



ORIGINAL ARTICLE

Catatonic Cocoon

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Abstract

This poetic mediation explores catatonia from a personal perspective and sensory geography, including its interrelationships with trauma survival, threat responses, and the use of catatonia to create a safe harbor within the self. This creation of a world within the self allows a shutting down and shutting out of broader realities to find healing space when no safety can be found, and a recuperation in self-sanctuary. The catatonic cocoon is untethered from time and the expectations of movement, sound, speech, and performance. By re-positioning catatonic experiences as having emotional and physical functions outside of biomedical conceptualisations of neuropsychiatric disorder, these experiences can be explored as both incidents of vulnerability and as powerful survival strategies, at times subconscious and at times agentic. Approaching this concept with curiosity provides the opportunity to consider how to connect with a person experiencing catatonia, and insights into its timeline, meanings and purpose.

Keywords

Psychosis; Catatonia; Lived Experience; Trauma; Post Traumatic Stress; Dissociation; Iatrogenic Harm; Suicide; Eating Disorders; Mad Studies; Extreme States

History

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Content note: this poetic work includes themes of trauma, eating dis/order, suicidality, and iatrogenic harm.

Catatonic Cocoon

My breath is torn,
ragged,
claws its way to my lungs as though
there will never be room to suck enough air down. My eyes grow to
discs and collapse to pinpricks, disappearing into blackholes,
a spell whispered over a grave.
I am dying alone with a vast audience, unmoving in these last moments,
witness to pain, bestowing no rites, flower wreaths unleft at the empty foot of my
tomb.

If they could peer through a window to my heart¹, they would see a flock of hummingbirds.

Robbed of my words, they see me as a scarecrow inside a tinman's shell:

broken mind, cardiac arrest, cataleptic cocoon.

¹ Poetry as scholarly methodology can be used to provide multi-sensory research, providing a “window into the heart of human experience” (McCulliss, 2013, p. 83) and an integrated understanding of sensory phenomena and sensory geographies (Paiva, 2020), such as catatonia. Scholarly poetry can also provide a means to challenge power dynamics, dominant discourse, and act as a socio-political and critical form of resistance (Parsons & Pinkerton, 2022).

Strangled scream muted by heavy drugs and heavier distain, and gloomy stupor blanketing the atmosphere, a moody shroud of doubt.²

The taste of mad fear³ lingers here and hereafter – its song begins its *echo* into my bones *la la la*.

I do not fall in the physical world,
I fall inward, unravelling in parallel.
Vanishing into the farthest corner of myself,
imagining severing cords that connect mind
to body
to world.

Meteors orbit, collide, neutron stars collapse into the weight of themselves.

I am screaming internal ‘pull the plugs, kill the nerves. Turn it off.’

Until

all
goes
dark.⁴

² Catatonia (from Greek kata = down + tonos = tension) is defined in psychiatric and medical literature as a syndrome that involves a constellation of phenomena or symptoms characterized by specific motor, affective and cognitive-behavioural disturbances (Dhossche et al., 2016; Hirjak et al., 2022; Remberk et al., 2020; Ungvari et al., 2018), stemming from an underlying disorder that may be psychiatric or medical in nature (Oldham, 2018; Solmi et al., 2018). Motor phenomena include: stupor, waxy flexibility, akinesia, posturing, catalepsy, and stereotypies (Dhossche et al., 2016; Hirjak et al., 2022; Remberk et al., 2020); affective signs include: anxiety, fear, impulsivity, aggressiveness, flat affect, uncontrolled/involuntary affect and expression), and cognitive-behavioral disturbances include: negativism, mutism, mannerism, grimacing, agitation, rituals, verbigeration, echolalia, echopraxia, ambitendency, grasp reflex, resistance to passive movement (counterpull) and automatic obedience (Dhossche et al., 2016; Hirjak et al., 2022; Remberk et al., 2020). In psychiatric classification systems, catatonia is recognised as a distinct diagnostic entity (i.e., ICD-11; Oldham, 2022), as a well as a residual category (i.e., “catatonia not otherwise specified” (DSM-5; Tandon et al., 2013). Catatonia is also recognised as being connected to other psychiatric diagnoses or medical conditions (DSM-5), or as within the ‘sensorimotor domain’ of sensorimotor system and psychomotor disturbances in psychiatric disorders (RDoc; Hirjak, Wolf & Northoff, 2019; Sanislow et al., 2019).

