

INTERPRETATION OF SCHIZOPHRENIA

The Third,
or Preterminal,
Stage

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The Third, or Preterminal, Stage

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The Third, or Preterminal, Stage

I Introductory Remarks

Whereas the first stage of schizophrenia has been intensely studied by many psychiatrists from a dynamic point of view, and the second stage has been studied in great detail by the early descriptive authors, the third and fourth stages have been relatively neglected.

This neglect, even by those authors who limit their studies to a description of the symptoms, may seem difficult to understand, because almost the majority of patients in advanced stages of regression are hospitalized. The classical symptoms of schizophrenia, however, are no longer prominent in these stages, so that many observers may have felt that the patients did not present symptoms worth reporting. They have described these patients as approximating more and more a vegetative existence. Very little more than similar generalities is mentioned in the literature. The result is that even from a simple, descriptive point of view, relatively little is known about

these patients.

When I was working in Pilgrim State Hospital, I had an opportunity to study these very regressed patients, and I felt that such study could eventually reveal important information. As I reported in a previous contribution (Arieti, 1945b), I gave the name “preterminal” to a stage that is rather difficult to delimit or to differentiate. This stage occurs generally from five to fifteen years after the beginning of the illness but may occur sooner or later.

In this phase of the illness, hallucinations and delusions have disappeared or cannot be elicited. In some cases they are still present, but they are completely disorganized and deprived of any apparent emotional charge. The patients present severe disintegration of thought processes, so that their ideas are conveyed to the examiner with great difficulty.

In this stage, it is difficult to distinguish a catatonic from a paranoid. Now the different types converge toward one another even more than they do during the second stage. Although all the types of schizophrenia may pass through the preterminal stage, in a large

group of cases belonging to this phase we find a predominance of patients previously diagnosed as affected by the paranoid type. This preponderance may be due to the fact that paranoid patients remain at this level a longer time or even indefinitely without regressing further. Hebephrenics and catatonics, on the other hand, regress sooner to the terminal stage.

The reason why patients of the four classic types seem more alike during this phase is that most of the obvious symptoms have disappeared. On account of the absence of many symptoms, these patients are at times discharged from the hospital, if a suitable nondemanding environment is found. They manifest what Lewis (1944) calls "improvement by regression." It would seem as if in these cases the illness had really been able to achieve its purpose. A little more than the most superficial examination, however, reveals that these patients are very sick. Not only is the impairment of their thinking very marked, but they also present peculiar habits, which are typical of this stage.

These habits are numerous but probably many of them have escaped the notice of observers. Often, in fact, institutionalized

patients learn to conceal them very well. Examples of some habits are picking of the skin, pulling out of the hair, and performance of rhythmic movements. Particular attention will be given in this chapter to two habits that, in my opinion, are the most common—the hoarding and the self-decorating habits.

II The Hoarding Habit

The hoarding habit is the practice of collecting a more or less large number of objects, generally of limited size and generally of no practical use. The objects that, in the course of my investigation, were found to have been hoarded by the patients were papers of any kind—old letters, toilet paper, pages of newspapers, and so on—pieces of wood, stones, leaves, sticks, soap, spoons, strings, rags, hairpins, old toothbrushes, wires, cups, feathers, cores of fruit, stale food, feces, hair, pencils, pens, combs, small boxes, cardboards, and other things. Until she was discovered, one patient used to carry a large number of teaspoons, which she had taken from the dining room, hidden in her bosom. Another patient had collected a large number of her own feces, and still another had collected 117 prune pits in a stocking. Another

patient preferred to hoard her daily ration of food rather than eat it. She eventually had to be tube fed. Less regressed patients, whose habits have been developed more recently, may collect objects that have some symbolic or actual use—letters, pictures, recent papers. However, their subsequent behavior discloses that they do not collect these things with the purpose of using them, but just for the sake of collecting them. Not only do they not use these objects, but they start to hoard other things that have no use whatsoever. Some patients start to develop this habit by collecting and wrapping objects of the same kind in separate bundles. Later, however, they no longer continue to divide them and keep them separately according to their kind; instead they put them all together.

The patients collect these objects in their pockets, in bags or boxes, in their stockings or socks, and not infrequently in their shoes. Female patients very often hide them in their bosom or in other parts of their body. Many carry the entire collection with them always as if it were an important part of their person. Others collect the objects under their beds, pillows, or in other relatively hidden spaces. Some patients put paper and other objects wherever they can find a hole. One patient had made a hole in the lining of a mattress and had put

into it an enormous quantity of toilet paper and other trash.

