Patterns of Behavior in Claustrophobia*

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This paper is a continuation of my studies on claustrophobia, all of which represent an attempt to delineate the intricacies of the clinical picture and to relate them to underlying claustrophobic fantasies. I have previously described the interrelation between claustrophobia and depression (1964), as well as between claustrophobia and indecision (1973). By this time, after intensive study, I have come to the conclusion that when we speak of claustrophobia we are usually referring not to an isolated symptom, but a whole symptom complex. It would seem, therefore, appropriate to designate these patients as suffering from the claustrophobic syndrome.

This constellation manifests itself in marked ambivalence; in affective shifts between anxiety, depression and uncertainty; in the weakening of executive ego functioning; in impaired object relations characterized by distancing phenomenon (fears of closeness and of separation); in behavioral approach-avoidance patterns to enclosure of all types, both concrete and abstract; in negative and primitive self and object representations with narcissistic sensitivities in the extreme; in the presence frequently of psychosomatic problems, particularly in the respiratory system; in sexual inhibitions of all kinds and in phenomenon such as splitting, fragmentation, depersonalization, hypochondriasis, imposturing.

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acting out, and others as responses to overwhelming anxiety and fears of loss of control. These rather generalized areas of pathology reveal themselves is a whole host of specific symptoms and behavior patterns, many of which I have previously outlined, invading almost every area of their lives.

Milder forms of claustrophobic reactions have reportedly been experienced by patients who simply displace onto the claustral situation a feeling of entrapment in a present work or love conflict. I do not, however, think of this as common, for most of the patients I have treated or supervised have a more pervasive pathology.

The forms of relief these patients pursue, other than the direct avoidance of the claustrum, seem to concentrate in four major areas, in movement, action and acting out of all kinds, which give them the feeling of freedom; in being creative, which many of them are, finding in their artistic productions, be it painting, writing, poetry, dancing, etc., a sense of mastery of confinement and temporary relief, in the establishment of a system of control over their objects associated with a demanding dependency; and in an expertise in the provision of exis of all kinds from commitments to work and love situations, as well as from space and time boundaries. These patients suffer more than most neurotic patients because they are neither in or out of anything—they preserve contact with reality and are constantly in touch with their problems, they search continuously for an identity which eludes them and they always feel incomplete.

In this paper I intend to elaborate further on the claustrophobic syndrome by describing claustrophobic behavior, emphasizing two particular areas: namely, counter-phobic behavioral patterns and the phenomenon of distancing in relation to their objects and their object representations, both of which behavioral patterns are so typical of this clinical syndrome. This will follow a general discussion of claustrophobic symptoms and relationships.
CLAUSTROPHOBIC SYMPTOMATOLOGY

For the beginning we must consider two important characteristics of the enclosure, which make it an ideal object for projection, displacement and avoidance of anxiety stemming from psychic conflict of all kinds. First, the claustrum is readily available to the individual for this projection, since enclosures of all kinds exist everywhere in our modern world. Conveyances are in constant use and not at all subject to continuous personal control. Vehicles can be stuck in traffic, tunnels and elevator shafts, and they are affected by winter road conditions, fog, smog and breakdowns of all kinds. Overpopulation, energy shortages and pollution plague us, as does the summer heat. Decisions, responsibilities, commitments of all kinds, as well as educational pressures, create all kinds of traps. The vicissitudes of the political, social and economic world convey a feeling of helplessness and entrapment in their overwhelming complexity and relative insolubility. The wide dissemination of news, the constant exposure to death and violence, and the necessity of auto and air travel enhances this helpless feeling. Access to exits amidst the crowds, pollution and the skyscrapers are sometimes difficult to arrive at.

Secondly, the claustrum as phobic object is most capable of providing an excellent symbolic vehicle for significant approach avoidance behavior. As a source for claustrophilic stimulation, the enclosure as a symbolic equivalent for the womb, or the interior of the female body, or the body in general, provides an attraction for oedipal and preoedipal (especially oral) wishes, both sexual and aggressive. The movement frequently associated with enclosures adds to its erotic quality. The body with its potential for representation as foetus or phalus, moving in all directions in relationship to the space, permits all kinds of projections and fantasies. On the other hand, neurotic fears mobilized by such wishes and fantasies
can take the form of claustrophobic avoidances. It seems to me that we will see increases in the number of patients presenting claustrophobic symptomatology in the future for the reasons above, as well as the basic attraction of phobic formations as sources for the externalization of internal conflicts, which then can be motorically avoided. For example, one might subconsciously choose claustrophobic anxiety over depressive affect, because the former represents the fear of getting stuck, which can then be avoided, while in the latter it is difficult to find relief from the state of being trapped within oneself subject to the unleashing of dangerous superego forces against the self, such as exists in depression.

I have never seen a patient in whom claustrophobic symptomatology existed as the only phobic symptom. The widest variety of phobic objects share the stage with the claustrophobic ones. I have seen bird phobias, insect, mice, spiders, food aversions, bridge, height, sun, water, reptiles and I could go on. What seems to be most interesting about the emergence of animal and insect phobias in the clinical material in the analytic process is its late appearance. These phobias seem to emerge as more significant or even make their first appearance in the material as oedipal conflicts assume the analytic spotlight. As to the bridge and height phobias, they are so frequently present that I feel they are both merely extensions of agoraphobic-claustrophobic symptomatology. What I am about to say concerning agoraphobia and claustrophobia is that I think of them as two outward manifestations of the same neurotic state, and pathological formation. I also hope to confirm that where clinical claustrophobia or clinical agoraphobia predominates, the other is also part of the clinical picture, either overtly and just as intense, or covertly hidden in avoidance patterns.

