A Three-Year-Old Schizophrenic

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This three-year, four-month-old patient was brought for therapy by her mother because of severe panic and tantrum episodes. To the parents, these unprecipitated episodes were unmanageable and emotionally intolerable.

The focus of this paper is twofold. It shows first, the importance of mobilizing the ocular segment in a schizophrenic child and second, the role of a parent in the child's functioning and armor. The mother's intolerance of emotion and the importance of assisting her in tolerating and not interfering with the child's movement are noted as they occur in therapy sessions. Each step of the way, when aggression was forthcoming, the mother's resistance had to be dealt with in order to help the child.

This paper also documents the progressive sensory-motor integration of the child as therapy moved forward. Behavior, quite primitive initially, became more organized, with movement through several segments observed. From little organization within the ocular and oral realms, integration occurred, with looking, purposeful "not looking," then oral "no's," verbally and coherently expressed, stuttering (holding in the armored muscles of the throat and jaw), and biting, then, through the chest and hands, vigorous and purposeful hitting.

The patient was seen for 79 sessions.

Parent's Report

Lee was without speech except for a few words spoken at home. She did not play with other children. At preschool, her teachers described unpredictable panic attacks: her face would become very worried-looking, her hands would flap in agitation, her voice would take on a higher pitch; she might cry, bolt, or run. The mother described Lee as becoming frantic and frustrated if she did not get to do something or to have something she wanted, such as food. She would then scream single words such as, "Raisin, raisin," repetitively, have tantrums, and become upset and unresponsive. She also had unusual fears. Anything that might cause her to lose her balance was frightening. This included walking in the snow or on a dock. Her parents used extra caution, her father noting that he never threw her up in the air. Confusion, staring, and hanging back were described. She did not like to be touched and had shown no interest in the "potty." Recent attempts at training met resistance. She typically slept 12 hours at night, and her appetite for food was described as "enormous."

History

Lee's family included two likable, educated, quiet parents who each had some sense of humor. Her preschool described them as an asset, supportive, understanding. The

mother, depressed, had been in therapy with me for about a year and had repeatedly brought up issues and concerns about her child, asking for direction in management. As her depression lifted, she chose to bring Lee in for examination and therapy.

Lee was the product of an unplanned pregnancy. Plans for her home birth were disrupted by a lengthy labor, and she was delivered vaginally in the hospital. No abnormalities were noted. Although a "high rate of breathing" prompted a pediatric consultation, she was reportedly fine within a few hours. As an infant, Lee nursed a great deal, cried a lot, and got upset. The mother stated that she anticipated that Lee, "even when first born," would be willful and tantrumming. A friend reported that Lee was difficult as a baby. She had a period of diarrhea (medical tests showed nothing) and would stick out her arms and legs stiffly rather than bend them when touched or played with. The mother suffered from postpartum depression but also related that she was "very happy" with Lee. In the course of therapy, she once stated that while she hated to admit it, there were periods in the early years of Lee's life when she (the mother) was physically present but "not there." Since eight months of age, Lee has been in full-time daycare. After the first four days, her first caregiver said Lee cried too much and that she could not take care of her. Lee was nursed until 11 months. She fell off the bed once at about one year of age without losing consciousness and without and evidence of head trauma. The father felt the mother was overanxious.

Independent testing showed 10-14 months delay in gross and fine motor coordination, cognitive development, and socialization skills.

Neurological examination with EEG and CT-scan showed no neurological abnormalities.

Initial Presentation

At initial consultation, Lee was without speech or communicative sound and responded to few verbal or non-verbal directives. She appeared shy, moved haltingly at first, and showed little contact. She did not want, either then or in subsequent therapy sessions, to be separated from her mother. She clung to her mother, and her mother clung back to her. Her physical movements were awkward, and she tripped occasionally as if she did not see what was in front of her or near her feet. Although a few objects attracted her interest, she did not visually scan or look about in an organized manner, and details of the environment did not seem to register. The parents' initial concern and questions, mainly of a management nature, had not given hint of the severe lack of integration now observed. On the Stanford-Binet Intelligence Scale, Lee successfully responded to several of the non-verbal items at the 24-month and 30-month levels, but either did not respond to, or failed, all other items, verbal and non-verbal, at these levels or beyond, indicating significant intellectual delay. She was active, and there was at times a brightness about her, although communication was clearly quite primitive, contact highly fragmented, ego functioning severely limited, and development pervasively delayed.

