The Energetic Function of Tics in Tourette's Syndrome*

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Introduction

Tourette's Syndrome (TS), first described by Gilles de la Tourette in 1885, has its onset in childhood and is characterized by a constellation of symptoms that include motor tics of diverse muscle groups and vocal utterances (called vocal tics) which can progress to coprolalia (compulsive shouting of obscenities). This is often associated with other collateral symptoms such as echolalia (uncontrollable, immediate repetition of words spoken by another person), echopraxia (repetition of actions), and obsessions and compulsions. Other problems that may occur in TS include hyperactivity, learning difficulties, anti-social behavior, self-injury and suicide (1:843-845).

With the introduction of the Diagnostic and Statistical Manual (DSM) III, modern psychiatry established fixed diagnostic criteria for TS. The result is that today the syndrome is much more often diagnosed than in the past. These are the DSM IV criteria (2:101-103) for TS:

> A. Both multiple motor and one or more vocal tics have been present at some time during the illness, although not necessarily concurrently. (A tic is a sudden, rapid, recurrent, nonrhythmic, stereotyped motor movement or vocalization).
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> B. The tics occur many times a day (usually in bouts) nearly every day or intermittently throughout a period of more than 1 year, and during this period there was never a tic-free period of more than 3 consecutive months.
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> C. The disturbance causes marked distress or significant impairment in social, occupational, or other important areas of functioning.

*Translated from the Italian by Dale G. Rosin, D.O.

D. The onset is before age 18 years.

E. The disturbance is not due to direct physiological effects of a substance (e.g., stimulants) or a general medical condition (e.g., Huntington's disease or postviral encephalitis).

The presence of the involuntary movements in TS has led many authors to suggest an organic (neurological) origin. The most widely accepted view is that it is a condition on the frontier between neurology and psychiatry (3:136-161). Treatment is mostly limited to neuroleptic medication and the prognosis is unfavorable.

The following case presentation describes initial phases of the treatment of a Tourette's-afflicted patient with medical orgone therapy. The therapy afforded the patient much relief and allows for a bioen- ergetic understanding of the cause of the disorder.

Case Presentation

B was referred by his pediatrician who was trying to find a psychiatrist willing to take on the care of this severely ill fourteen-year-old boy. He lived with his mother who was said to be difficult, authoritarian, and intrusive.

I saw B for the first time in April of 1990 accompanied by his mother. At the door he demonstrated the severity of his illness. With the intention of shaking my hand he froze, his hand stopped in front of him, his body rigid and unable to move further. I grasped him by the hand and brought him into the office. Seated next to his mother he repetitively and mechanically turned his head left and right but without an awareness of the emotional significance of the "No" he was expressing with this movement. The mother showed herself to be extremely mistrustful and suspicious with an unstoppable impulse to control and direct everything regarding her son. He, in turn, appeared not to hear her and continued his muscular litany with absolute indifference.

Chief Complaint and History

B's chief complaint was his tics. He suffered with them, he was ashamed of them, and he wanted to get rid of them. Because of his tics and his incessant obsessive-compulsive behaviors, he couldn't

go to school. He was unable to leave home without his mother because separation from her precipitated in him overwhelming fear and panic. Because of his refusal to bathe, she washed him like a baby, including his genitals. He involved her in his increasingly pervasive compulsive rituals forcing her to count numbers and to repeat words with the hope that this would alleviate his unbearable emotional tension.[1] She did not oppose these commands even though she felt herself becoming more and more exhausted. Occasionally she exploded in verbal rage toward her son.

According to the patient, his mother, and his pediatrician, these symptoms started to develop eight months before in October 1989, after B was required to change schools. By January 1990 he presented with fully developed TS. Prior to this time, B was described by his mother as having been a normal child, polite, diligent in school, and obedient. However, I learned from the medical reports that B had been seen by a psychiatrist when he was six years old because of difficulties at school and problems separating from his mother. At that time he refused to go to school and had violent temper tantrums.

B was born when his mother was forty-four years old.[2] There were no problems during the pregnancy, although cesarean section was necessary. Nothing unusual was noted in the perinatal period.

Toilet training began at age two over B's violent protests, which often ended in B becoming cyanotic. From the age of two, B cried frequently and was minimally social. When he was three his eighteen-year-old sister left home because of irremediable conflicts with the mother. From the age of six he was often derided and harassed by other children and his mother would rush to his defense, verbally attacking her son's tormentors. (This continued up to the time of consultation.) B applied himself in school and did well, but made very few friends. He was described by his mother and his school teacher

[1]B explained to me, almost one year later, that he thought only his mother could relieve his tension.

[2] Although the mother was a fervently religious woman, her pregnancy with B occurred during a relationship with a married man. Fifteen years before, she became pregnant by another man and gave birth out of wedlock to a daughter.

as having been a well-mannered boy, obedient and a loner before the crisis of 1989. He and his mother have always lived in the same small apartment and slept in the same room.