Abraham (1913) in an earlier paper on agoraphobia, described a five year old child with this condition. He stated, "Neurotics who are afraid of walking in the street without being accompanied by a particular person, suffer also from a second phobia, the fear of being indoors. The
unconscious of such patients does not permit them to be away from
those on whom their libido is fixated. Later he reports the child’s state-
ment: “I do not want to be a walking child, I want to be a mother’s
child.” These fears Abraham later traced to oedipal anxieties. In this
child we see the spread of agoraphobic separation anxiety symptoms
into claustrophobic separation anxiety symptoms. The need for the com-
ppanion exists in both instances, and the agoraphobic fear of loss of
support becomes the claustrophobic fear of being pushed or flushed
out by what is usually the father’s intrusion or the process of birth.

Lewin (1935), in writing the first full length paper on Claustrophobia,
stuck very closely to a narrow definition of claustrophobia introduced
by Raggi of Bologna (1871). This restricted the meaning to a dread of
being enclosed. This definition Lewin states, “would exclude such fears
as that of entering a closed space, which might if one wishes, be consid-
ered claustrophobic.” However, in a later paper, Lewin (1952) enlarged
his concept speaking of two types of claustrophobia.” He was referring
to the fear of entering a closed space, and the fear of being disturbed
by intrusion or dislodgement from the security of an enclosed space.
Similarly, Weiss (1964), who published the first monograph on agora-
phobia, speaks of Westphal, who introduced the term agoraphobia in
1872 to mean the inability to cross a wide open space. “Later,” he states,
“the term agoraphobia was extended to designate all anxiety reactions
to abandoning a fixed point of support, e.g., the anxiety reaction to
venturing some distance from home.” In a later paper Weiss (1966) makes
the following statement, “In all cases of agoraphobia we find several
characteristic features, though I will mention only a few of them here.
We always find in agoraphobic patients what I call the ‘claustrophobic
syndrome.’ These patients cannot tolerate the sensation of being enclo-
sed somewhere. They must feel free to leave a place whenever they
wish. They are intolerant of any kind of restriction. (Could this be a
fear of regression to the womb?)—while every agoraphobic patient
has the claustrophobic syndrome, not all claustrophobic patients are agoraphobic." I must disagree with the latter part of this statement, since I have found in claustrophobic patients a consistent agoraphobia, an agoraphobia, however, not always evident in open space anxiety, but sometimes in the anxiety about the openness of unfilled time, or the openness at the top of the ladder of success, or the openness in being free from a stultifying relationship, etc. The fear of being trapped is always associated with the fear of being free and on both sides there is a constant flow of approach-avoidance behavior and a preoccupation with exits and entrances.

In my own discussion(1966) of Wiss’ paper in the Forum I related the history of an agoraphobic patient who would talk of "lying in the couch" and who saw the street and open places as huge devouring mouths waiting for her, and the ocean threatened as a “great big empty” calling to suck her in. Lewin(1952), in speaking of Friedman’s classical paper on bridge phobias, in which Friedman considered mainly oedipal factors in causation, states, “In certain respects the fear of crossing the bridge is related to the street phobias.” Lewin found oral fantasies as well with a fear of being devoured, sucked in, swallowed by the waers beneath. If the agora in street phobias and the siren call of the space in height phobias can all represent the call of the mother to incorporate the child, then the street phobia can represent the fear of fusion with mother, not only separation from her. To quote my own conclusions in the discussions of Weiss’ paper mentioned above, “My findings indicate that this wish and fear of symbiosis a constant factor in these phobias. If the patient never abandoned his symbiotic ties, how can the separation anxiety be viewed only as a consequence of the ego disturbance? Perhaps it’s the other way around, the potential ego disturbance had its causation due, in part, to the early mother-child relationship, which did not foster separation and individuation.” Rhead(1969) in his work confirmed these conclusions precisely.

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Despite the fact that both agoraphobia and claustrophobia fulfill the criterion of the symbiotic neurosis, as defined by Pollock (1964), it remains for a full evaluation of the individual patient for one to know whether we are dealing mainly with an oedipal or pre-oedipal problem and its viscissitudes. Pollack makes the point that "one sees pathogenic symbiotic ties in neurosis, psychosis, perversions, psychosomatic disorders, as well as other psycho-pathological states. There may be a hierarchy of symbiotic relationships that may involve conscious and manifest physical cations at one end unconscious psychological demands at the other end." In this paper Pollack gives an in depth report on a patient with pruritis ani and a history of childhood asthma, whose attachment to her mother was such as to make her unable to separate without attacks of severe upper respiratory infection or severe asthma. In a previous paper I reported on a severely claustrophobic patient who would develop asthmatic attacks on the couch in relation to conflictual material and it was my belief that in many cases of asthma, as well as in some other respiratory conditions, that we were dealing with the somatic equivalents of claustrophobic anxiety. In a panel on Phobias and their viscissitudes, Ferber (1959) reports Schur's comments as follows: "Phobics develop psychosomatic illnesses. These will erupt when the phobic cannot avoid the phobic situation and are the equivalent of anxiety attacks." To this he added that there are transition states between phobias, hypochondriacal states, and paranoid anxieties. At this point I would like to defer any further discussion of comparison between the two phobias until I have developed my thoughts on claustrophobic behavior patterns.

