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The Theory of Schizophrenic Negativism

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The theories of negativism that have been advanced heretofore are incorrect or unsatisfying. Negativism is a complicated symptom, having in some cases, many coöperating causes.

The predisposing causes of negativistic phenomena are:

1. *Ambitendency,* which sets free with every tendency a counter tendency.

2. *Ambivalency,* which gives to the same idea two contrary feeling tones and invests the same thought simultaneously with both a positive and a negative character.

3. *The schizophrenic splitting of the psyche,* which hinders the proper balancing of the opposing and coöperating psychisms, with the result that the most inappropriate impulse can be transferred into action just as well as the right impulse and that in addition to the right thought, or instead of it, its negative can be thought.

4. *The lack of clearness and imperfect logic of the schizophrenic thoughts* in general which makes a theoretical and practical adaptation to reality difficult or impossible.

On the ground of this disposition there may occur direct negativistic phenomena in such a manner that positive and negative psychisms replace one another indiscriminately, only the incorrect reactions standing out as pathological negativism.

[1] E. Bleuler, Zur Theorie des schizophrenen Negativismus, Psychiatrisch-Neurologische Wochenschrift, Vol. 12, 1910/11, Nr. 18, 19, 20, 21.

As a rule, however, the negativistic reaction does not appear merely as accidental, but as actually preferred to the correct reaction.

In ordinary *external negativism* which consists in the negation of external influences (Ex. Command) and of what one would normally expect the patient to do (Ex. Defaecation in the closet instead of the bed), the following causes are at work:

(*a*) The autistic withdrawing of the patient into his phantasies, which makes every influence acting from without comparatively an intolerable interruption. This appears to be the most important factor. In severe cases it alone is sufficient to produce negativism.

(*b*) The existence of a hurt (negative complex, unfulfilled wish) which must be protected from contacts.

(*c*) The misunderstanding of the surroundings and their purpose.

(*d*) Direct hostile relations to the surroundings.

(*e*) The pathological irritability of the schizophrenic.

(*f*) The pressure of thought and other difficulties of action and of thought, through which every reaction becomes painful.

(*g*) The sexuality with its ambivalent feeling tones is also often one of the roots of negativistic reaction.

Inner negativism (contrary tendency opposed to the will, and intellectually opposed to the right thoughts) is accounted for, in large part, by ambitendency and ambivalency, which in view of the inner splitting of the thought renders intelligible a slight preference for the negativistic reaction. Very pronounced phenomena of inner negativism probably have other coöperating causes, which we, at the present time, do not know.

A conclusive explanation of all negativistic phenomena would be premature. It seems to me, however, that the falsity or unsatisfactory nature of the theories hitherto erected might be demonstrated. It is always possible to discover roots of negativism in other directions and to understand genetically, at least, a part of the symptoms grouped together under this name. A better attitude is gained in this way for further progress.

At this point we must first make clear that negativism is not a unitary symptom. The chief and predominating group is characterized throughout by the fact that the patient, by outside influences, by command, will not do precisely, what under normal conditions would be expected (passive negativism); or, that he does exactly the opposite (active negativism). A command is not executed, most often after a clearly repulsing mimik. If one tries to bring about a desired movement passively (raise the arm, sit up to slip on clothes) they show opposition, seek to get away, resist often with abuse and blows. The patients will not stand up, will not go to bed, if it is desired of them; they will not sit at the place assigned to them, will not eat the food offered them, they take the soup with the spoon for the preserves, and the preserves with the soup spoon; they satisfy natural needs out of time and place. From simple opposition to the active execution of the opposite of what is expected there are all gradations.

Not even this circumscribed group gives an impression of unity. Most patients indeed combine their negativistic actions with an affect of irritability, vexation, anger. This emotional reaction is, however, not a necessary component. If the negativistic action is simply the contradiction of a custom, if it is not interfered with from without, the previous mood is usually maintained; the patient lies down, with apparent indifference, in

the bed of his neighbor; in some cases one sees even a certain mirth over a successful trick. Repression first awakes irritability in these cases.

