The Murder and Terror in Schizophrenia

Alberto Foglia, M.D.

The case of a paranoid schizophrenic patient with severe clinical manifestations is presented. Orgonomic treatment resulted in her improved contact with and increasingly intense expression of deep rage and terror. A progressive amelioration of her symptoms accompanied these developments, which are clarified by the perspective provided by Reich:

> When the schizophrenic breaks down he doesn't break down anew. He had a crack there right from the beginning....In infancy something must have gone wrong in the process of the separation of the self from the world....Now can you imagine that such a thing could happen if a child of two or three weeks, just in the process of integration, is beaten very severely? If that [very strong push of energy outward] meets nothing outside, just nothing. There's no contact....Can't armor yet....It could develop rage, screaming rage....If there is such a lack of the melding together of the different functions...then something happens to the eyes. The eyes don't go with it. The organism refuses, so to speak, to take the eyes into the total function, as if terror were connected with it. And there is terror in the eyes....The base of the brain doesn't go with it....There is a crack....[T]he schizophrenic split or crack is centered in the head, especially two regions. One is the eyes connected with the base of the brain and the other is the mouth....Murder comes in his eyes, murder. He may have quite clear eyes and then suddenly murder pours into them, or terror. (1)

Case Presentation

M is a forty-eight year old single mother and teacher. She was committed to inpatient psychiatric treatment because of a persistent state

of *folie a deux*[1] with her thirteen year old daughter.

As a child, M was frail and frequently ill with the flu or bronchitis. Although she was a nervous, rebellious girl, demanding and spiteful, her grades in school were good. When she was fifteen, her seventeen year old brother manifested symptoms of severe schizophrenia characterized by bizarre behavior and threats to kill their parents. It was at this point that M began to develop dizziness and anxiety. At the age of seventeen she fell in love with a young man employed in her parents' business. Her father opposed this relationship and fired the boy. Subsequently, M began to have fainting episodes unrelated to any medical condition, but was unable to see any connection of these to what she was feeling emotionally.

At age twenty, she graduated as a primary school teacher. When she was twenty-three, she married a young lawyer whom she described as kind, protective and understanding. They were bound together more by political ideology and social interests than by mutual attraction.

Because of her chronic anxiety, dizziness and fainting episodes, she began psychoanalysis at age twenty-five. She felt her therapist was as kind and protective as her husband. At the age of thirty, M was the victim of an episode of violence in a pub. As a result, her anxiety increased and her fainting episodes became more frequent. She began experiencing panic attacks and developed agoraphobia. From this point on, she couldn't leave her home alone. She dropped out of psychoanalysis and went to a psychiatrist who prescribed anxiolytic medication, which she abused. The quality of her marital life deteriorated and her husband fell in love with another woman. He divorced M when she was thirty-two. She began another relationship, became pregnant and, at the age of thirty-four, gave birth to her daughter, F.

Problems began immediately with the child. She refused to breastfeed and was often ill with abdominal cramps. As infancy turned into childhood, mother and daughter increasingly began to cling to each other, talked together in an infantile voice, refused contact with

***The term *folie a deux* was introduced in 1877 by Lasequeand Fairet to describe the association between two psychotic individuals where the dominant psychotic person induces a delusional state in the passive one. Usually the passive one recovers within several months after separation (2).**

relatives and expressed increasing rage at the father. M left him and the isolation of the two intensified. Taking only liquid food, they soon both became emaciated. F exhibited severe temper tantrums any time she had to separate from her mother. At the age of seven, F's behavior worsened. She refused to go to school, threatened to kill the maid and dramatically threatened suicide with a knife. These behaviors forced M to bring her daughter to the local psychiatric clinic. Records indicated that, at the time, F was a thin and sickly child. Her academic knowledge was limited, she was unable to socialize and she talked in an infantile manner. Working intensively, her psychiatrist succeeded in getting F to attend the day hospital, where her behavior slowly improved. She began to talk with other children, took car rides with her teachers, and was able to tolerate separations from her mother.

But this was not the case for M, who showed more and more anxiety and panic. She was consumed with fears that F might have an accident or become ill if she wasn't there. Three years later, when F, for the first time in her life, went on a week's vacation (with the members of the psychiatric facility), M became terrified and harassed the psychiatrists and teachers with incessant calls and visits. This behavior brought about an involuntary hospitalization.

First Impression and Biophysical Status

M presented as a frail, thin woman, 5 feet 3 inches tall and weighing eighty-four pounds. Her face was drawn and her bright eyes protruded from their sockets with an expression of both hostility and terror. Her mouth was large and she talked incessantly in a voice that was sharp and penetrating. She argued, complained, and was unbearably demanding all the time. Her neck appeared stiff and her chest showed minimal excursion on respiration. Her epigastric area appeared tense and her pelvis was trembling and stiffly held. Her legs also trembled and she appeared extremely weak and unstable on her feet.