COUNTER-PHOBIC ATTITUDES IN CLAUSTROPHOBIA

The term counter-phobic attitude has been in common usage since Fenichel used the term in a paper first published in 1939. He states, "It often happens that a person shows a preference for the very situations
of which he is apparently afraid. And even more frequently he will later on develop a preference for the situation which he formerly feared. That situation represents an unconscious instinctual impulse. Originally there was a active striving for it. Only the veto of the external world or the superego produced the anxiety. The original striving may reappear.” The essential thrust of Fenichel’s paper is the concept of mastery and the control of anxiety through a searching out of potentially anxiety provoking situations. Fenichel takes the position “that the people, for whom sport, or at least ceratin kinds of sport (as for example mountaineering) are not a mere occasional relaxation but a matter of significance in their lives, are true counter-phobic subjects; and finally one may assert generally that all abilities in which people take special pride fall within the same category.”

Let us now look at claustrophobic fears in the light of these concepts. One is immediately mindful of the escape artists and daredevils of all kinds. The escape artist may approach a situation in which he is handcuffed, placed in a box, which is then locked and placed under water, and in a few seconds emerges, miraculously escaping death. In claustrophobic terms they seek the claustrum and avoid its destructive potential. Some of these people even prophesy their escape from death by elaborately prepared signals and times for their intended return from the grave. They will not be abandoned or be eaten by worms. They will not fall victim to their oral fears and fantasies. What is most interesting is the psychology of the audience in these situations. They are inordinately attracted to the trick motorcyclist, or the trapeze artist. They want to look, are afraid to look, and they are further teased by the performer, who knows their fascination and pretends to lose his balance or his nerve. Eventually it works out and all are relieved, having approached a counter-phobic experience. I say approached because of the presence of anxiety, but there is no question that they actively seek to participate in some way in the dangerous situation. After a sufficient number of
exposures, the audience, like the performers themselves, experience through identification the thrill and the reassurance of the counter-phobic experience.

I would like at this point to recall a paper by Abraham, published in 1925, entitled “The History of an Imposter in the Light of Psychoanalytic Knowledge.” This paper is a rather detailed report on a man whom Abraham saw on only two occasions in 1918 at the age of 22 and in 1923 at the age of 27. Both of these visits were for psychiatric evaluation. The first examination was ordered by a court martial proceeding, which followed innumerable arrests for forgery, stealing, imposturing, etc., both civil and military. Prior to his examination Abraham had ordered that the prisoner be detained in custody under reliable and intelligent guard. Ten minutes after his admission, when he went to check on the prison security, he says, “To my amazement I found no guard outside his room, only three empty chairs. On entering the room an astonishing sight met my eyes. N. was sitting at a table drawing; one of the guards was posing for him, the other two were looking on.”

This was the pattern of this man’s behavior. He was constantly in and out of difficult situations, he was so personable that he disarmed suspicion, and eventually disappointed those who trusted and helped him. He was the supreme con artist who eventually ran off with the loot. However, he never showed much aptitude for eluding the law. Once he was incarcerated, then his skill at escape would manifest itself, “it was as if the doors of the prison seemed, as it were, to spring open of their own accord before him.” On this first examination Abraham learned that this behavior began when this man was 5 years of age, starting with pretending to be a general’s son in order to obtain credit for purchases of the kind being made by wealthier children. This behavior eventually led to a reformatory, where he became a favorite.

This, of course, is not an unusual story. We have all come across such histories in newspapers, books or magazines, and we have also
heard of escapes from prison. There was one case recently where, after
the prisoner escaped, the guards explained that they did not lock the
door of the cell because the prisoner was claustrophobic. However, Abra-
ham’s case had a most unusual and fascinating twist. On Abraham’s
second examination five years later, he found to his surprise that after
June, 1919, N. had committed no more offenses. He had been discharged
in March from the service, had committed a number of thefts and frauds,
was being prosecuted, when suddenly all this behavior ceased. He had
become a respected, trusted business associate to people who were not
unfamiliar with his past. His record for honesty and reliability was excel-
 lent, and he was trusted with large sums of money, and he was happily
married.

In this examination the history of an unloved child was revealed.
He was the youngest of many siblings, he had heard his mother say
again and again how unwelcome he, the late comer, was and what
a financial strain he was imposing. He felt rejected by both his parents
and all his siblings. In June, 1919, he met a much older woman who
was a widow with several adolescent children. She immediately favored
him and eventually they married, and she turned over her husband’s
business to him which would have been the inheritance of her sons.
When Abraham pointed out that his wife represented his mother, he
agreed and responded that he was unable to call her anything but “Mum-
my”. He admitted, however, that the persistence of his present behavior
depended on his wife’s continued presence, for he felt deep down the
old impulsive restlessness still there.