³ Catatonia has been described as a ‘madness of fear’ (Shorter & Fink, 2018), and fear has been suggested to be central to catatonia and stupor (Fink & Shorter, 2017; Shorter & Fink, 2018). Descriptions of catatonia in the context of trauma history, trauma treatment and processing have indicated that catatonia may be an extreme fear-based freeze/immobilisation response (Van Duppen & Sienaert, 2020; Zingela et al., 2022). In humans, catatonia as an extreme fear response with associated parasympathetic nervous system shut-down, is also argued as being consistent with animal responses of tonic immobility to threat and sudden terror, a “death-feint” defense mechanism in the face of overwhelming threat and imbalanced power (Gallup & Maser, 1977; Moskowitz, 2004; Zingela et al., 2022). Catatonia may involve a reaction to threats and terror that feels unsurvivable, and in response, a complete shutting-down or closing up of interaction between self, others and the world (of intercorporeality and subjectivity) occurs (Hirjak et al., 2019; Van Duppen, 2017; Van Duppen & Sienaert, 2020; Zingela et al., 2022). Catatonia is, therefore, a severe disturbance to embodiment and temporality that may occur in part as a threat response (Zingela et al., 2022), and can be regarded as “a disruption of intercorporeality... it could well be a disruption between the patient’s body and her mind as well. Indeed, the body could be almost completely separated from the mind” (Van Duppen & Sienaert, 2020, p.11). Catatonia has also been suggested to represent a dislocation from intersubjectivity (Parnas, 2013). Few first-person accounts of catatonia are present in psychiatric literature, however descriptions of fear, isolation, feelings of threat, and fear of dying are present in these accounts (Northoff et al., 1996; Northoff et al., 1998; Shorter & Fink, 2018; Zingela et al., 2022). An individual may also feel that their death has already occurred (Zingela et al., 2022).

⁴ Modern psychiatry typically positions catatonia as a specific neurobiological syndrome, often occurring as a secondary feature or symptom associated with diagnoses of schizophrenia spectrum disorders, bipolar disorder, major depressive disorder, autism, medical conditions (i.e., infections, endocrine abnormalities, electrolyte disturbances), neurological conditions (i.e., epilepsy, strokes, multiple sclerosis), drug withdrawal, or multiple

Body is still, slips into rigor mortis.
 Deep in the cavern of this skeleton, all is numb, all is hushed.
 I can see the world above from a distance that folds back on itself.
 I pool my blood into a corner, shield my heart in the warm shelter of my arms,
 lace the dark and quiet around its damp thudding
 until it slows.
 I sing my heart a lullaby in the quiet dark, and rock.
 There is no echo here.
 I exist within myself and time and space immortal
 immaterial,
 eternal.

Time ekes on; body's shadow must have cast an inky blot into the thin carpet.
 Time begins to disappear. Nothing matters here, the pounding thud of the heart above
 a distant sound of thunder raining down to pitter patter.
 Thoughts are not my own – they reverberate out,
 broadcasts from a distant satellite - SOS to nowhere, messages to centre control.
 I can see my tiny soul, a green seed, curled and soft
 way way down in the dark bellied chamber of this giant body-self
 so huge in the unsafe world.
 It cradles me in its husk.⁵

co-occurring diagnoses (Solmi et al., 2018; Weder et al., 2008). Although experiences of agency have been described in unusual sensory and perceptual experiences [USPE]/psychosis (Jones et al., 2016; Swyer & Powers III, 2020), no known descriptions of catatonia describe experiences of partial agency, such as dissociating, choosing to disrupt the mind-body connection, and actively maintaining immersion within the catatonic state.