M argued against the involuntary hospitalization perceiving it as a plot and was agitated and anxious in her behavior. She denied suicidal ideation and acknowledged her disorder only in its somatic manifestations: dizziness and weakness in her legs. She explained her fear of walking alone and her panic attacks as consequences of her somatic disturbances. Her diagnosis was paranoid schizophrenia.

Course of Treatment

M was admitted to the closed (locked) division of our facility where many medications were employed to help alleviate her overwhelming anxiety. After one month, treated with lithium and a tricyclic antidepressant, her anxiety decreased and her behavior was less frantic. She was admitted to the open division and contact with her daughter was resumed. With F, she was observed to be seductive, eager to please and intrusive. She tried to control her daughter with various well- rationalized explanations for their current circumstances. With the staff, M continued to be anxious and agitated. She was relentless in demanding their presence and care while also attacking them with arguments and provocations.

After one year of inpatient treatment, including the pharmacotherapy above, M was still unable to leave the hospital alone. She began therapy on the couch twice a week. She had great difficulty rolling her eyes when requested. Every time she tried to do so, she became anxious, stopped circling her eyes and began to talk, often to excess, in order to avoid the anxiety elicited by the ocular movements.

Eighty sessions in the following year were devoted to encouraging her to keep quiet and roll her eyes—and to stand her anxiety. When she succeeded in this, a panic attack with opisthotonos[2] occurred, together with the fear of being abandoned by me. I encouraged her screaming out her fear which resulting in her feeling less anxious and with improvements in her behavior outside of therapy. This was followed by a worsening of her anxiety and panic attacks whenever she met with her daughter. Consequently, she refused to see her daughter unless I was present.

As ocular mobilization continued in therapy, memories from M's past began to emerge: she recalled the terror she felt dealing with her schizophrenic brother and the dizziness, fainting and panic she experienced years earlier when going to the supermarket with her father. She recalled feeling afraid that her father would leave her alone in the store if she didn't hurry. Many memories were recalled, most with

Opisthotonos is described as a sustained contraction of the back muscles producing an extreme arching of the back. Although seen in tetanus, it is also observed in other non-medical conditions. Reich, in *Character Analysis,* associated opisthotonos with catatonia as a basic (involuntary) bodily attitude expressing holding back. (3)

intense terror. Her spontaneous reaction was to jump off the couch and run out of the room. However, contact with these long repressed emotions allowed her to discharge them through crying and screaming. This provided her with a relief that lasted for one to two days.

In the ninetieth session, the patient shouted that she wanted her daughter back, wanted to be free from her disease and wanted to live her life in a healthy manner. At this point, however, her behavior worsened. Her complaining, harassment and provocation of the hospital staff was intense and impossible.[3] It was clear that deeper rage was surfacing. She admitted the presence of intrusive thoughts of killing her daughter accompanied by visions of her own father standing in front of her. In sessions, referring to her daughter, she began to shout, "Go away, let me be free! I don't want to kill you!" With this the visions and the intrusive thoughts disappeared. Whenever she was able to discharge rage on the couch, her behavior in the hospital improved. When her efforts in doing this were not successful she displaced her rage onto me or the staff, and became increasingly provocative and demanding. When confronted with this "acting out" behavior she began screaming at me, "You have to listen to me, you have to do whatever I ask you, you are a coward! I want to slap you in the face!"

In the one hundred eighteenth session she turned on me with fury find with murder in her eyes. I allowed her to strangle my forearm as if it were a neck. This was obviously pleasurable for her. The opisthotonos eventually evolved into a pelvic reflex, bringing to the surface intense violent feelings and a desire to smash everything around her. At one point, when her feelings again overcame her, she jumped from the couch and tried to hit me. I was able to treat her only because of her small size.

In the one hundred thirty-sixth session M cried out desperately for me and for her father. She then became furious and wanted to kill me. She could not tolerate her feelings of dependency and weakness— they made her feel vulnerable. She responded with rage, "I don't want to feel! I don't want to submit to your whims!"

Her general behavior was now improving. Her contacts with her relatives were becoming calmer and more enjoyable, and even with her

[3] Throughout M's treatment, her demanding and provocative behavior was addressed characteranalytically. The defensive function of this behavior and her lack of regard for the staff was consistently identified and pointed out to her.

daughter, M was more mature and less panic-stricken. Her feelings toward me were distinctly ambivalent. On the one hand, she felt I understood and cared for her and she was aware of the need for her therapy and the relief it gave her. On the other hand, however, she felt dependent on me and also dissatisfied with me. I could never give her enough.

By the one hundred forty-first session the impulse to attack me and her fears of abandonment became even stronger. Her hatred became homicidal and she felt abandoned. During sessions she now wanted to kill herself by jumping out of the window. With great difficulty I prevented this by keeping her on the couch. Only then could she stand her feelings and discharge them with murderous screaming and hatred directed at me.