Biophysical Picture

She was a pleasant-looking child, unremarkable in height, weight, and appearance. At times a placid expression appeared on her face. Occasionally, slight facial contortion suggested worry or incomprehension. The appearance of her eyes was vague, and she made only fleeting contact. When upset, her eyes were unfocused, unseeing, and completely contactless. She was very sensitive to touch, exquisitely so in the occipital region. Her forehead and jaw, and the area around her eyes, were also sensitive, though not rigid. Tight paraspinal muscles were slightly less sensitive. In contrast to the severe ocular armoring, the rest of her body was only lightly armored. Her pelvis, in particular, seemed very loose.

Course of Therapy

In the initial therapy session, Lee appeared very frightened, stayed close to her mother, but ventured to retrieve a stuffed animal. In the next session, placed on the couch, she cried, screamed, as in great terror, and seemed unconnected and far out of contact; in was difficult to get her to focus but she followed my finger for a few seconds. Asked to look around the room for her mom (who had stayed in the room as in all therapy sessions and was, in fact, sitting right next to her), she did so, sometimes smiling as if deeply relieved to find her. After a few minutes, she was cheerful and playful.

The father, in consultation, noted that "letting Lee have her fits" around the dinner hour and giving her more time in the morning to dress herself was helpful. It seemed the parents needed assistance and encouragement to allow the child to find her own way in activities such as dressing or getting ready to go somewhere.

After several sessions, Lee would smile rather beguilingly and clutch her mother when I tried to put her on the couch. Asked to "find mother," she began pushing her mother away and then grabbing her back as if acting out coming and going and asserting control over the disappearance and reestablishment of her mother. She seemed to find comfort in this and laughed lightly. The unpredictability of her mother’s presence or its lack of relation to her behavior seemed to be an issue for her. Through the next several sessions, much terror was visible in Lee’s periodic screaming. Following my finger or looking for her mother seemed to focus her, occasionally bringing her into the present. At these times she seemed relieved. Her mother, on the other hand, was barely tolerating the expression of her daughter’s fears, although she was now more aware of and talked about her own degree of limited emotional contact with Lee in the past.

In the next session, using gestures, Lee asked to be put on the couch. She looked less frightened but just as scattered. She took the cloth bats and hit her mother once, then the teddy bear, and me, and was delighted. In a subsequent session, Lee initiated a hitting interaction with her mother by giving her a cloth bat. Quickly, however, she made a decidedly worried-looking face, said, "No hitting," and put the bats away.

Lee began showing an interest in movement; standing up and jumping from the couch to me, clearly not trusting herself to leave much ungrounded room between herself, the couch, and my hands. On the couch, there was some crying, then smiling. She enjoyed kicking, saying, "Momma, come," and then, "Momma, go," reaching for, then letting go of her mother or pushing her away. More words were appearing in therapy.

Frantic behavior was still evident, however, as if she had to have-a glass of water, a toy. She was unable to wait or delay, to speak coherently or engage in purposeful, problem-solving behavior to obtain what she needed. She would lose focus and contact with the world around her. In session, she cried, then yelled without focus, and without real expression of anger. She neither looked at nor engaged in any behavior directed toward the object she wanted, but had momentarily lost, e.g., a stuffed animal she had brought from home which had fallen out of her hands. It was difficult to engage her directly, but with repeated work on her eyes and talking to her, some eye contact and focus appeared, accompanied by spontaneous, purposeful, kicking. Afterward, she was bright-eyed, cheerful, calmer, and more talkative on leaving.

The mother reported Lee was becoming more verbal with the family, was dancing beautifully, and was more responsive to suggestions and "no’s." Work continued on the ocular segment, mobilizing the eyes and allowing her screaming discharge of terror. She was encouraged to "come back" when she frequently "went off," by my asking her to focus with her eyes on her mother or myself. She gave me a vigorous, sustained hug on leaving.