Both Deutsch and Greenacre quote this case in their papers on the
imposter. Deutsch(1955) believes that the imposter tries to force his
ego-ideal on the world and thus to maintain it himself. Greenacre(1958),
in studying the relationship between the imposter and the artist, finds
that what seems to be an attempt to assume the place of king-father
is “really no effort to do this in order to gain the love of the mother;…”It
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can readily be seen that the libidinal development of the imposter is always infantile and rarely reaches a true genital and heterosexual level." In keeping with what I have said about escape artists of all kinds, I would like to suggest that in Abraham’s case we are dealing with another form of escape artistry, with the imposturing, as well as his other behavior, providing a vehicle through which approach-avoidance behavior towards the mother is achieved. This in no way contradicts what Deutsch and Greenacre have postulated—it is an additional way of looking at such dynamic relationships and helps to explain the constant repetitions. Counter-phobic mechanisms, seeking for mastery of frightening relationships with parental figures, particularly maternal, drive the patient into endless performances of capture and escape. It is a typical claustrophobic manipulation to get in so as to be able to get out, to enter or to be thrust into the claus trum and to prove that exits always exist, even when it would seem impossible. Such manoeuvres along the way may satisfy oedipal or precocital aggressive or libidinal needs.

The interesting and different aspect of this case was the finding on N.’s part of the good mother, with whom he could assume a more stable and a sexual relationship. As with every counterphobic mechanism, however, there is the danger of the return of anxiety. As Fenichel(1954) states, “Behind such attempts at repression or denial of anxiety, the over-tense nature of the attitude, general fatigue, symptomatic acts or dreams may betray the fact that anxiety is still operative…” We may see, for example, combinations of counter-phobic and phobic attitudes: to a certain degree and in favorable circumstances phobia…” In the midst of the triumph which the counter-phobic can enjoy because of his saving in emotional expenditure, unpleasure may break out if something occurs which seems to confirm the old anxiety.” In Abraham’s case the patient was not without the discomforting doubt that he could maintain his adjustment if something were to happen to his relationship to his wife-mother.

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The symptomatic relief that Abraham's patient achieved on his own, through finding a good mother, tells us something about what frequently happens in the course of analytic or psycho-therapeutic treatment of the claustrophobic or agoraphobic patient. The longing for a relation with the good and non-threatening mother is so great that the transference gratification and relief from anxiety supersedes the desire for insight and the unraveling of the defensive structure. The patient may follow only intellectually the course of the enlightenment for the purpose of approval, continued care, protection, or super-ego reinforcement, but he or she may be unwilling to face the antidotal aspects of the relationship in keeping repressed the fantasies and the negative and the anxieties, guilts and depressions so connected. I believe that some of the positive results obtained in all treatment modalities, including group or individual behavioral techniques, may follow this pattern. Of course, another factor in these results have to do with what I will cover in the next section on phobic interactions with character attitudes.

CLAUSTROPHOBIA AND CHARACTER ATTITUDES

I believe it is equally important for us to study the character of our phobic patients as it is to elucidate their symptoms. At times it is difficult to say where the symptom leaves off and the characterologic reaction begins, and this is especially so in the distancing behavior of claustrophobics. The maintenance of the optimum distance from their objects, neither too close nor too far away, is an ever present and consistent preoccupation of claustrophobics and, I might add, of agoraphobics as well. In the middle area there are all kinds of prevalent behavioral patterns that help to maintain the balance and at either end, too close or too far, there is phobic anxiety.

This balance seems to me to be an interesting combination of symptoms and behavior, so well expressed by W. Reich (1949) in his studies
on Character Analysis. He said, “The development of a phobia indicates that the ego was too weak to master certain libidinal strivings. The development of a character trait or typical attitude at the expense of a phobia means a strengthening of the ego in the form of chronic armoring against the id and the outer world. The phobia means a splitting of the personality, the formation of a character trait, a unification, a synthetic reaction of the ego to a conflict in the personality, which finally becomes intolerable. In spite of this contrast between phobia and ensuing character formation, the basic tendency of the phobia is continued in the character trait.” Later he states, “But it should be remembered that the spreading and dilution of the symptoms damage the ability for action no less than the circumscribed symptom: now, the patient seeks treatment no longer because of a painful symptom, but because of general work disturbance, lack of joy in life, etc. Thus, there is a continuing struggle between the ego and its symptom, between symptom formation and symptom incorporation. Every symptom formation, however, goes hand in hand with a character change. These later incorporations of the symptoms into the ego only reflect that process in childhood in which an infantile phobia was transformed into character structure.”

The maintenance of the optimum distance from objects, seen in the real sense as well as in terms of their internal representations, poses a particularly difficult problem because of the need to balance avoidance of anxiety concerning closeness or separation with the longing for fusion, control, protection, growth and gratification of all levels of libidinal and aggressive discharge. The patterns of approaches and avoidance become persistent and pervasive and result in complicated reactions and manipulations, which produce only limited satisfactions and much frustration and despair. All the claustrophobic patients I have treated report relatively major problems in relating to their spouses sexually. They seek libidinal satisfactions but avoid the ultimate closeness, warmth and satisfactions by a wide variety of inhibitions and disturbances. They are frequently
troubled by the presence of promiscuous, homosexual, pedophilic, feti-
shistic and/or other perverse impulses which result from all levels of anxie-
ties about the self and objects. They frequently dilute their sexual rela-
tionship at home with other temporary or even more permanent relation-
ships. The relationship of these phobic patients to their children in sexual
or aggressive terms is complex and would require extensive exposition.
Suffice to say, in keeping with the manipulation of optimum distance
from their spouses or peer sexual objects, the children serve as diluting
relationships and sources of substitute gratification for sexual, aggressive
and symbiotic needs. The parents of the couple also serve similar purpo-
ses and especially so since they are involved in neurotic interations
with their children in the origins of their problem.