⁵ Trauma is associated with greater psychosis/USPE severity, frequency, and psychiatric co-morbidity (Loewy et al., 2019; Misiak et al., 2017; O'Connor et al., 2019; Schalinski et al., 2019; Stanton et al., 2019), however it may be that dissociation is one key mechanism through which this occurs, in turn influencing psychotic/USPE experiences such as voice-hearing severity (voice-hearing may reflect non-integrated trauma memories or dissociated or disowned components of the self as a result of traumatic experience or sociocultural inequalities) (Bloomfield et al., 2021; Bortolon et al., 2017; Haarmans, Vass & Bentall, 2016; Longden et al., 2012; Longden et al., 2020; Piesse et al., 2023; Varchmin et al., 2021). Furthermore, certain types of dissociative coping responses may be key mediators in differentiating experiences such as voice-hearing. In a non-clinical sample, only the detachment-type and absorption-type dissociation, but not compartmentalisation-type dissociation were significantly associated with psychotic-like experiences (Humpston et al., 2016). It may be that complex dissociative mechanisms occur within the course of catatonic experiences and differentiate catatonic subtypes. Despite not currently formally recognised a psychiatric diagnostic category, 'dissociative psychosis' is regarded by many working in trauma-related dissociation as significant and as having real-world and clinical utility (Ball and Picot, 2021; Graham and Thavastoby, 1995; Van der Hart et al., 2006; Van Der Hart et al., 2018). Dissociative psychosis has been proposed to be an episode or condition that is "trauma related and embedded in a structural dissociation of the personality" (Van Der Hart et al., 2018, p.307). Dissociative experiences should also be present within the psychosis/USPE, in addition to goal-directed actions that are outside of the individual's conscious control (Van der Hart et al., 2006). The individual experiences a severe compromise in the hierarchy of the degrees of their reality (Van der Hart et al., 2006). Hearing threatening voices for example, the experience of dissociated parts of the personality re-experiencing trauma (traumatic resurgence), or related intrusive thoughts and fantasy, are rendered as *more real* in the present above the individual's present orientation in identity/age, and orientation in time/age and place (Van der Hart et al., 2006). The shift in hierarchy of degrees of reality, therefore, can lead to an individual becoming preoccupied and immersed in dissociative psychotic experiences with a disconnection from other degrees of reality (time, place, degrees of identity). This shift in hierarchy may also occur in catatonic experiences; it's plausible that catatonia or subtypes of it involve structural dissociative processes.

A nurse stops in front of the body and speaks. She receives no answer.
 She tells it she's worried – for two hours, it has remained unmoved.
 She will talk to a psychiatrist and come back soon.
 She doesn't know the body is only remains, soul detached, parachuted to safety,
 a dandelion spear in a draught,
 gone before she can utter a wish or mutter observation.
 Body is severed from soul and perserverates,
 fingers flex and make tiny circles – finger thumb, finger thumb, finger thumb.

All the King's Horses return; nurse, psychiatrist, security.
 They speak in megaphone to the body, and wait.
 Lift body's arms, and stare as they hang in the air – dead tree limbs beginning decay.
 "Oh".
 "Is she written down for ECT?"
 "No".
 They see madness tensed over my bones⁶,
 an animal with eyes to the headlights of a truck on bitumen.

They move body, lifting it high for a solemn funeral march,
 through lonely corridors void of mourners,
 slide it roughly onto the mattress slab in a cold room.
 Waxy arms stay stiff and upright where last held and forced into place,
 a fingerprint marking the air in accusation.
 Neck bent to the side, crooked and grotesque. The eyes stare at up them, and blink.
 Nurse and psychiatrist glance and pass guilt, take an arm and push them down.
 Throats are cleared in the thick air. The head and neck awkwardly repositioned.
 "That's better. You'll be more comfortable like that."
 They hasten to cover the whole thing up with a thin sheet.