Speech was developing with the use of more sophisticated words such as "canoe" and "broccoli." This atypical development helped to clarify the child’s condition, signaling an intelligence obscured by ocular contraction. Biting occurred. Extreme and persistent pronoun reversal, unusual syntax, echolalia, and stuttering punctuated her developing speech, further substantiating the case against retardation and for pathological development of the ego, related to armor in the ocular and oral segments. She spoke with longer phrases and began speaking to people other than her parents and myself.

In the next therapy session, she was behaviorally active, wanting to throw, hit and laugh. On the couch, she voiced loud, contactless protest. I said, "It’s okay to get mad," and "You can say no." That seemed to help- she calmed and seemed more focused. Encouraged, she thought it quite funny to say "no." (The mother reported that at home Lee was newly assertive, saying, "No, not want to.") When she was on the couch and was "off," she was asked to look at me. When she could and did look into my eyes, she seemed at first disconcerted, as if far away, and then lit up with much apparent joy and relief.

Five months into therapy, she had become more verbal and seemed desperate to be heard; I began repeating everything she said in an attempt to affirm her speech. At times on the couch, when asked to focus, she still evidenced extreme fear and little contact; but after some expression of her feelings, play was more sophisticated and imaginative - she acted out activities and simple stories.

Work continued to address her ocular manifestations. In the initial session, when Lee was curious but not yet focused on or attached to an object, her mother was encouraged to "go with her" the three feet or so it took to get to some object of her curiosity rather than getting it for her; this worked well, and it wasn't long before she was exploring and acting on her own. More commonly, however, when she wanted an object not immediately available, she would frantically cry (instead of reaching), "give up," become upset, and go out of contact. At this point in therapy, she began to respond to encouragement to reach out toward objects, was more active in getting them, sometimes even aggressively so, and laughed when her own efforts succeeded. She showed more problem-solving ability as well as more tolerance for what must have been an overwhelming sensation of frustration. Rather than go "berserk," Lee was now capable of doing something directed when she did not get an object she wanted.

Intellectual Progress

At 3 years, 11 months of age, Lee passed the vocabulary test of the Stanford-Binet at the four-year-old level. Prorated, and using the tables of norms, this accomplishment suggested an IQ of about 90. Lee was looking sturdier intellectually.

In interaction on the couch, Lee more vigorously pushed my hand away in a game or, with encouragement, when she did not want to follow my fingers with her eyes. She spontaneously kicked with delight.

In the next session, Lee looked tired, worn, and seemed to have a veil over her eyes. It was difficult getting any focus from her. Her mother found it difficult tolerating Lee looking like this and said she didn't know if she should make Lee go through therapy. It is terribly painful for a mother in symbiotic relationship with her child to see these intense, raw emotions. After a session of working her eyes and allowing discharge, Lee hugged me warmly several times.

At the next meeting, Lee was reported to have been more assertive at home, telling her dad, without panic, to go away when he told her "no." In the therapy session, as before, even the anticipation of parting with a toy made it difficult for her to engage and make eye contact or for others to make contact with her. After some "giving up" behavior that looked like hopelessness, she spontaneously kicked, said, "No," pulled on my hair and clothes once, seemed more present, and, on leaving, hugged me.

In the next session, Lee was charming, bright-eyed, and difficult to engage. She wanted to push against my hands with her hands and feet and did. Her stubbornness was also most cheerfully evident-although now able to engage, she refused at times any attempt at looking. She said "no" with equanimity and seemed pleased to be able to refuse. On a family outing, Lee played well with a family friend her own age and with the other children as well.

The mother reported that at home Lee was frequently saying, "No, I don't want to." Sometimes on the couch, as she started to "go off," she would, instead, purposefully

and literally peek out from behind something and look. Experimenting with movement and space, she converted the top of the couch into a downhill slope, jumping and sliding and pushing stuffed animals on it.