My treatment approach remained consistent: I insisted that she roll her eyes and not talk. Now, when she rolled her eyes, a wave of movement commenced upward from her pelvis, only to be stopped in the oral and cervical segments. With this her eyes became fixed in terror and she began to shout out, "I want to kill you! I have to kill you! If I don't kill you I will always be sick. I want, I desire, I have to kill!" At one point she took a pointed decorative object from a table near the couch and wanted to stab me with it. I disarmed her, physically put her back on the couch and ordered her to keep quiet. She immediately broke into deep, desperate crying and with outstretched arms reached out with longing for her father and mother. She asked me to hug her, which I did.

This was a pivotal session after which her behavior in the hospital changed dramatically. She was no longer harassing and provocative but instead acted like a little girl, asking for reassurance and physical contact.

She was now able to see and understand that her aggressive demands and excessive talking were defensive—they disguised her rage as well as her fear. She began to act more responsibly, trying hard not to talk excessively. Stopping her partial, substitute discharge of rage (overtalkativeness and rationalizing intellectualization) resulted in her coming into better contact with herself. This and the fuller discharge of emotion that followed allowed her to meet with her daughter with less fear and to relate rationally.

Subsequent sessions served to consolidate her gains. Each time,

after several minutes of rolling her eyes, M was able to scream her murderous rage at me and later toward her daughter. Desolate crying would finally break in as M, feeling abandoned and alone, experienced longing for her mother and asked to be hugged by me.

In the one hundred forty-eighth session terror appeared together with anger. She felt abandoned and began to shout out her fear of being alone and her desire to be taken in the arms of her father and mother. She shouted she wasn't able to walk on her own, she depended on her parents. She recalled her little white bed and saw herself laying in it, only a few months old, desperate and alone, longing and screaming aggressively for her parents. She screamed in terror, "There is nothing, nothing, nothing! I am alone, alone." She asked me to hug her, which I did and which reassured her.

By the one hundred fiftieth session, M rented an apartment in anticipation of leaving the hospital. However, this was not yet possible. She was still unable to walk around alone and to meet her daughter without my being present.

From the one hundred seventieth tp the one hundred seventy-third session, the intensity of her emotional expression increased in a dramatic, quantum-like fashion. Her fear and rage were now distinct and separate, alternating during the same session. Throughout therapy the routine was always the same: She stopped talking and rolled her eyes. This was now done with greater intensity. The rage became a concrete impulse to murder which was expressed mostly by hitting and kicking with visions of her mother and daughter bleeding. The fear became screaming terror at having killed them and losing them forever. The increased intensity in therapy produced greater relief that now lasted for one week or longer. The behavior of the patient became progressively softer and she was more sociable. Even though she was still not yet able to go out alone or to meet with her daughter alone, she felt more confident and optimistic. Her treatment continues. She now knows that therapy is a way for her to relieve her explosive feelings and she looks forward to feeling better and gaining her independence.

Discussion

This case confirms the validity of medical orgone therapy in the treatment of schizophrenia, as originally described by Reich. The patient's

symptoms of anxiety, panic, dizziness and agoraphobia, present on admission, still bother her but are significantly diminished. They are the superficial aspect of a deeper disturbance in the energetic functioning of the patient: the primary ocular block with splitting between perception and excitation, described by Reich in the introductory quotation. This quotation is from a tape-recorded lecture, given by Reich in 1949 or 1950, just recently made available to the public in 1996. It provides us with a deeper understanding of the profound inherent relationship between the ocular and the oral segments in the schizophrenic.

The consistent and systematic uncovering of the negative transference of this patient together with the reduction of her rationalizing intellectualization and her overtalking allowed the establishment of a deeper contact and a better degree of trust. Faced with her incapacity to control me though her talking, she experienced first anxiety, then rage, which were able to be discharged, in turn, through the upper segments. This was possible and therapeutic only because ocular contact was maintained (which prevented her from "going off" in her eyes), and because her focus on me prevented delusional projection.

Other emotions surfaced with her rage, especially deeper fear and terror, as well as sadness and longing. The release of armor allowed energy to flow downward producing a pelvic reflex which was defended against by a contraction in the upper segments, reactivating deeper layers of armoring which were then released in treatment. This brought about a noticeable improvement and softening of the patient's behavior and symptoms. Further improvement will depend on the consistent release of rage and terror from the upper segments, while keeping the eyes in contact, thereby avoiding splitting and with it, delusional thinking.

REFERENCES

1. Reich, W. "Process of Integration in the Newborn and the Schizophrenic," *Orgonomic Functionalism,* 6:51-71, 1996.
2. Arieti, S. *American Handbook of Psychiatry.* Italian transl. 1982, p. 729.