When the patients become more regressed and approach the terminal stage, they start to use the cavities of their own bodies as deposits for the hoarded material. Male patients frequently deposit small objects in their external auditory canals or in their nasal cavities. Female patients resort to their vaginas. In my series, seven patients had the habit of placing objects in their vaginas. One of them had put into her vagina a small metal cup, two handles of teaspoons, several small pieces of soap, and a little rag, by the time this practice was discovered. Another patient used to hoard small objects in her oral cavity, but she did not eat them. During her meals she would remove the objects and then put them back in her mouth afterward. In a few cases, the patients had resorted to their somatic cavities only when they were deprived of their bags or pocketbooks.

In my opinion, this hoarding habit is extremely frequent among regressed patients, but the extent of its incidence cannot be easily evaluated because nurses and attendants try to prevent it. In fact, if the patients were permitted to hoard as many things as they were inclined to, the large quantity of garbage and trash that they would

collect would interfere with the hygienic management of the hospital wards. The repression of this tendency is a real problem of administrative psychiatry.

Although I have observed and studied this habit in patients of both sexes, I was able to do statistical investigations only in female services. I collected a series of sixty-four patients presenting this habit, although for the reasons mentioned above the actual number of patients having the hoarding tendency probably was many times as large. Forty-eight (75 percent) of the patients were diagnosed as cases of schizophrenia. The other sixteen were diagnosed as follows: involuntal psychosis, paranoid type (1); paranoid condition (2); manic-depressive psychosis (4); alcoholic psychosis, paranoid type (1); cerebral arteriosclerosis (3); psychosis due to epilepsy (4); general paresis (1). Such variety of psychiatric entities denies the specificity of this habit. It could be that, at least in some of these sixteen cases, the initial diagnosis, made many years previously, had not been the correct one. In fact, at the time of this investigation their condition, at a clinical level, was in no way different from that of an advanced schizophrenic regression. I am inclined to think, however, that the hoarding habit is not pathognomonic of advanced

schizophrenia, but that it may be found in all the conditions that bring about a state of regression. As a matter of fact, several years after I had reported the original investigation of this habit in schizophrenia, I observed similar, although much less pronounced, hoarding tendencies in several very old nonpsychiatric patients who were institutionalized in a home for the aged. The fact remains, however, that schizophrenia is the most common condition that brings about a regression to the level of the hoarding habit.

Within the schizophrenic group, twenty-nine patients (60.42 percent) were of the paranoid type, nine (18.75 percent) were hebephrenic, seven (14.58 percent) were of the simple type, and one (2.08 percent) was of the mixed types. The group of paranoid patients was by far the largest and becomes even more outstanding if we add to it the other four patients diagnosed as paranoid but not schizophrenic (involutional psychosis, paranoid type; alcoholic psychosis, paranoid type; and paranoid condition).

In addition to the statistical and diagnostic importance of the hoarding habit, there remains the problem of its psychological meaning. Attempts to obtain information directly from the patients

were unsuccessful. The majority did not answer inquiries; they reacted only by smiling in an apparently incongruous manner. Several gave evasive replies. Only a few attempted to give a logical explanation. The patient who had filled the mattress with toilet paper said that she had done it so as to be ready in case she developed diarrhea. Another patient replied, "I use what God has given me." It appears to me, however, that such practices give a certain amount of pleasure to the patients. As a matter of fact, when they are deprived of their collections, they are obviously displeased and sometimes resist and resent these hygienic steps. They are not as resentful as one would expect, however, considering the constancy and apparent zeal that they often show in this collecting tendency. It is hard to estimate whether relatively more pleasure is derived from the act of collecting or from keeping the collection; probably pleasure is derived from both of these actions.

Textbooks of psychiatry do not mention this habit, which is common in advanced schizophrenia. However, occasional instances have been reported in the literature. For example, Staercke (1920) described a paranoid patient who had the habit of collecting corks, and Abraham (1927) reported the case of a psychotic patient who used to

collect stones.

In the orthodox psychoanalytic literature, the habit of collecting is interpreted as an expression of the anal character. Abraham (1912) and Jones (1938) have described the same hoarding habit in neurotics presenting anal traits. In these cases, however, the habit occurs in a much less accentuated and bizarre form than I have observed in the preterminal stage of schizophrenia. Abraham (1927) describes persons who “collect bits of paper, old envelopes, worn-out pens, and similar things, and cannot get rid of these possessions for long periods of time.”