Nine months into therapy, Lee's speech was more elaborate, and she spoke to more people outside the home, including strangers. Her syntax was still unusual and disturbed.

Leaving therapy sessions was difficult for Lee. She often got quite upset, focusing on something she wanted or some activity she would like to do after she left but which her mother seemed unable to provide. I noticed that if stayed right with her, engaging her eyes and attention throughout the activity of leaving, her typical screaming episode was aborted.

The next time, Lee seemed a bit tired, but when she went "off" it was less severe. She cried for her mother's hand, which she received. Her mother volunteered that perhaps crying and asking for her hand was "just a habit" and that she should leave the treatment room (although she did not attempt to do so). This seemed to reflect the mother's ambivalence and impatience with her child's emotional working through as well as her difficulty in tolerating the pain Lee was still experiencing. The mother reported further improvement in her daughter's manner with other children. Active with and around children, she was, nonetheless, still behind in her capacity for abstract thought. She went to a birthday party and enjoyed herself but did not understand the concept of birthday.

During the following week she behaved less frantically. In session, Lee was less contracted biophysically. Given free range, Lee made herself a slide out of the couch and now threw herself about or slid down in a new and vigorous fashion. One felt the need for alert supervision in order to prevent injury. Contained on the couch after this active play, she began to look frightened and disorganized; the vigorous movement seemed to have stirred her up beyond her tolerance. She demanded some item and when this was not provided, she began to scream without letup. Although her recent improved functioning helped her to get what she wanted, her cry was heartbreaking and contained anger.

Physical Awareness and Speech Development

The mother reported first a rough, then a good week since last meeting. Lee was identifying flying objects in the sky and, when in an airplane herself, had noticed and pointed out objects below-a new skill for her although she was an experienced flier. Lee was clearly becoming more visually aware and attentive. One could see her difficulty when asked to focus, bust she was showing more ability, interest and willingness to focus, up to a point. As her curiosity grew, Lee asked several times, "What is this?" and reached for things repeatedly on leaving.

At play in the next session, Lee repeatedly said, "Don’t do that again," as if she had just learned this phrase. She also said, "It’s mine," and used "my" as an adjective many times. This appropriate use of the pronoun and references to "you" and "I" were striking and seemed to mark a major development, a significant differentiation of self.

In the next session, Lee was energetic in her movements, playful, and she spoke more about what she wanted. While on the couch, without any random movement, she looked quietly at her mother and myself. In the past, looking was not sustained and was always accompanied by physical movement. On leaving, she gave me some whops as if she were establishing my edges and impressing herself with the fact that I was really there in 3-D. She then gave me a big but notably soft hug.

The word "now" became prominent in Lee’s statements and requests. She seemed more present and was more demanding of others’ contact.

In the next session she verbalized many "no’s" and "mine’s" as if she wished to be playful with the words and wanted to engage and interact about those ideas, much as adults might bring up a topic for discussion.

Speech and play with other children continued to improve. Lee was experiencing, responding to, and clearly more tolerant of stimulation and movement without disintegrating. She went sledding during the winter and was now canoeing with pleasure.

In the next session, she chattered away, brightly and cheerfully. Her play was imaginative, and she used many words I could not understand. She hid herself playfully in the couch cover. She moved about in excitement. It was very difficult to get her to use/focus her eyes. Her "no’s" had a quality that seemed to negate others’ schedules and direction. She was not frantic, however, in her refusal and did not seem to drift so far away. At this point Lee was noted to check out people in the waiting room with imperturbable curiosity.

Intermittently but persistently throughout therapy, Lee gathered up many things and protested loudly if any object were taken from her. Originally, one could not see or get close to her because of all the stuffed animals that she amassed around herself. This helped not only to define her space, but to fortify and defend her boundaries. Today she let go of all but one object.

In the next session, Lee’s activities were more imaginative and toy-oriented. This was in contrast to her usual more muscularly physical play. At home, she played by herself for hours in a focused, involved way-also may unusual for her.

