The Importance of a Correct Diagnosis: Depression in a Schizophrenic Adolescent

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Traditional psychiatry recognizes schizophrenia as a disorder, but requires the presence of overt psychotic symptoms[1] during some phase of the illness to justify the diagnosis. For example, patients who present with sadness and no overt psychosis, past or present, are generally considered depressed. The schizophrenic's split between perception and excitation, as described by Wilhelm Reich, is generally unknown to and hence not evaluated by the traditional psychiatrist. Since this is the central feature in the characterologic diagnosis of schizophrenia, many cases will be misdiagnosed. Throughout medical science, a correct diagnosis has always been the essential starting point in treatment of illness. The following case presentation is an example of this.

Case Presentation

In January of 1994, P, a nineteen-year-old college student, came for a second opinion about his depression, which was characterized by increasing sadness, restless sleep, ruminations, fatigue, weight loss, and feelings of helplessness. He had seen a social worker in May 1993 who quickly referred him for antidepressant medication because of fleeting suicidal thoughts associated with his depression. Therapy continued with the social worker until December 1993 when his symptoms worsened causing him to leave school, move back with his parents, and seek help elsewhere. He described the general problems and stresses in his life as shyness around girls, poor school performance due to lack of interest, and feeling intimidated by others. This was especially true of his father who P typically responded to by either withdrawing or becoming

[1]The presence of hallucinations, delusions, markedly illogical thinking or formal thought disorder.

extremely angry. Additionally, he complained of racing thoughts, outbursts of anger, (mostly at his family), anxiety, fear, inappropriate laughter, and what he called "zoning out." There was no history of hallucinations, delusional thinking, or overt psychotic symptoms. P described a long history of moodiness. He also reported having had a large circle of friends which progressively diminished since his early adolescence. Throughout his teenage years he acknowledged spending considerable time in his room, mostly to avoid conflict with his father. He never had a sexual relationship.

Although his significant social withdrawal troubled him, he had never sought help. Prior medical history included three episodes of fainting in high school, the last occurred in 1992, and acne which was treated with antibiotics. Because of the history of fainting I referred him to an internist who found no abnormalities on physical and laboratory examination, except an asthenic habitus and hyperextensible joints.

P has an eighteen-year-old brother with a bad temper and a twenty-two-year-old sister with "mood swings." His father is successfully self-employed, prone to angry outbursts, quite controlling, and frequently critical of P. His mother is described as chronically depressed with the mannerisms of a timid mouse.

On initial examination the patient was thin, casually dressed in loose fitting clothing, had disheveled hair, and appeared a few years younger than his stated age. He was notably shy, had flat affect, and avoided eye contact. When he did look at me it was through half-closed eyes. On having him open his eyes fully, he looked terrified but did not feel this emotion. He appeared very sad although he described his mood as anxious. Psychomotor activity was markedly diminished almost to the point of immobility. His minimal speech and tightness of voice was strong evidence of a significant throat block. P's chest appeared soft and had minimal movement with each shallow respiration. He had little ability to move his eyes. When I raised his arm, cerea flexibilitas was present.[2]

[2]Cerea flexibilitas (waxy flexibility) is commonly observed in the catatonic. The patient will maintain the body position in which it is placed for an extended period of time.

A schizophrenic split, the most prominent feature of P's initial examination, was demonstrated by his complete lack of emotional contact with the evident terror in his eyes. The presence of this split, his significant throat block, the characteristic appearance of his chest, soft with minimal movement and barely apparent respirations, physical immobility, cerea flexibilitas, and his history indicated a diagnosis of catatonic schizophrenia with depression.

Course of Treatment

P was initially seen sitting up. His minimal verbal expression, lack of eye contact, and psychomotor retardation made emotional contact with him difficult. I pointed out his disconnected emotional state with little if any response. Because of his minimal respiratory excursions, I had him breathe more deeply.

Within a few minutes his neck and right shoulder began to twitch. Circling his eyes caused dizziness and was immediately followed by his "zoning out," described as "a deadness," feeling nothing, and losing vision as if he were blind. Over the next ten therapy sessions having him breathe and move his eyes allowed him to become more verbal and to tolerate more of what he was feeling without "zoning out" (splitting off perception from excitation). P began to be aware how feelings of anxiety, especially when they occurred in the treatment room, often lead to a sensation of blindness. Continuing work on his ocular segment, I had him move his forehead and express different emotions with his face.

