction represented a genuine inner defense and was not merely for the staff's benefit (cf. Rorschach below). The desperate pseudo-control suggested here is apparently sufficient to bring about entirely normal verbal behavior respecting such items as those of MMPI. The defensive façade is, however, of a sufficiently "subtle" sort that it does not show up as a deviation on K; hence the profile, even corrected, is normal. In terms of the momentary clinical picture, the MMPI profile here gives a fairly accurate description. However, it seems impossible that this patient should be "internally" this well, and clinical experience with the psychotic scales does not give us great confidence in the power of, say, Sc in this latter respect. The Rorschach findings justify this scepticism.

Wechsler-Bellevue Intelligence Test

The patient seemed rather bewildered and very tense during the testing, asking frequently if it weren't soon over. At the end of the session she commented, "I don't know if it's what you want or not—but it isn't because I didn't have a good education." She was greatly lacking in self-confidence, and laughed somewhat bitterly if encouraged by being told she was doing well. The full-scale I.Q. was 104, verbal 106, performance 103. This would seem rather poor for the kind of job she was trying to handle, and would fit in with the mediocre to unsatisfactory academic and professional history. On the other hand, it is not likely that the obtained I.Q. is a satisfactory measure of usual capacity, because of both the probably continued negative influence of the personality disturbance, and the fact that she was undergoing electroshock therapy.

The performance as a whole was rather spotty and contained a number of contradictions. Poorest subtest performance was a weighted score of only 4 on Digit Span (5 forward, 3 backward). Her best score was on Similarities (weighted score 14), which would seem to argue against an organic deterioration interpretation of the low digit span. Block Designs and Digit Symbol were the other poor tests (weighted score of 6 on both). There were a number of marginal failures throughout, where she either worked a little too slowly or failed to carry her

line of reasoning out to the end. She also failed the easy questions on the Information test while succeeding on much more difficult ones. For example, she knew what *ethnology* and the *Apocrypha* are, yet she thought Paris and New York were about 1,000 miles apart, that the heart pumps air into the lungs (repeated when pressed on this), and did not know the height of the average American woman. The Rabin Schizophrenic Index was less "schizophrenic" than the normal, at .71. The pattern of test output does not fit any of the alleged psychometric patterns, except that there is at least evidence of some abnormality or impairment in the presence of some very deviant subtest scores.

Rorschach Test

This examination presents us with clear evidence of abnormality. The patient gave only one response to each of the ten cards, and all of them were fairly crude wholes. In 60 per cent of them the determinant was pure form. There was perseveration and stereotypy, in that on eight of the cards the patient saw "a butterfly," but she was able to fit this concept to the blots enough to elaborate in more or less detail. The other four determinants used were FC (on Cards VIII, IX, and X), of which two were scored minus, and the popular M on Card III. She did not spontaneously see the animals on VIII, and when they were suggested to her she called them "fish," and later, "lobsters because they are pink."

We see here a relative poverty of inner life and a low-level performance, especially considering her education and profession. There is apparently an attempt to maintain control and a good surface impression through the emphasis on form, which occasionally relaxes and reveals the inadequate character of this "pseudo-control" when she responds on a more affective basis (FC—). The perseveration is different from that of organics in that she does attempt to elaborate and fit her concept to the blot, and is able to achieve a more complex type of response than an organically involved person usually does. Although none of the "pathognomonic" signs such as contamination or confabulatory DW occur, the Rorschach indicates the abnormality still present under her external appearance, and is quite consistent with a diagnosis of schizophrenia.

Thematic Apperception Test

Here the same sort of perseveration occurs as on the Rorschach, and there is an emphasis on the importance of "planning and organizing" that fits in with the marked pseudo-control displayed there. The patient tells over and over again, with variations in detail, the story of a happy marriage, in which husband and wife are both hard workers, good planners, neatly dressed—and plan their lives so that they have time for reading and their days are not all drudgery. The husbands are kind to their wives, and the wives are all good managers. The patient ignores all the emotional implications of the pictures, except some signs of illness, sadness, or loneliness. In the three instances where these appear, all turn out well at the end. The stories are short and superficial, and the emphasis throughout is on externals rather than inner feelings. It would seem that the patient's fantasy centers about the theme of a happy, comfortable marriage. There is an apparent clinging to externally structured situations which are freed of affect, and upon a rigid planning which tries to avoid coming to terms with inner conflicts. The extreme shortness and superficiality of the stories reduce the analytic value of the data on this test, yet the over-all picture ties in well with that of the Rorschach, the "normal" MMPI, and the personal history and ward behavior at the time of testing.

Clinical Summary

We are dealing with a person who is apparently not functioning at her optimal capacity at this time (estimated at bright normal, from discrepancies in the test record and the history). The disturbed intellectual functioning is apparently due to the severe emotional disturbance she is suffering. It would appear that here is a person who has clung to a rigidly ordered existence for security in the face of underlying emotional conflicts, probably centered around thwarted sexual and affectional needs, wishes for a home and marriage, a basic dissatisfaction with her profession for which she is apparently unsuited and which puts her constantly under stress, and deeper hostilities toward her mother which have not been analyzed. Possibly the recent breaking off of her abortive relation to the soldier was a final blow to her self-esteem, and to newly aroused marital aspirations which then had to be dealt with afresh after being briefly revived. The stress of additional responsibilities at school combined with her weakness

and illness left her without strength to maintain the rigid control, and breakdown ensued. Following an acute episode displaying guilt, anxiety, and powerful sources of aggression, she has now regained her pseudo-control and is apparently even exaggerating it, emphasizing externals and verbal normality and trying to present an orderly front in spite of continued disorganization underneath.

ADDENDUM

As is often true in these cases, there are affective elements which also suggest a manic-depressive or involutional depression. It is quite conceivable that at some clinics this patient would have been so diagnosed. Our staff felt that the catalepsy, negativism, mutism, blocking, stereotypy, bizarre behavior, and somewhat schizoid-paranoid prepsychotic personality justified the present diagnosis. On the other hand, the patient did not show silliness or gross incoherence, nor was there evidence of hallucinations. There was not a marked dissociation of affect and content, except that the violence and assaultiveness sometimes had the mechanical, impulsive, relatively non-hostile character of catatonic excitement. The rapid fluctuation from hyperactivity to quiescence also argues for the diagnosis given. It is extremely rare to find a completely normal MMPI profile taken only six days after a very acute phase of affective psychosis, especially one where depression predominates. Typically, psychotic depressions show considerable elevations on the Depression scale, even upon discharge as clinically "recovered" or "much improved." On the other hand, a normal curve obtained in a case of schizophrenia is much more common. The pathological performance on the Rorschach, in the absence of a mood disorder at the time, would presumably support the diagnosis also. Possibly this case, as is true of many cases called "catatonic," is best conceived under the unofficial rubric of "schizo-affective" psychosis, except for the factor of age.