The distancing phenomena which appear in adult life, in a clinical
sense, come to our attention mainly through difficulties encountered in
relationships to the spouses of these patients, as well as to their children,
as mentioned above. It is not infrequent to find the treatment precipitated
by complaints of the spouse in relationship to the marriage or the prob-
lems of the children or of one particular child who has for many reasons
become more intimately involved in their interaction. It is only later
that the phobic problems emerge as intricately connected with the rela-
tionship. Much has been said about the phobic parent producing the
phobic child. This is not only true for mothers but for fathers as well,
and for the reasons mentioned. In the interaction between the patient
and the spouse, the patient, through the use of withdrawal, silence, humili-
ation, anger, jealousy, resentment, as well as through pleading, promises,
presents, and tokens of affection, helplessness, real or imagined illnesses,
depression, or the use or abuse of drugs and frequently alcohol, manipu-
lates the relationship for control of the distance operations in order
to achieve, as far as possible, the optimum balance. Guilt and fear are
predominant emotions and passive-aggressive alternations are frequently
present.
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The behavioral analysis could continue but at this point I would like to introduce some case material. The first three cases represent a series in themselves. The first patient presented himself for treatment because of claustrophobic symptoms that had become incapacitating to some degree, as well as a sexual problem. The characterological aspect of his problems were in the background and became available in treatment. The second patient entered into treatment because of marital problems and only in treatment did claustrophobic symptoms emerge in the material. The third patient presented severe characterological disturbances which had as an important aspect of their etiology a pervasive defense against claustrophobic anxiety.

The first case is that of a man in his late thirties who developed his first attack of claustrophobia at the age of twenty while in an airplane. The claustrophobia grew in intensity to where he had to avoid tunnels and elevators, and he had to carry a flask of alcohol and tranquilizing pills with him at all times as a potential protector, as well as reliever of anxiety. He was successful in his career but he always arranged to have a superior or a protecting companion with him at any times he was confronted with major responsibilities or major decisions. He was very dependent on his wife for support, and he was sexually impotent with her. Despite these characteristics, he was also tyrannical, avoiding close contact by well timed arguments and avoidances, and he maintained tight reins on her every activity with his jealousy, financial and intellectual controls. In analysis he would fall asleep frequently on the couch and find multiple reasons to cancel hours but always calling and apologizing to assure reentry. This patient is rather typical of the claustrophobic patient, whose passive claustrophilic longings for fusion and incorporation result in need for the object and a need for control of the object in order to provide a safe milieu in which to express these feelings and fears. His overall behavior is dependent and passive and when he is away from home he carries with him, in flask and pill,
links and representations of his protective wife-mother. The two objects, as well as his car, become companions and extensions of home to relieve his claustraphobic and agoraphobic anxiety.

The second patient is a middle-aged man who entered treatment at the insistence of his wife. He was not aware of any phobic symptoms in the first interview. This patient grew up as a bully, relentless, sadistic, ambitious and unable to share authority with anyone. He had to keep himself continuously active and busy, otherwise he was uncomfortable and had to drink to alleviate his tensions. In situations where he was unable to move he constantly smoked. He was very successful and insisted on making all the decisions in his work, as a result his subordinates shared no responsibility.

After a few weeks in analysis, he reported the following dream: “I found myself in a complex of buildings—a resort or institution. I was trying to leave, but I could not find my shoes.” After reporting this dream, he recognized himself that it represented ambivalent feelings about analysis. He then began to talk about some repetitive dreams about confinement whenever he took a trip. For the first few nights he would dream that the room compartment or the plane was on fire and he was trapped and could not get out. He also mentioned that on occasion he walked in his sleep with a dream of entrapment and would wake to find himself clawing at the walls, trying to get out. He then reported a recent attack of near panic when he was near the top of the statue of Liberty. At home, like the first patient, he too was a tyrant, but not with the force of his intellect and logic as the first patient, but with a heavy handed aggression and with anger and humiliation, he exercised control over his mother-wife. Like the first patient his sexual functioning was inadequate and he was in a hurry to remove himself from too close quarters with her. As treatment progressed with the analysis of the defensive aspects of these behavioral patterns, he became overtly phobic. He was unable to make any decisions, no matter how small.
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He could make no public appearances without panic and he was considering withdrawing into his home. This patient remained in analysis until termination after six years. He was always punctual and, as can be imagine, never fell asleep on the couch. In this patients, therefore, the outward manifestations of an aggressive, hard driving, fear inspiring, successful and super-masculine kind of individual served as characterological defenses against his passive claustrophobic anxiety and his separation anxiety. He covered up his claustrophobia through a combination of counter-phobic and characterological attitudes.