At home, there was yelling at, demanding of, and hitting the parents. Her mother felt that these "upsetting" behaviors came particularly after a positive experience, e.g., playing at a friend’s house without her parents the previous day. The hitting reflected downward movement of energy utilized in a focused, purposeful way. In the office, she

was less "off" but seemed reluctant to engage. It was difficult getting her to track and focus in a sustained way. I related this to her difficulty in expressing aggression at home.

The mother reported that Lee had become "violently aggressive" with her mother and father. There were still frantic demands and, it seemed, newer, more articulate ones which were disruptive and disturbing to the parents. Working biophysically on the muscles around the eyes, and having her track my moving fingers or a light helped her to respond more directly.

Strong hitting impulses surfaced. This layer of hitting demonstrated greater integration of the eyes and chest and was different from earlier discharge. Over the next several sessions, Lee seemed well, although some clinging behavior was noted. In one session, she smiled and hit her mother which was distressing and intolerable to the mother. She reported that Lee had a "hitting problem." Lee wiggled on the couch to avoid any connection. If she could hit at my hand or an object which I held up for her to track, she seemed more settled, present, and comfortable. She was encourage to do so. She also liked a game where she could say, "Go away," and she expressed a few "don'ts."

Lee clung to her mother in a way that was both playful and aggressive and irritating to the mother. I did not push and her mother commented that I was "not getting much out of her" today.

For several sessions Lee seemed to be "playing possum." Her mother noted and commented on "the same old thing here," and was impatient with the therapeutic process although she noted that Lee was making progress "elsewhere in life" and was asserting her independence and identity. Lee made good contact with me on leaving: direct, simple, and warm.

A new element appeared in the therapy room: Lee played in a sustained way with small cars, verbally and physically articulating their action. I tried without success at first to work with her legs and get her to kick. When she did kick, her eyes focused. She eventually sat on her mother's lap and from there kicked the couch with some satisfaction.

Her mother reported distress over Lee's continued panic episodes and temper tantrums, which she felt occurred once a day. The father reported a decrease to 1-5 times per week. Also distressing was the difficulty in handling Lee in public, although Lee had played well for an unusually long time, all day, with a friend. In sessions, she was playfully active and averse to being contained. She responded to biophysical work on her forehead and eyes with increased contact. In between these brief periods of looking and taking more in, she was off on new, somewhat self-encapsulated activity.

Working on her legs and very gently on the back of her head led to some tears and playful kicking. "Not enough room" and "own space," were concepts she verbalized and

experimented with in her play over several sessions. On the couch, working her back and, ever so gently, the back of her head elicited some tears.

Social Progress

The next session Lee reacted with brief, angry crying to touch and light pressure on her paraspinals. The mother's immediate reaction, soothing her and telling her to "hush," stopped this. She said she was "not sure" about the process. Following the outburst of intense anger, Lee engaged in the most purposeful, charming, and engaging interactive play thus far. Her mother and I could not help our awed amazement. Lee draped her head with the couch cover, made herself into a ghost with growling, aggressive sounds, and then came out showing her own face, a sophisticated, timely, Halloween version of peek-a-boo. She extended this to making various animal sounds and asking me to identify them. The play involved direct eye contact. It was an expressive, imaginative, social exchange between two people and included a modulated use of emotion. The latter was a first, as emotionally had previously appeared mainly in a raw, intense form.

Two problems now arose. First, as Lee was getting older, her tantrums, although less frequent and of shorter duration, were more intense physically. Lee, for example, threw things, and her mother was concerned that she and her husband would not be able to handle such episodes. Lee's aggression was more focused, and therefore, more threatening. Second, the mother's ambivalence was reflected in the child: Lee was cooperative but reluctant in therapy. The mother, although feeling mostly positive about therapy, "wondered" if Lee would remember therapy negatively.

Lee played cheerfully in the office and called me several times by name if her mother began speaking. In contrast, putting Lee on the couch and asking her to talk from there led to much protest. My only intervention, other than asking the mother how she felt, was to tell Lee not to kick or hurt me when she protested vigorously. She left in a cheerful and playful mood.

