Wrong Diagnosis, Wrong Approach: A Clinical Case

Alberto Foglia, M.D.

Abstract

The following case history is an illustration of a therapeutic impasse. The incorrect handling of the emotional expression of the patient originated from an incorrect character diagnosis. The patient's reactions during treatment reinforced the erroneous diagnostic impression and in a vicious cycle perpetuated the incorrect approach. This unfortunate situation was a direct consequence of a disturbance in contact between the therapist and the patient. However, the mistake was recognized and therapy continued on a corrected course, with positive practical consequences.

Case Presentation

The patient, a 45-year-old woman, sought medical orgone therapy in 2005 for recurrent episodes of depression since her adolescence. She reported severe seasonal mood swings and a chronic deep feeling of unsatisfaction in practically every aspect of her life. There was a marked inconsistency in her life, especially in her work life. She admitted to have frequent thoughts of ending her life someday, but denied suicidal plans.

Fran grew up in a caring family with two younger siblings. Academically, she always did well, but interrupted her university studies because she was unhappy, unsatisfied and disappointed. She later obtained an administrative assistant diploma. However, every attempt to maintain a job failed after a few months because of disappointment and resentment. She always blamed others. When I met her for the first time she was cooperative, but appeared vague in her communications, aloof and emotionally flat. Her mouth was proportionate and she tended to talk too much. Biophysically, her eyes

were clear and mobile and she was able sustain eye contact. Her jaw was slightly tender to the touch and her throat exhibited signs of blocking manifesting, in particular, by her coarse and low-pitched voice. Breathing was superficial although her chest was soft. Her breasts were underdeveloped and her legs were well-proportioned, athletic and strong. The pelvis seemed fairly tight and solid.

Course of Therapy

During the second session, Fran complained of feeling depressed, and appeared immobilized and emotionally and energetically deadened. When I asked what she felt, she revealed a state of fear, a feeling she always had when depressed.

She came into the third session overexcited and talking too much. When I encouraged her not to talk, she became angry and started to curse at me. For many sessions she was rebellious, full of rage, and destructive. I had the impression that she was expressing contempt and blame toward me and her parents for being too strict with her. These outbursts seemed to help her overcome the severe depression for a while. I therefore allowed her to discharge rage during the sessions. However, for the 29th session, she came in again depressed, apathic, immobile and desperate. This pattern of severe mood swings continued for the subsequent two years and no improvement was seen either in her mood or in her work function.

After two years of therapy, during my summer vacation, Fran experienced a sudden panic attack with delusions of persecution and fear of being murdered. She had to be hospitalized for 2 weeks. Discharged on a low dose of neuroleptics and a diagnosis of "Bipolar Disorder," she continued to exhibit mild mood swings.

The Change

This incident made me aware of the hidden panic present in this patient. Suspecting a diagnostic mistake, I began to take a firmer position and asked her to stop the frantic, destructive behavior in session. I told her she had to stop her chaotic expressions, like

running away from the couch and messing up and throwing the sheet. She slowly adjusted and began to follow my rules. She became calmer and more appropriate.

With time, a new trait came to the surface: a strong tendency to complain and suffer, accompanied by a tendency to blame others and avoid responsibility. In short, she looked like a suffering and whining baby. Although already present, this attitude had never been so clear and open. This allowed me to point it out to her, with an important consequence: she started to face and stand her anxiety about accomplishing something. She eventually took the initiative to change jobs and achieve a higher position. The following sessions were calmer and she has been softer than in the past. No doubt she still complains and suffers chronically, but she is now aware of it and works hard to take responsibility for her work and life.

How she responds to and deals with her fear has more and more taken center stage as an important determinant not only of her emotional symptoms but also her work difficulties. She is slowly making progress in facing this feeling.

Discussion

Adequate emotional, energetic contact between patient and medical orgonomist is essential in the therapeutic process. In this case the aggressiveness of the patient, her defensive expression of rage, was allowed chaotic expression which interfered with, even blocked this contact. As a result, therapy was ineffective, as evidenced by her chief complaints of depression and severe work incapacity remaining unchanged. Once the mistake was recognized and the therapeutic stance changed, the patient became calmer and her contact with the therapist, herself and her problems improved. This led to substantial changes in her life, especially in her work function.

Clinically, the patient presented with clear symptoms of affective instability, oral unsatisfaction and phallic aggression which made her look like a manic depressive character type. Rage behind oral unsatisfied manifestations (overtalking, instability) (Baker, 121-123)

seemed to be the right emotion to discharge in therapy. However, several signs were present from the beginning that should have raised the possibility of a paranoid schizophrenic disturbance: the soft chest with superficial respiratory excursion, the throat block (Baker, 144-147), the initial impression of vagueness and the vagueness of her love and work life, together with the subjective feeling of fear, present during every "depressive" episode.

When the patient was asked to stop her frantic violent behavior in session, an underlying layer of infantile suffering and complaining appeared, which, in turn, had the function of warding off a deeper layer of fear, yet to be expressed. The discharge of complaints and infantile suffering, however, were more contactful and directly linked to her daily life. Facing these feelings allowed the patient to improve the degree of contact with the therapist and herself. Consequently, she was able to focus on her very real problems with work, one of her major complaints when she first came for therapy.

References

Baker, E. 2000. *Man in the Trap.* Princeton: ACO Press.