Afterward he said, "My face never looks how I feel." He was becoming more aware of how emotionally disconnected he was. When he looked in a mirror during one session, an expression of fascination appeared as if he were seeing himself in a different way. In another session, with my encouragement, he brought in and played his guitar and sang. He was quite good. Following this expansive experience he was very proud of himself. Now the twitching associated with breathing (on the couch) began to include his arms, leas, and chest.

Within two months of P's starting therapy his parents noticed that he was more social, spent less time in his room, and no longer appeared

depressed. After three months of weekly sessions which continued to focus on his ocular segment, his forehead was more mobile and his ocular symptoms occurred less frequently. The lower half of his face, however, remained motionless which I pointed out to him. Light, direct pressure was then applied to the muscles of his jaw. This elicited fearful yelling, following which he described experiencing a feeling of liveliness in his lower face. He began to speak up spontaneously in therapy and at home. I continued encouraging him to express emotions with his eyes, loosening his occipital armor with direct biophysical work, and having him move his eyes. After twenty-five sessions, with an improved ability to make emotional contact with himself, he was able to stand up to his father without losing control or withdrawing. Although prominent before, anxiety, especially in therapy sessions, was now clearly associated with doubting, overintellectualization, and feeling "frozen." Addressing this characteranalytically was of little help, but having him stamp his feet on the floor and punch a cushion gave him much relief from "thinking too much." P now reported that his vision became more acute and sometimes three-dimensional after his sessions. This often lasted for up to two days. In general, he appeared more lively. P was also more aware that his doubting occurred in relationship to his feeling "frozen."

By August 1994, after thirty sessions, feeling better and stronger, he resumed his college education and came to therapy monthly. Within three months, however, P was again depressed and experiencing more frequent ocular symptoms: "zoning out" and confusion. He resumed weekly sessions, took a medical leave from school, and began working in a shopping mall.

In treatment, screaming and kicking while on the couch now resulted in sensations of deadness in his arms. His response to anxiety in the sessions, freezing up with frustration and doubt, was also more pronounced and obvious to both of us. Gagging himself loosened tension in the muscles of his throat, and with my encouragement of emotional expression, resulted in a fuller voice.

As treatment continued, he increasingly appeared on the verge of crying, but could not allow this expression. Finally, while looking at me he said, "You are saving me, you can see what is

wrong when no one else could." He then sobbed from his chest and looked more integrated and alive. Over the next few months he came to realize that the frustration he had felt so strongly was simply a response to holding back sadness. The frustration had increased his ocular symptoms, his doubting, and being "frozen." The reactions are now much less prominent and interfere far less with his general functioning. P continues in weekly therapy Interestingly, although he stopped his antibiotics, his acne cleared as his face became more mobile.

Discussion

Although P was clearly depressed, his characterologic diagnosis was catatonic schizophrenia. The essential features of schizophrenia, as delineated by Reich, were clearly demonstrated by the patient and include the split between perception and excitation, a severe throat block, and minimal respirations in the presence of a soft chest. In P, these manifested in his extreme emotional disconnection, his tendency to "zone out"(described as "a deadness," feeling nothing, with loss of vision), his constricted emotional expression, minimal speech, and tight voice, and his apparent lack of respiration with low bioenergetic charge. His catatonic symptoms included physical immobility and waxy flexibility.

Careful attention to and biophysical mobilization of his ocular segment loosened his ocular armoring. Together with breathing and the physical expression of emotion his bioenergetic charge was increased, the quality of his emotional contact improved, and his depressive symptomatology was alleviated. In the process, underlying feelings of sadness emerged and were able to be expressed. As a result of these positive developments, he demonstrated a greater capacity for work, interpersonal relatedness, and social interaction.

Conclusion

This case demonstrates the importance of an accurate characterologic diagnosis. Although some of the patient's symptoms appeared to be

and some were related to depression, they were more specifically a consequence of his intolerance of bioenergetic charge and movement.

An appreciation of the schizophrenic split led to the correct characterologic diagnosis. This, in turn, determined a therapeutic approach which specifically addressed the patient's major biophysical pathology, primary ocular segment armoring with decreased bioenergetic charge. Unlike traditional psychiatry's diagnostic criteria for schizophrenia, the presence or history of psychotic symptoms was not required to make this diagnosis. In conclusion, if the diagnosis had been made on the basis of the patient's prominent depressive symptomatology without consideration of his biophysical presentation, the bioenergetic significance of his depression and severe emotional contactlessness would have been missed—to the detriment of their resolution in treatment.

References

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