Chapter 10
Ingenious Regression: A Case of Hallucination

A woman of 60 had been in an assisted living environment for her entire adult life. Over the years she had consistently scored in the I.Q. range of 65 to 70. Such scores placed her in the category identified as “mild deficiency.” In the more antiquated I.Q. language, she would have been classified as retarded.

The mild deficiency designation meant that she could work at a job, especially if her tasks on the job were structured, and if they enabled her to perform in a repetitive and consistent fashion. And indeed, throughout her adult life, she was always employed in one way or another, within the context of a variety of programs that could be defined as “assisted abilities” programs.

This woman had two siblings, a brother and sister, who were never very involved in her life, and would only visit occasionally—a family interest on their part that was perfunctory. Her mother, age 97, was still living and surprisingly, quite active. She was a devoted visitor, and would escort this woman, her 60 year old daughter, home for holidays and for other special occasions.

This mildly deficient woman was hardly ever ill. In fact, her health was excellent, and she was quite proud of the fact that she had never missed a day of work. Her only identifiable problem was that she was obviously, and severely, dependent on her mother, and would make decisions only with her mother’s say so. All of her clothing, and all items and materials she needed, were provided solely by her mother.

Suddenly, at the age of 97, her mother died. She had expired in her sleep. After having been told of her mother’s passing, this woman became quickly withdrawn and depressed, and for the first time that anyone could remember, she stopped working.

“Devastating,” would be an apt adjective to reflect this woman’s state of being after she had been informed of her mother’s death. The loss was apparently so profound and her depression so deep, that she stopped eating, and would lie in bed, moaning. She was hospitalized and diagnosed with major depression.

Within one day of hospitalization, and even before any plan was made for medication, her depression lifted, and instead, she was floridly hallucinating. She began talking to the air as well as providing dialogue by answer.
The Initial Consultation

During the first consultation, she continued talking to, and answering the air, as well as relating to the examiner, and did it all with relative ease, and in the absence of any depressive mood. She never grimaced or in any other way showed any trace of schizophrenic mentation or behavior. The only exception with respect to psychosis, was the presence of the auditory hallucinations that, it seemed, had entirely usurped her psyche. Her depression was nowhere to be seen.

“He told me I’m ‘independent’; he said, ‘independent.’ And that I shouldn’t worry. And that I could take care of myself now. He said he was sure.”

This quote was a reference to the psychiatrist who initially conducted the intake interview. Apparently, what had occurred was that in an effort to reassure this patient and to try to be encouraging, the psychiatrist told her that now that her mother was deceased, that he was sure she could handle things herself. This psychiatrist’s thinking was that if the patient felt reassured about her abilities then perhaps she would feel less depressed or less lost.

Although the psychiatrist was trying to be supportive—commendable, no doubt—but as it turned out, not insightful. The problem was that the psychiatrist did not at all understand what had happened to the patient. The patient’s concern was about her lost object, her mother, upon whom she so depended. She was devastated that her mother was gone. For the patient’s entire life, her mother was the person upon whom she was dependent for anything and everything.

Although, in this initial consultation, the various events that had occurred since she learned of her mother’s death were reviewed, nothing could explain her dramatic shift, after she was hospitalized, away from depression and into a hallucinatory world. The only intervening and possibly important event seemed to be this exchange between the patient and the intake psychiatrist.

Applying the Symptom-Code

Without the use of the symptom-code to unscramble the mystery of her shift from depression to a psychotic hallucinatory state, it would have been extremely difficult to know where to start. Yet, by applying the symptom-code to this problem, the mystery instantly yielded.

It was assumed that the intake psychiatrist was the who. Of course this meant that the patient was angry with him, but that the anger was repressed. In addition, and parenthetically, the assumption was made that perhaps in the unconscious, retardation or even mild deficiency, are not relevant phenomena. Even those people who have lower I.Q. scores still demonstrate conventional psychological symptom formation. This implies that whatever psychodynamics operate to produce psychological-emotional symptoms in people of average or above I.Q.s, must also, by definition, operate with people of below average I.Q.s. Thus, symptom formation, it is proposed, only follows rules of the psyche – and not necessarily solely rules of biology.