Mental Status and Biophysical Exam

B was of average height, slightly obese, and moved mechanically like a robot. Sudden muscular jerks of his shoulders, neck, or legs often appeared. He also exhibited more complicated movements which seemed to have ritualistic significance: looking at objects while holding strange body postures, or staring and moving his arms back and forth. At times he emitted sounds which resembled grunting, humming, clicking or coughing, and throat-clearing. His thinking was somewhat tangential and he acknowledged having obsessional thoughts obliging him to move in a definite way, to emit sounds, to count objects, etc. He appeared depressed and his affect was flattened. He denied hallucinations or distortions of perception.

On the couch, B's tics would occasionally stop momentarily. He appeared rigid and inanimate which contrasted with a generalized muscular flaccidity that gave the impression of insufficient armoring throughout his body. His eyes were dull, inexpressive, and poorly mobile. The jaw was slightly tense and his mouth was closed in a lifeless expression. The thorax did not present much resistance to pressure although there was only minimal respiratory excursion. A slight ballooning of the abdomen on expiration revealed armoring of the diaphragm. The abdominal musculature was extremely soft and flaccid and he had abundant fat around the flanks. The pelvis was not rigidly held: when he kicked on the couch it was with an unexpected energy and strength, given his deadened appearance.

Therapy

On the couch B obeyed every one of my directions in a mechanical, contactless fashion. I was surprised then to see how quickly he understood my intentions and gave in easily to encouragement to show anger. This culminated in expressions of rage directed toward his peers who harassed him daily. He kicked and hit the couch with his fists while yelling, "Stop it!" The results were immediate: his general demeanor brightened and he felt subjectively better. This scenario

occurred repeatedly during the first ten sessions over a period of about two months. Outside the office during this time, B felt more freedom of movement. His tics diminished progressively, as did his incapacitating rituals. He began to go out of the house on his own, enrolling at an athletic club that he frequented with enthusiasm. The general appearance of severe somatic illness was diminishing.

He then admitted to me the presence of visual hallucinations centered on the figure of the devil. He said that to keep these away he had to subject himself to his incessant rituals of counting, repeating keywords, emitting vocal sounds, and making complicated movements and motor tics, all with the purpose of diminishing his tension and fear. He also admitted that he didn't say anything about this before because of distrust of me. B saw these thoughts, rituals, and hallucinations as a sickness that he wanted relief from. And he told me that he had not masturbated in more than a year, adhering to religious principles taken directly from his mother.

B resumed daily masturbation with a resulting sense of relief and a noticeable improvement of his mood. In sessions he felt more comfortable confronting his ideas about the devil. He previously had not trusted me enough and he was ashamed of revealing his thoughts. This was a feeling he had with everyone and it became clear that it was associated with the fear of being judged and abandoned because of his condition. His psychotic fantasy was of a continuous fight to avoid the devil who B felt compelled him to frightening "impurities," such as the thought of sodomizing God and behaving "badly." He also felt that the devil was making him feel a sensation of "wickedness" throughout his body. He fantasized sadistically squeezing and crushing the penis of God, which, when expressed on the couch by squeezing his own arms, hands, and legs, permitted him relief and a noticeable diminution of his motor tics and vocal tics.

Discussion

An appreciation of the energetic function of tics provides an explanation of this feature of Tourette's syndrome that remains unknown to contemporary psychiatry. Contained in every neurotic symptom are impulsive and oppositional defending forces. Tics are the result of the partial breakthrough into the somatic realm of forbidden,

unreleased impulses. Sexual impulses emanating from the core turn to rage when blocked by armor. The rage can only be partially discharged through motor and vocal tics. Emotion, because of armor, is blocked from perception. Consequently the individual's discharge is only in the somatic realm. Because he is not in *emotional* contact with the repressed impulses, and cannot discharge them with feeling, symptoms must continue with no hope of progress toward cure.

When practicing psychoanalysis and before discovering the biologic energy, Reich wrote of the treatment of a woman with "Psychogenic Tic as a Masturbation Equivalent" (4:180-198). In this patient masturbation brought about significant relief of symptoms. With the discovery of the functional identity between psyche and soma he stated "...that such spontaneous movements [tics] in the patients represented split off parts of the orgasm reflex" (5:310).

In B's case we saw improvement with the emotional expression of rage on the couch. This expression contained rage from both present- day, real life frustrations and from the deepest levels of his being. His tics and rituals diminished and he felt subjectively better. With masturbation his mood improved. The relief of symptoms and overall improvement came about as a direct result of the dissolution of somatic armor and the partial re-establishment of the flow of biologic orgone energy. The effects of this patient's treatment stand as further confirmation of the validity of Reich's discovery of orgone energy functions.

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