Often the patients maintain their indifference in spite of opposition; it may be that very strongly negativistic patients are permanently euphoric and do not come out of this mood, while they resist with bites, scratches, and blows the invitation to shake hands; their defense is sport for them like a jolly play. More commonly the whole behavior looks like that of a flirt; women patients watch the physician, as if they were waiting for him to offer them his hand, or bring forward a request, so that he must busy himself with them, and then, in their negation, behave like a maiden who stimulates her lover, but tries to appear as if she were keeping him off. At other times the negativism has a plainly erotic character, sometimes in the agreeable sense of a love-play, sometimes in an unpleasant sense, as the aversion to an attack, and often in both directions at once.

Besides this outer negativism there is also an inner, which most frequently affects the will. The patient can not do exactly what he wishes to do. In the stage between thought and expression an inhibition, a contrary impulse, or a cross impulse can make the action impossible. So we see patients who rush to take a proffered bit of food, stop half way between plate and mouth, and finally refuse the morsel; with every other act the same results follow. If they start to shake hands: at any point the action may not only stop but the hand, as the result of a contrary impulse, may be placed behind the back.

Often the patients frustrate the results of an act by other movements. They stretch the arm out in order to proffer the hand but flex the forearm and hand so that the hand can not be

taken; or on the request to show the tongue they put it out but turn away the head. In some of these cases of simultaneous obedience and disobedience one usually sees the external negativism. But undoubtedly the phenomenon occurs as a pure will-negativism. I have noticed it when the patient spontaneously occupies himself in something without outside invitation, for example in eating; mostly I have observed it in piano playing. They reach out for the stroke and strike down with the forearm, but towards the end of the movement dorsally flex the wrist to the maximum, so that the fingers do not reach the keys, or the patient turns the eyes to one side, in order to observe something, and at the same time turns the head to the other side (or the reverse).

Cross impulses assert themselves, in that, instead of a willed or begun act another is carried out; the patient starts to take a spoon (to eat), the begun movement is changed however and he takes the fork, puts it in the bread basket or does something else equally peculiar. These cases present all transitions to the apraxoid appearances of schizophrenia, which on their side again have different roots.

Not infrequently negativism shows itself towards a task which has already been completed. The patients destroy what they have made. Sometimes as if in anger, sometimes as if from a free resolution, sometimes compulsively, resenting it in the doing.

It is very difficult to get a clear idea of the subjective process of this will-negativism. Very few patients offer any explanation. It is certain, nevertheless, that some are aware of the disturbance, but not others, and that all possibilities actually occur with regard to the psychological point where this sets in. The patients sud-

denly no longer will what they have just intended, or they suddenly will the opposite; their motive may come into consciousness or not; the goal idea becomes altered. This can, however, also remain the same, while the centrifugal impulse becomes disturbed somewhere in the tract z-m, which one can not conceive sufficiently long and complicated (compare for example Liepmann's researches on apraxia). Here the patients of course become more or less aware of the disturbance; but some bear it with the thoughtless indifference of schizophrenia, others feel it as a peculiarity which has befallen them, and conceive it, sometimes as something abnormal, sometimes as an influence from outside. Not at all seldom the negativistic impulse is transferred into hallucinations, which then, like other sensory falsifications, are interpreted subjectively in the most varied manner. A catatonic, for example, who will say something, hears his neighbor command, "Hold your mouth." Another, who will eat, the voices forbid, or say, it would not be right; if he does not eat, it is again not right; he asks despairingly, what in heaven's name he may do. To a third the voices always say the opposite of what he must do. A fourth receives hallucinatory commands for example, to write a letter; as he is about to obey, the voices forbid him. He calls these hallucinations very significantly "plus and minus voices." There is probably little difference in principle when the negativism is transferred into delusions. If one requests such a patient to eat, stand up, walk, he does not do it. Afterwards he complains that he gets nothing to eat, that the physician compels him to lie in bed, forbids him to walk. The commonest negativistic delusion is in general that the patient believes it is forbidden him (under threats of danger or temporary or everlasting punishment) to do what he wishes. It is often shown from the change