Verbal post-mortem follows – an interrogation, demanding cause of death.
 Why won't it speak? Why did it retreat into a shell?
 Body remains graven.
 Blurred visages millimetres away, yell into its face.
 It *must* give an answer,
 it must rise and show life,
 it must eat and move and take its pills!
 They wait in three heartbeats of silence.
 No miracle resurrection,
 no cause to bestow epithets
 or gratefulness.

Clumps of dirty threats are thrown down instead, a handful at a time:
Confinement, ECT⁷, more medications, injections, restraints.

⁶ Historically, catatonic features have been reported and described in the literature outside of the concept of a unique nosological syndrome (Hirjak et al., 2022). Catatonia as a distinct nosological psychomotor entity was first developed by German psychiatrist Karl Ludwig Kahlbaum (1828-1899). Kahlbaum's "Catatonia or Tension Insanity" describes the concept of catatonia as a distinct psychomotor syndrome, with a cyclic, alternating, and progressive course (Kahlbaum, 1874).

⁷ ECT; Electroconvulsive therapy is commonly used to treat catatonia (Leroy et al., 2018). No standardized protocols for treatment of catatonia with ECT exist, though an algorithm has been proposed to assess appropriateness for ECT treatment in cases of catatonia (Lloyd et al., 2020). Despite its common use, a recent systematic review and meta-analysis concluded that published studies fail to demonstrate efficacy and effectiveness (Leroy et al., 2018).

No visitors, belongings taken, locked away forever, left alone to a slow demise.

It's bad luck to rob a grave. They'll be hexed, crossed by unluckiness, accidents, sorrow.
The body is dead. It doesn't respond to threats.⁸

Nurse begins to search the estate, holding up artefacts one by one.
"Is this what you want? I'll confiscate everything you love!"
Her hands stumble across a hidden scalpel and broken glass. "Oh."
"Oh dear". Says psychiatrist. "We'll need to document that."
Nurse swallows, pats the body's hand. "It's okay sweetheart. Maybe when you're feeling a little less... distressed, you can talk to us."

Night passes. Body is visited by gravediggers, torches glowing over its bones, searching for signs of life.

Resting place desecrated, bones rolled in effort to shake them awake.

Morning comes. Psychiatrist tells body if it doesn't come back to life, it will be taken away and shocked into activity.

Deep in the soul chamber, the tiny seed is curled and soft. It rocks itself.

...

...

...

...

Her fingers entwine with mine and close like sundew teeth.
I smile somewhere on the inside, muscles taut beneath their frost.
She talks, tries gently to move me, and looks into my face.
Embers glow where our souls collide, and the darkness begins to melt.⁹