The third case is that of a man in his late thirties who came for treatment because of marital problems. His wife was threatening to leave him if he did not go for treatment and although he questioned his feelings for her, the thought of her leaving him was intolerable. He described her as cold, frustrating, stubborn, willful, and sexually depriving, and he felt she was much to blame for his present unhappiness. He felt that he had provided well for her because of his being successful in business. The only legitimate complaint he felt she had was that he could not sit still. He was always on the go and no sooner did his involvement in one situation, business or otherwise, simmer down, he was off to the next. He had no patience for people and he was extremely abrupt in his dealings. Actually, people made him uncomfortable and he would drink to relax himself. He too always carried alcohol around in his car for emergent trap situations and when he was younger, the alcohol in the car was always accompanied by a package of contraceptives. Every commitment made to or by him had to be short term ones and he seems to continuously have gotten himself into potential trap situations in business and then the would very aggressively attack the problem and rescue himself. When his wife would particularly provoke him he would over drink and over tranquilize himself. He would get into a state of insomnia and then he would become an irresponsible, impulse ridden person who was menacing and threatening, and at times
so out of control that the line between dangerous acting out behavior and control became very thin, indeed.

The patient had had an extremely disturbed childhood. His father was a man who was an absolute tyrant in the household. If the children misbehaved at dinner, he would throw at them whatever was in his hand at the time—a glass, which would crash against the wall, or a knife, fork, or whatever. If he did not like the patient's behavior, he would tie him to a bedpost or a stove and beat and kick him. He was made to go out to work when he was seven years old, like his brothers were doing, to bring home money. Instead of doing this, the patient would visit the five and tens, steal things, sell them and bring home the money. From this petty stealing he went to larger things—bikes, then motorcycles, and in his teens, automobiles. His ring of friends would change the serial numbers and resell them. He was in jail a couple of times for this and was rescued by his family putting up money for his defense. He had a penchant for speed. He had to go fast. He not only lost his license many times but drove without it. A typical example of his reactions was when he described a chase by the police in which he went faster and faster through eight red lights, at times over 100 miles an hour, being shot at at the same time, until he was finally caught. The more he ran, the more he had to run to prove no one could beat him or catch him. At one time in school a gym teacher for whom he had a liking was angry with him and cuffed him on the head. He thought about this for some time and was so enraged that he decided to kill him. He planned this for a long time as to the place, the angle and the gun. However, he finally gave up this place, the angle and the gun. However, he finally gave up this plan as he moved into further delinquent acts. When he was 21 he had taken to minor forms of robbery and he and his two friends began to roll drunks. At this point he stated something happened which headed off his life of crime, which would have rapidly escalated, as it did with his two friends, who shortly thereaf-
ter killed a policeman and are now serving life terms.

What happened was that he had decided when in his teens that he was going to have a lot of money one way or another and along with the activity just described he had taken a factory job. He had worked hard and at 21 was offered a foreman's position with a good salary. He took this job, saved money, and at 23 had his own business. The money which now came into his hands gave him the power and freedom of movement that he needed. His father had been extremely stingy about money, demanding help from his children. The father also kept a thumb on the mother, who was not allowed to be away from the house or to go out on her own. On two occasions the father, who had a violent temper outside as well in the home, had gotten into a drunken brawl in a bar and came home, once to get a knife and once a gun to kill the other man. He remembers when he was 8 seeing his parents having intercourse and thinking, "my mother is a whore and some day I will call her that." His mother was afraid of the father and would cover up for the patient's misdemeanors, not only for him but to protect herself as well.

The patient's approach to girls was the same as in other areas. All represented conquest and he had many and could tolerate no defeats. He had to have immediate satisfaction and had little feeling for the person herself. He did some amateur fighting and would be afraid to get in the ring, but once he got started, he would lose his fear. There were two times in his life in a bar that he avoided a fight and he still thinks of these incidents from long ago as black marks in his life. He feels today that the worse feeling he could ever have was if someone were to grab him and try to hold him down. Then he knows he will lose control and kill him.

The patient reported that throughout his life he had three repetitive dreams. They were: he would dream he is in a fight and cannot swing his arm. It is as if paralyzed: that he would be in the street naked
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and would be hiding behind to conceal himself, since he felt shame; and thirdly, he would be going somewhere and he was taking very large steps. Each step would take him high in the air and down over large areas. The dreams reflect his exhibitionistic conflicts, his feelings of impotence and castration anxiety, as well as the defense in and libidinization of movement. This patient, besides his experiences of rejection and overprotection by his mother, was actually tied down in a number of traumatic events in his childhood. His impatience, his need for movement, his busyness, his use of money and alcohol as transitional and linking objects, his need to repeat situations of entrapment only to be able to free himself, and this included what might be considered extreme risks and gambles, his extreme dependence on his wife, with whom he had a sado-masochistic relationship, although a controlling one at that, and his penchant for speed and freedom, all are rather typical, although exaggerated, of the claustrophobic behavior patterns. In this exaggerated, of the claustrophobic behavior patterns. In this extreme case one sees the kind of fear of loss of impulse control and the need for external support for super-ego control, in bold relief. These are the problems with which the claustrophobics and agoraphobics have such difficulty in contending.

A fourth case is that of a young woman who demonstrated an interaction between acting out behavior, claustrophobia and an animal phobia. She was 20 years of age when she came for treatment because of markedly regressed behavior. She was unable to study, stay in school, she was frequently very depressed, needed all kinds of stimulating drugs, was preoccupied with tremendous shifts in weight, engaged in polymorphous sexual behavior and had failed to receive help in therapy in several attempts. At the outset of treatment she reported three different phobic reactions. She was terrified of dogs, so much that on one occasion when a dog appeared outside my office, she arrived sobbing hysterically and wondering if she could ever return. She was unable to be by herself,
she had to always have a companion and would not stay in an apartment or house alone. She was claustrophobic and would wake at night frequently with feelings of suffocation, when she would have to throw open a window and put her head outside, even in the coldest winter. She enjoyed mostly hikes in the open air and open country, but always with a friend.

