

### *The psychology of catatonia.*

How are we to view catatonia among body disorders? It is not an infection, not a metabolic disease, not a cancer, not a disease of a single body organ or the brain. Interest is recently focused on psychological factors that sustain catatonia, that if untreated may persist for weeks or months. We seek to restore a mental side arguing that persisting fear is the sustaining influence.

Karl Kahlbaum, the German psychiatrist who formulated the syndrome of catatonia in 1874, describes his patients as “*astonished*” or “*thunderstruck*.” Catatonia appeared “*after very severe physical or mental stress . . . such as a terrifying experience*”; “*the patient remains motionless, without speaking, and with a rigid masklike facies, the eyes focused at a distance . . . devoid of any will to move or to react to any stimulus*”. He continues: “*The general impression conveyed . . . is one of profound mental anguish, or an immobility induced by severe mental shock*.” To the extent that Kahlbaum concedes a psychology at all to catatonia, it is to mental pain and fright.

A telling question asks whether the mind of a patient in stupor is *inactive*, as the blank state that we picture in anesthetized patients, or *active* and so preoccupied as to exclude other influences. Catatonic patients do not respond to questions, to commands, or to pin-prick or other painful stimuli. The long history of the disorder favors an active inner life with persisting thoughts and preoccupations.

In 1833 when psychiatry trainees asked patients what they recalled from their stupors, Mme C, much upset by the July Revolution in Paris of 1830

reported: *"Soon her reason left her. She hears the cannon, sees the wounded, the blood, the dead. She gradually becomes overwhelmed. She stays motionless, her eyes fixed, mute, barely murmuring a few incoherent words."*<sup>1</sup>

Monsieur X, emerging from a catatonic stupor in 1862, saying: *"I imagined that both my parents were dead, that my native city had been flooded; it seemed to me that a new deluge had submerged all the land. While that was going on, I was always hungry, and I believed that people were going to let me die of inanition. In the garden where I was taken for walks, I was afraid of the patients around me; to my eyes they looked like brigands and assassins, and I lived in continual anxiety. In walks outside the asylum I would walk slowly, with loathing; I was convinced that people wanted to drown me, or else have me crushed on the railway tracks that passed nearby."*

August Hoch, a New York psychiatrist working on Ward's Island, described 35 of 36 patients with "benign stupor" meeting our criteria for catatonia reported *"thoughts of death or closely related conceptions."* Of 100 patients with "catatonic dementia praecox" admitted to the Hudson River State Hospital between 1927 and 1931, 48 had ideas "expressing fear": fear of being killed, 18; vague fears, 15; of castration, 10; of homosexuality, 6; of being buried alive, 5, and other fears.

After prolonged cardiac surgery, a patient was *"immobilized and almost like a statue"*; another *"was frozen and expressionless. She spoke barely audibly in a monotone with long pauses and made no spontaneous comments."*

Sexually assaulted women are often overwhelmed by fear, feeling physically restrained and immobile, unable to move or resist. It is reported when humans are confronted by an inescapable, fear-inducing situation.<sup>2</sup>

A "resignation syndrome" of stupors so severe as to end in death is being reported among refugee children coming to Sweden from Syrian wars. In the Uganda conflicts, a stuporous, repetitive "nodding syndrome" progressing to death

is reported. Some patients in this Uganda study were relieved by lorazepam, the effective treatment for catatonia.<sup>3</sup>

The picture sharpens with the introduction of the sodium Amytal interview in 1928 in France, because with a few grains of the barbiturate drug, the stuporous patients awaken and begin to speak, often requesting food (after they had been tube fed for weeks) and generally behaving amicably (after weeks of negativism). In this narrow window, which opened only for an hour or two, they had a chance to relate what they had been immediately experiencing during the stupor. Fear was the overriding theme that burst out as they surfaced from their catatonic states. A woman, 38, who had been mute, refusing food and muttering to herself for four weeks, *"lost the suspicious and apprehensive expression in her face,"* two minutes after the injection. *"She appeared relieved, looked around in an interested way, and spontaneously asked the examiner, 'Where am I? Who brought me here? Where are my children? Can I go home?' She reported that something terrible was pressing down on her, that she had a tremendous fear of impending danger, that she heard God's voice talk to her, that she was in a coffin which was prepared to take her to hell, and that she had a profound feeling of guilt with reference to autoerotic habits of her early adolescence."*

Tonic immobility is a behavior frequently described in non-human animals. A rigid motionless posture is elicited by slowly and quietly stroking an animal, gradually releasing, with the animal now remaining immobile with limbs in the unusual postures in which they are placed. The phenomenon is demonstrated in the prey animals as chickens and other fowl, rabbits, frogs, snakes, and guinea pigs. A tradition of pretending to be dead is described as the behavior of the Virginia opossum – “playing possum,” in childhood play.<sup>4</sup>

Recognition that clinical catatonia is present in 10% of acutely ill psychiatric inpatients, that it is relieved by anxiolytic drugs, and that patients give the

appearance of intense anxiety led a psychologist to propose catatonia as “*a relic of ancient defensive strategies, developed during an extended period of evolution in which humans had to face predators in much the same way many animals do today and designed to maximize an individual’s chances of surviving a potentially lethal attack.*”<sup>5</sup>

After recovery no damage to the body remains in catatonia patients treated in a timely fashion, even in the more lethal conditions. If untreated or poorly protected and not spontaneously relieved, however, catatonia patients may end in wasted states or die. Such observations encourage us to view catatonia as an adaptive syndrome outside the common accepted causes of the body’s disorders.

Seeing catatonia as behaviors sustained by severe fear offers a mechanism that encourages study while applying effective treatments, and suggests the mechanism by which sedatives relieve catatonia.

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<sup>1</sup> Shorter E, Fink M. *The Madness of Fear: A History of Catatonia*. In preparation.

<sup>2</sup> Marx BP, Forsyth JP, Lexington JM. Tonic immobility as an evolved predator defense. Implications for sexual assault survivors. *Clin Psychol Sci Prac* 2008; 15:74–90.

<sup>3</sup> [Kakooza-Mwesige A](#), [Dhossche DM](#), [Idro R](#), [Akena D](#), [Nalugya J](#), [Opar BT](#). Catatonia in Ugandan children with nodding syndrome and effects of treatment with lorazepam: a pilot study. *BMC Res Notes*. 2015 Dec 28;8:825.

<sup>4</sup> Galliano G, Noble LM, Travis LA, Puechl C. Victim reactions during rape/sexual assault. *J Interpers Violence* 1993; 8:109–114.

<sup>5</sup> Moskowitz A. 2004. “Scared Stiff”: catatonia as an evolutionary-based fear response. *Psycholog Rev* 111:984–1002.