I shall not refrain from calling this habit anal, if the use of such a word is for the sake of common understanding. However, in my opinion, this habit has nothing to do with the anus or with sexual pleasure. I am inclined to think instead that it is a primitive or archaic habit that is found at a certain level of mental integration. The child's ability to retain feces, in spite of the urge to defecate, may require a level of mental integration that corresponds to the level of the hoarding habit.

Primitive levels of cognition, starting with the paleologic, lead to transformation or mutability of inner objects as well as of external objects. As I have described in this book (Chapter 16) and in *The Intrapsychic Self* (Arieti, 1967, Chap. 7), the patient who thinks in accordance with primary process cognition tries to go beyond the particular, but his attempts lead him not to Platonic universal but to transmutability. If things change according to the wishes of the patient, he acquires a feeling of grandiosity and even omnipotence. If the patient believes that things change contrary to his wishes, anxiety increases again, in spite of the regression.

Like the primitive man, the patient tries to counterbalance the transmutability of the inner reality by plunging into external reality; that is, by collecting and possessing. The volume and plurality of external objects will be the best antidote to the uncertainty of the inner objects, because what is familiar by volume and plurality will be less likely to transmute. Its existence is less likely to be doubted.

In human phylogenesis, hoarding became prominent when human beings ceased to be interested only in the present, that is, in activities connected with immediate needs, such as finding food and

eating it immediately. When *Homo* became *sapiens*, he started to think and worry about his future needs and collected food in order to prevent famine. Anthropologists have often reported that primitive people used to hoard food in holes made in the earth. Man abandons the most primitive state of savagery when he becomes a food gatherer. In the schizophrenic, however, the habit seems inappropriate, like a shallow or sham reproduction of the utilitarian activity of the habit of the primitive. The schizophrenic seems to hoard in order to possess; the objects he collects have no intrinsic value; they are valuable only inasmuch as they are possessed by the patient. The patient seems almost to have a desire to incorporate them, to make them part of his own person, and puts them in his mouth, nostrils, vagina, anus, and so on.

The hoarding habit of the regressed schizophrenic can be interpreted in accordance with Fairbairn's theories of object relations. To my knowledge this connection has not been made in the psychoanalytic literature. The regressed patient has lost so many object relations that he is now in the position of making the last effort to maintain some of these relations, no matter how concrete, inadequate, and inappropriate they are. The useless objects that the

patient collects are very useful to him: they represent the last vestiges of his object relations; they replace the important relations he once had; they maintain some ties with the external world. By counterbalancing transmutability they permit the maintenance of some enduring inner objects. By collecting and controlling real objects, the patient sees some correspondence between external and internal objects, correspondence that is very defective in interpersonal objects. Kanner (1944) has described similar preoccupation with inanimate objects in children suffering from infantile autism.

The possibility has to be discussed as to whether the hoarding habit is an artifact, a result of prolonged hospitalization. I have mentioned that I have observed this habit also in homes for the normal aged, although to a much milder degree. Any incarceration and hospitalization may impoverish the human being of human contacts, of the things of the world in general, and may bring about symptoms of regression. However, I am convinced that the schizophrenic process has an important role to play in the institution of the hoarding habit. I have sometimes seen this habit in nonhospitalized patients kept home and also in some regressed schizophrenics, most of them belonging to the simple type, who had never been hospitalized or officially

diagnosed as schizophrenics. The famous case of the Collier brothers may be interpreted in this way. Some patients whom I have seen in consultation, and who had not previously been recognized as suffering from schizophrenia, had filled their rooms with old newspapers and other discarded material.

Goffman (1961) stresses that the habit of collecting exists in all prisoners. According to him, in an environment that deprives the individual of almost everything, collecting enables one to retain a minimum of privacy. It becomes a secondary modality of adjustment in the “underlife of the institution.”

Petrella (1968) has followed my original works (Arieti, 1945a, 1945b, 1955) and has added new dimensions to the understanding of the hoarding habit. He has studied the relation between the patients and the nurses and attendants who want to deprive the patients of their “valuable property.” The relational cycle between patient and nurse may lead to frustration and further regression. Although Petrella too attributes to the psychosis itself the largest responsibility for this regressive habit, he stresses the following environmental factors, which push the patient toward this and other regressed forms of

behavior: (1) real frustrations; (2) impossibility of finding and retaining private space; (3) the rule, more or less explicitly formulated, against keeping personal objects; (4) the rigid distribution of roles to staff, personnel, and patients.

Whatever interpretation one gives to this hoarding habit (libido at anal stage, primitive level of integration, institutional, cultural, or interpersonal influence, or a mixture of all these interpretations), the fact remains that this tendency is a manifestation of advanced schizophrenic regression, although not a pathognomonic one.