After some years of treatment, with marked changes ensuing in her adjustment, and after graduating college, she met a boy whom she liked and for the first time wanted to get close. When he attempted to kiss her, she became stiff and removed and unable to feel anything but a kind of estrangement. After this experience, she reported the following two dreams: "I am among some other people. My boyfriend is at my side. A girl(lab assistant sort of) is performing a dissection on a dog according to instructions given to her by a male voice. Upon the instruction to cut off the dog's penis (which was a human penis), I began to menstruate. She was horrified, so was I. His blood was my blood. I said, 'How embarrassing,' although I did not feel embarrassed. I said it more to be polite because he is so proper. I accept natural body functions. He said, 'It's natural.' " The second dream was that she was in a car with her parents. Her mother gets out to knock on the door of a friend. The door opens and a big dog runs out (the kind she was most afraid of). Her mother is frightened. The patient calls the dog to come to her and lets the dog nuzzle her. She is shaming everyone, especially her mother, because she is unafraid. Needless to say, these two dreams led to an extensive analysis. The important aspects for this presentation is that she reported that her dog phobia had disappeared almost completely. She never talks about it or thinks about it any more. Her fear of being alone had also disappeared, she had lived in an apartment by herself for a year, and there was no more contact with drugs for a long time. She still engaged in binges of eating, following by remorseful dieting. What had emerged was her feminine self with a full blown
oedipal conflict and a feat of a close relationship and a commitment to a boy. The acting out counter-phobic behavior with boys, along with the dog phobia, which had acted in combination to contain her fear of the male, had disappeared and in their stead was the overt anxiety of the oedipal neurosis. Her relationship to her mother, contained in the claustrophobic-agoraphobic complex and in the eating problem, developed into oedipal phase conflicts with mother. She was pleased with her ability to integrate herself and her life.

This patient displays an important feature of the claustrophobic conflict in that it is difficult to know at the onset, despite the seemingly deep regression, whether one is dealing with the regressed appearance of an oedipal conflict or an early fixation of such proportions as to be among the borderline patients. Despite the dissociated episodes this patient never experienced the splitting or fragmentation of the self that carries with it the kind of narcissistic considerations that make the prognosis more questionable.

I could continue on with patient after patient and we could continue to see the patterns emerge. I want to mention just briefly one more patient who displays the operation of the obsessive compulsive character in a phobic patient serving the same purpose of distancing through isolation of affect and intellectualization. The character in a phobic is not consistently hysterical but can be compulsive or even primitive, narcissistic and borderline. This patient, a woman in her thirties, came into treatment because of frigidity. She was intelligent, intellectual and a veritable efficiency expert. She felt most comfortable on the move and engaged in her career. She was unable to be close to her children or even play with them because it made her feel trapped. She generated distance from her husband with frequent quarrels and dominating attitudes. Incidentally, there are many female patients, as well as males, who can accomplish the same purpose by being so compliant that they are removed from the situation themselves. This patient reported no phobic
reactions on starting treatment except for an inability to sit still and a feeling of suffocation whenever she wore a high or tight collar. Her collar was always kept wide open and away from her neck. It was only after a long period of analysis of early relationships to her mother and symbiotic ties that she began to speak of other phobic reactions to mice, insects and dirt of all kinds. It was then that oedipal fantasies began to emerge in the material and in the transference.

These patients are not only space and distance manipulators, but they manipulate time as well. They are afraid of time being filled with deadlines, commitments and decisions and at the same time they are afraid of the emptiness of time being phobic on either end. They are easily bored and depression is not far away, so they insist on being busy, and their drinking, smoking and compulsive activities help fill time and lessen anxiety. They may also titrate space, distance and time relationships in a multitude of other ways, which may include extramarital relationships or multiple relationships of all kinds. These patients find it difficult to concentrate, not only on their work or intellectual pursuits, but in every sense.

In the panel on phobias reported by Ferber (1959), quoted before, he mentions Greenson’s speculations, which later appeared in a paper on phobia, anxiety and depression. In these speculations Greenson categorized phobics as “avoiders, distance makers, projectors, who avoid object relations except for a special few.” Rubinfine, in the same panel on discussing Greenson comments, disagreed and took the position that “phobics are not distance makers who avoid objects, but rather they cling desperately to their primary internal object representations and their external representations, seeking the very object they seem to avoid.” It seems to me, as I have demonstrated, that phobics both cling and avoid, they wish for closeness and for distance at the same time. As far as the question of agoraphobia vs. claustrophobia, I feel we are dealing with the same phobia with one particular symptom being more
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emphasized than the other, both being present. These responses to space, time and distance belong together with the clinical picture of the claustrophobic syndrome.

SYMPTOM-BEHAVIORAL IMBALANCE

No study on symptom-behavioral balance would be complete without some statement about imbalance. Certainly, one aspect of this would relate to interchanging of symptoms and behavioral patterns, as one or the other seems more adequate to deal with changing internal or environmental pressures or stimuli. The other has to do with the problem of dealing with overwhelming anxiety arising when the usual avoidances, displacements, dilutions, controls, counter-phobic, distancing, motoric devices, and object substitutions of all kinds are not available or are no longer able to contain the conflict. We are, of course, talking about what really happens when the elevator does actually get stuck between floors or any symbolic equivalent of that situation.