A consultation with the parents was arranged in response to the mother's apparent difficulty with the intensity of emotions emerging in Lee's therapy. Questions regarding management of home situations were discussed and the parents were encouraged to allow and accept Lee's angry expressions.

The mother decided to resume her own therapy. Her depression had resolved some time ago, but she felt the need for assistance in standing up for herself, in becoming more appropriately aggressive and assertive, and in exploring problems in her marriage. In effect, she wanted to begin dealing with her own withdrawal, fear, and anger. With this decision, therapeutic movement in the child progressed anew.

On the couch, whining, vague sounds, and protests appeared with a few kicks and "no's." Lee felt miserable and unable to express her distress. I proceeded to work biophysically on her throat block by gently massaging her throat and encouraging sound. Sitting on her mother's lap, she gave me some "no's," which I encouraged along

with any pushing she wanted to do. After I thanked her for these communications, she came over and gently put her head in my lap.

The family vacation prompted a break in therapy. On return, Lee was cheerful, playful, and bright-eyed, and called me by name several times to engage me. Her mother related that the night before she gave Lee medicine for a troublesome cough. The child awakened during the night, tripped, and then saw images of spiders, snakes, dinosaurs, and lizards. Lee was quite upset and told her mother who was comforting her that the spiders were coming out of her mother's eyes. In the session, Lee referred to spiders and the dark, finding a hole in the couch and other spots in the room. When I asked her what she'd like to do about the spiders, she talked about and briefly acted out "getting" them. On the couch, she was moderately cooperative in following my finger with her eyes. She pushed my hand away preventing me from touching her forehead, occiput or legs, but was more tolerant regarding her back (paraspinals), and this seemed to bring her into direct interaction. Lightly touching her occiput led to a bit of painful crying. Subsequently, Lee began speaking of a rabbit she wanted to take to school. Her mother told her that it was at home; this ("It's at home") Lee relayed to me. When Lee reiterated to her mother her desire to take the rabbit to school her mother said, "Tomorrow," Lee contentedly turned and repeated to me, "Tomorrow." Lee was exhibiting a newfound capacity for delay and postponement. Getting off the couch, Lee said to her mother, "I feel better." She insisted that I wait for her as I stood up to leave the session, and she bounced out the door.

At the next session, Lee had a cold and was more diffuse, her speech was less intelligible and sounded slurred. She was roller-skating now and in delight playacted this activity with a toy bear.

Final Status

The patient is improved but still has problems. With subsequent environmental change and stress, and with further therapy not possible, Lee had tantrums contained within the home (not in public or in school). This was frustrating to the parents. However, they have accepted her display as a means of letting off steam in the absence of other ways of discharging feelings, and they refrain from overreacting or responding punitively.

Discussion

To date, mobilizing the ocular segment has been of critical importance and has allowed Lee to see, to cognitively relate to, and to process more fully, what is going on around her. Terror has been a prominently held-in emotion and has been elicited and expressed. All emotions released in therapy have resulted from the dissolution of armor in the ocular, oral, cervical, and thoracic segments. In addition to the terror, emotions from the chest stand out: heartbreak, bitter sobbing, some rage, reaching, and longing. These seem to reflect very early, inarticulate memories, of extreme disappointment, of not being received, or being received but poorly. Her laughter, her ability to reach out, her use of arms, and her grasp, physically and mentally, of her environment, are now

stronger. Her sense of self, her ability to articulate her needs, perceptions, and sensations, and her ability to tolerate and take pleasure in the movement within her own body and in the outside world, have increased. Her contact fluctuates and continues to be fragmented, and her understanding and interactions are, more often than not, concrete; abstract concepts (those expected at her age) continue to elude her.

No specific etiologic traumas or events have been identified except for the mother's depression (present until Lee was age 3 ½) and the inevitable lack of energetic contact. The parents' handling of the resulting diffuse temper tantrums and their difficulty tolerating rage and emotional expression were and are factors in determining the nature of symptom patterns. The parents have shown fortitude and persistence in assisting their child to face her extreme terror and distress, and in dealing with their own intolerance of her tantrums and intense, raw emotions: terror, heart-breaking sorrow, and rage in particular.