III The Self-Decorating Habit

Another habit that recurs especially during this stage of regression is the selfdecorating habit. As a rule it is observed in patients who are slightly less regressed than those presenting the hoarding habit, patients who are at what may be considered the beginning of the preterminal stage. Though in my experience this habit has been observed to be less common by far than the hoarding habit, it is generally better known because it meets the eye more easily. For reasons that I was unable to determine, but that make one

think of complementary social factors, I observed this habit more frequently in black patients. The habit consists of the primitive use of small objects or stains for decoration of one's body. Pieces of paper and rags are cut into several bands, and bracelets, rings, necklaces, and belts are made with them. Many, predominantly female, patients paint their faces in a conspicuous, ridiculous manner. Many patients of both sexes adorn themselves by placing buttons, stamps, small boxes, corks, or coins on their chests.

The same objects that are hoarded by other, more regressed patients are sought by these patients and are valued only for decorative purposes. It is therefore possible, though by no means proved, that the self-decorating habit is also connected with the hoarding habit.

A normal person cannot see any decorative value in this practice, which appears not only inartistic but often disfiguring and ridiculous. Such is obviously not the impression of the patient. Although he seems apathetic to his environment, he is interested in decorating his body. When he is asked why he decorates himself in such a manner, he often denies any decorative purposes. A female patient said that she used

paper bracelets “to cover her own arms.” Another one replied that she used necklaces “to tie her neck.” These practices, although not to be confused with other artistic activities of schizophrenics (see Chapter 20), retain some aesthetic value for the patients and represent primitive artistic tendencies. Anthropology teaches, in fact, that similar habits of self-decoration are probably expressions of primitive artistic tendencies. Bracelets, necklaces, and other small objects were commonly used by both sexes during the Paleolithic period. The practice of painting the body was also common among the cave dwellers (MacCurdy, 1926).

But what are the meaning and purpose of this practice? Desire to increase appeal, self-satisfaction in producing the artistic objects, or aesthetic admiration of oneself? In schizophrenics this habit seemingly does not have any practical or social purposes, but possibly it offers a certain kind of satisfaction through the making of the ornamental objects or through self-admiration. The fact that the patient denies the purpose of improving his appearance is not a proof that such aim does not exist.

By analogy, one might be tempted to interpret art as originating

not for utilitarian purposes but exclusively for the pleasure of the artist. Some interesting observations reported by Boas (1927) would seem to corroborate this point of view. This well-known anthropologist noted that the rawhide boxes of the Sauk and Fox Indians were made of a piece of hide that was carefully and skillfully ornamented according to a definite plan. When the boxes were made, the hide was folded and the pattern, which had required so much work, was completely lost. This author gives other examples to illustrate that when materials originally made with patterns were used for practical purposes, the patterns were disregarded. He reaches the conclusion that the previous work seems to be done only for the satisfaction of the maker.

Although my observations would lead to similar interpretation, I think it would be hazardous to reach such a conclusion from my findings on schizophrenics. The fact that a habit has not obvious environmental value in schizophrenics does not prove at all that its equivalents at a phylogenetic or ontogenetic level had no social value. The schizophrenic process engenders a resurgence of primitive habits, which often appears to us a shallow or an exclusively formal reproduction of what happened in ontogenesis and phylogenesis.

These habits seem worthless to us because they do not have the same utilitarian purpose that they had originally. It is an error on the part of the observer to look for the same purpose. However, these habits must indeed have a purpose. Even the schizophrenic, in spite of his withdrawal, has a need for activity. No matter how regressed he is, he needs some feeling of power, which is more or less gratified by actions and performances. He tends to act, therefore, and in the easiest possible way, in a manner that does not bring about anxiety. He tends to act in accordance with the mechanisms that correspond to the level or levels to which he has regressed. Moreover, the characteristics and restrictions of hospital life add to the peculiarity of these habits.

I am sure that other primitive habits of the preterminal period have escaped my attention. It is to be hoped that in the near future people in daily contact with regressed patients will publish their observations.

As far as the hoarding and the self-decorating habits are concerned, they will be examined again, and their interpretation will be continued, after the description of the terminal stage. It is important to add here, however, that like the asocial habits of the

second, or advanced, stage, the primitive habits of the third, or preterminal, stage have not been markedly influenced by drug therapy. After an interval of twenty-two years (from 1946 to 1968) I visited the wards of Pilgrim State Hospital, where I had made my original observations and studies, and could reconfirm the very frequent occurrence of these habits.

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