⁸ Psychosis/USPE has been linked to trauma and dissociation, in a dose-response manner (such that increased exposure to trauma, multiple forms of trauma and more severe trauma and abuse are correlated with greater risk for and severity of psychosis (Bailey et al., 2018; Bentall et al., 2012; Schalinski et al., 2019; Varese et al., 2012). Number of types of trauma are also associated with 'symptom' types of psychosis/USPE (Bentall et al., 2012; Scott et al., 2007; Shevlin et al., 2007) and frequency (Shevlin et al., 2007). This relationship has largely been conceptualised as a 'maltreated ecophenotype' or sub-population of psychotic disorder where trauma increases biological risk for psychosis/USPE development rather than a manifestation of trauma per se (Popovic et al., 2019; van Nierop et al., 2016). In dominant biomedical psychiatric discourse, catatonia is regarded as a neuropsychiatric syndrome characterised by motor and psychomotor abnormalities (Hirjak et al., 2023; Ungvari et al., 2018). Studies have suggested that motor functioning abnormalities including catatonic motor abnormalities precede the onset of psychosis/USPE in children and adolescents who are at high risk of psychosis/USPE development and are evident in first-episode patients and drug-naïve patients (Compton et al., 2015; Hirjak et al., 2018, Hirjak et al., 2019; Peralta et al., 2022; Walther et al., 2020; Walther & Strik, 2012). Catatonic features have been theorised to be a marker for a subcortical variant of schizophrenia, otherwise known as an endophenotype (Jablensky, 2006; Ungvari et al., 2018). Catatonia has also been suggested to represent a nonspecific stress and fear state-related reaction that occurs at varying points throughout the course of acute psychotic illness due to the stress and fear created by the psychosis itself (Moskowitz, 2004; Fink and Shorter, 2017). An alternate theory is that catatonia occurs as a *generalised* stress and fear response (Moskowitz, 2004; Van Duppen & Sienaert, 2020), and may represent the complex interrelationship between stress, tonic immobility, dissociative and trauma interactions and psychosis/USPE.

⁹ Psychosis/USPE may be an experience of dissociative response to a sense of threat, ontological insecurity and fear of nihilation (Ball and Picot, 2021). If a 'non-psychotic/dissociated' person can be together with the person experiencing the 'dissociachotic' state, and can accept and resist attempting to change the person's reality, this can result in mutual growth and evaporation of the 'psychosis' (Ball and Picot, 2021). This occurs by creating safety, connection, and change to the liminal space, thereby negating the need for the person experiencing the

One drop of light,
 it pools and catches in my chest.
 A fire starts, kindles regrowth. Tiny seed begins to unfurl, tender shoots reaching for light and warmth and help.
 She tells me she will call an ambulance and drops my hand.
 I want to cry out – tell her to stay, I am in here. *I am in here.*
 But she goes.
 The fire burns and burns and burns, terror overwhelms.
 Scorched bones and grey ash shock in the sudden loneliness,
 I shuffle out onto the rooftop ledge, inch by inch, ice and flames dripping from my veins.
 There is a yell, lights, a flood of sound and touch. She grasps my waist and takes my hand, her wrist crossing mine, a blessing knot around a tree.¹⁰
 Paramedics and firemen swarm around us, she shakes her head, the knot tightens.
 We stand frozen as I grow toward her light.
 Roots entangled with hers, I am growing before a small audience, their eyes wide in wonder.
 “You’re going to be okay; I can feel how strong you are. I understand. Let’s just stay here for a moment and breathe together, in and out,
 in and out,
 in and out.
 Let’s just breathe, in and out, in and out, in and out, in and out.
 Let’s just exist together in this moment. We’re okay. You’re going to be okay.
 Before whatever happens next, remember - you’re going to survive it.”
 Shoulders seized, knot untied. On the long ride to the hospital, I hold her warmth in my heart like the glow of fireflies.

Back in the deep of its soul chamber, the tiny seed is curled and soft underneath the slow wink of firefly light and dying stars. It rocks itself.

dissociative ‘psychotic’ reality to defend the threat of nihilation and exist in an altered state (Ball and Picot, 2021).

¹⁰ Blessing knots, rags, ribbons or ropes (e.g., shimenawa (注連縄) are tied to trees in multiple places and in almost all cultures across the world, including in Ireland, Israel, Japan, the United Kingdom, and Thailand (Dafni, 2007; Fereshteh, 2019; Lipset & Silverman, 2023). They can be used to mark a tree as sacred, mark a tree for preservation, left as part of a healing ritual or blessing, to commemorate death, to transfer illness to the tree, to ask for permission to pick fruit, or to mark a site for healing (Dafni, 2002, 2007; Fereshteh, 2019; Lipset & Silverman, 2023). Left on sacred trees, they may also act as channels that connect the leaver/worshipper with the object or worshipped (Dafni, 2007).

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