A patient demonstrating this was one who, amongst many disabling symptoms and a pervasive dependency, had an extreme fear of success. This was related to his great fear of heights, of being more alone at the top and more responsible and more vulnerable to attack. He also had a moderate degree of claustrophobia in theatres and a great difficulty with any decisions. As the time approached for decision, he would feel trapped by the deadline and the no exit aspect of the situation, as well as feeling that, once the decision was made, he would be open to criticism and abandonment. This combination of fear of high, close and open places and their symbolic equivalents restricted his activities. After a period of analysis he was able to return to work and be moderately successful. he had found a position in which his superior played the role of protected protector for him. His superior was intrusive, demanding and domineering in the extreme and the patient could criticize him
and hate him while basking in the safety of his supervision and this taking total responsibility for the final decisions. When his superior became ill and left work, the patient decompensated completely. He lived in panic, could no longer leave the house alone, was always agitated, spent a great deal of time in bed, and became hypochondriacal. His phobias extended to new areas, since before the had enjoyed swimming and diving, which he could no longer do. This fear spread to his being anxious in washing his face because he felt suffocated. He also was unable to speak in public, which he had enjoyed before. His financial needs demanded that he work, and yet his feeling of the loss of support made this impossible. In this man, therefore, the mounting anxiety produced spreading of the phobia, and a major withdrawal and regression to a state of complete helplessness. One sees such decompensation in other phobic patients, which may be precipitated by a move away from parents, or the loss of a protecting figure, such as a maternal spouse, male or female. This may occur through death, or change of job location, or through the treatment of the spouse who withdraws from the maternal position or many other circumstances. It frequently results in women on the birth or the adoption of a baby upsetting the distancing defenses. It is also not unusual to see this is a run-away transference reaction, which stimulates so much guilt, fear and frustration.

These situations in which the anxiety mounts and there is a feeling of loss of control and helplessness bring into operation in severe cases a whole host of more regressive and archaic defenses that continue the avoidance and distancing, such as mentioned in the patient above. There may also occur severe depressions with suicidal tendencies, psychosomatic problems, paranoid trends, fragmentation or splitting with distortion of self and object representations, depersonalization, derealization, dissociation, severe acting out and in some cases self-mutilation. In regard to self-mutilation, which is not unusual in severe cases that
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I have seen, there may be scratching and cutting of the body with knives or razor blades, or the insertion of razor blades in the vagina in one patient, or head banging or punching in another. These activities, of course, have a multitude of meanings in sado-masochistic terms, but what applies here is that they also serve as terminal points for extremely disturbed states, in one sense as the ultimate punishment and control for forbidden aggressive and libidinal drives, and in another a gross and demanding call to an awareness and delineation of the ego and body boundaries.

In regard to the phenomena of splitting, this is often seen in regard to strong transference reactions. When these patients, for example, come upon strong libidinal or aggressive feelings in the transference, they attribute these feelings to "she" or "the head", thus they become the shaming parent and remove themselves from the responsibility. This becomes a regressive substitute to the avoidance, distancing patterns mentioned previously. The split off parts of the self may be seen as stupid, weak, poor, little, bad, dirty, or as hostile, strong, omnipotent demanding selves interacting in complex ways. They, however, become necessary accompaniments of these regressed phases, and integration of the split off self representations becomes a frightening prospect. Therapeutic considerations in the face of these severe regressive reactions would require a lengthy discussion. The need at such times for parameters in the analytic treatment of such patients makes the prognosis for the resolution of severe claustrophobia a guarded one.

In conclusion, I feel that I have delineated the complex picture of the claustrophobic syndrome as I have seen it. Certainly, feelings of entrapment exist in anxiety states in general, and distancing phenomenon, symbiotic relationships, etc., are common in other diagnostic pictures. There are even specific claustrophobic anxieties described in more simple displacement types of phobic states. The patients that I have treated myself or supervised have all followed the patterns I have descri-
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bed. I find this clinical picture to be fairly common, not only in my own cases but others have reported confirming experiences to me. The problems encountered in the treatment of patients with the claustrophobic syndrome will require special consideration.

SUMMARY

In this paper I have attempted to further elaborate on claustrophobic symptoms and character. A concept of a claustrophobic syndrome embodying all aspects of symptoms and behavior seems valid and useful. The claustrum is an ideal phobic object because of its availability in our world today, in many forms as well as its capacity symbolically to represent the interior of the female body or womb. Claustrophobia and agoraphobia seem to be present simultaneously in each case, represented by direct space symptomatology or by symptoms concerning time, distance, decisions, commitment, etc.

Counter-phobic attitudes are frequently present in patients with underlying claustrophobic anxiety. Daredevils and escape artists are such examples. Abraham's case of the imposter is reviewed in this light. The phenomenon of distancing present so frequently in patients with claustrophobia is described in several cases. Other phobias or obsessive compulsive behavior may also function to maintain a distance in a basically claustrophobic patient. A balance between symptoms and behavior is developed to control underlying oedipal and preoedipal wishes and fears. Imbalances when they occur may demand quantitative or qualitative symptom and behavioral adjustment. More primitive, defensive operations may appear to deal with uncontrolled anxiety. Some case material is used to demonstrate such reactions.
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References


