

Regular Article

Cenesthopathy in adolescence

HISASHI WATANABE, MD,¹ TOSHIHIKO TAKAHASHI, MD, PhD,²

TAKASHI TONOIKE, MD,³ MAMI SUWA, MD⁴ AND KAORUKO AKAHORI, MD⁵

¹Department of Psychosomatic Medicine, Shiga Prefecture Adult Medical Center, Moriyama-city, Shiga,

²Health Science Division, Research Center of Physical Fitness and Sports, Nagoya University, ³Department

of Psychiatry, Nagoya Second Red Cross Hospital, ⁴Aichi Prefecture Mental Health Welfare Center and

⁵Center for Student Counseling, Nagoya University, Nagoya-city, Japan

Abstract

Psychopathological investigation was conducted on the basis of the clinical observation of 23 subjects whose cenesthopathic symptoms began before 30 years of age. This illness is called ‘adolescent cenesthopathy’ based on the specificity of this mental condition to the adolescent period. Adolescent cenesthopathy is compared to schizophrenia, depersonalization, sensitive delusion of reference and other symptoms. Outstanding features of adolescent cenesthopathy are shown from the perspective of its difference from schizophrenia in terms of the specific characteristics of the symptoms in this disease.

Key words

body dysmorphic disorder, cenesthopathic schizophrenia, cenesthopathy, depersonalization, endogenous–juvenile asthenic insufficiency syndrome, thought disorder, monosymptomatic hypochondriacal psychosis.

INTRODUCTION

It is well known that cenesthopathic symptoms are recognized in a wide variety of disorders¹ including not only: (i) cenesthopathy incidental to schizophrenia (cenesthopathic schizophrenia);² (ii) symptomatic cenesthopathy originating in organic brain disease;³ (iii) ‘transient course’ or types of cenesthopathy ‘responsive to specific drugs’;⁴ but also (iv) the cenesthopathy proposed by Dupré and Camus,⁵ which is dominated by bizarre cenesthopathic symptoms with a monosymptomatic course and may not be reduced to any other clinical entity. However, the monosymptomatic course has been questioned particularly from the viewpoint of understanding cenesthopathic symptoms in relation to depersonalization.⁶ Today, unsettled issues remaining to be resolved include the diagnostic positioning of cenesthopathy (i.e. whether it should be classified as the schizophrenic² or non-schizophrenic sphere)^{1,5–8} and understanding onset in relation to stage of life.

We have recently had the opportunity to be actively involved with patients who persistently complained of cenesthopathic symptoms and for whom a diagnosis other than cenesthopathy was impossible. Among these cases, we have reported on a group of adolescent patients^{1,7,8} and advocated recognition of the existence of ‘adolescent cenesthopathy’ as a clinical category. One may also note a few recent reports of monosymptomatic hypochondriacal psychosis with onset in adolescence, such as the study by Ulzen.⁹

As we have intensified our study of cenesthopathy in adolescence and contrasted it with schizophrenia, we have come to emphasize the peculiar characteristics of adolescent cenesthopathy.

SUBJECTS AND CASES

As in previous studies, subjects were selected based on the following three criteria.

1. Patients complaining of strange bodily sensations that are not simple pain or itching and are physiologically unexplainable. These patients are convinced of changes in their own body based on these sensations, and are persistent in seeking physical treatment. However, the following cases are excluded: (i) patients who have a basis for their

Correspondence address: Dr Hisashi Watanabe, 2-47-17 Motomiya, Otsu-city, Shiga 520-0804, Japan.

Email: hisasi-watanabe@mui.biglobe.ne.jp

Received 5 November 2001; revised 26 August 2002; accepted 1 September 2002.

complaints due to organic brain disease; (ii) patients who even for a short time had coexisting symptoms from which schizophrenia might be suspected (e.g. auditory hallucination and delusion of persecution); (iii) patients currently or previously dominated by depression; (iv) patients in the categories of chronic tactile hallucinosis and delusion of parasitosis; and (v) patients with somatoform autonomic dysfunction.

2. Patients with onset in adolescence. Here, we selected patients with onset before 30 years of age based on Kasahara's premise¹⁰ that adolescence generally extends to around 30 years of age.
3. Patients with whom we have been involved therapeutically over the long term and have observed for at least 3 years. We used the dialogue method¹¹ for psychotherapy. The direct pharmacotherapeutical

target was the unevenness in activity flows.⁸ Minor tranquilizers such as diazepam were mainly chosen. With the increase in this unevenness, major tranquilizers such as chlorpromazine were added in small doses. In contrast, pimozide⁹ and other drugs¹² are emphasized in monosymptomatic hypochondriacal psychosis. We selected the 23 cases shown in Table 1, which have been reported previously.^{7,8} We here present only one case, due to space limitations.

Case no. 18: Male, initial onset at 19 years of age

Before onset, while a junior high school student, this patient felt inferior and unmasculine due to his frail build. As a result, he joined a youth gang and indulged in violent behavior. After entering high school, the patient received good examination results and

Table 1. Cases of adolescent cenesthopathy

Case no. (C.N.)	Sex	Incipient age (years)	Chief complaints
1	Male	26	Nodule exists in left half of head; right half of head is not outlined and air blows through.
2	Male	23	Body moorings get loose. Backbone disappeared; Center pole of my body disappeared; My inner body is twisted. Both eyes straggle.
3	Male	19	Amorphous cool mass runs through body, a warm one splits out.
4	Male	22	Head and trunk are separated, snapping off at neck. Right half of head is filled, left half is hollow.
5	Female	20	A cotton-like hazy substance fills head, left half of body is hollow.
6	Female	19	Large cave in left half of my body. Left flank is stretched or hanging down loosened, head dangles down.
7	Female	20	Nodule exists in right half of head, left half is hollow. Body is divided into right and left.
8	Male	16	Tube is in head and straggles loosely.
9	Male	27	Brain hardens. Brain falls sloppily and is hollow.
10	Male	16	Backbone is out of position. Head receives a succession of shocks and itching.
11	Male	20	Head vibrates with a succession of shocks. Head is stretched.
12	Male	26	Head rocks around.
13	Male	16	Head is hollow and stretched about the nose.
14	Male	22	Brain cells squirm and drop off. Muscles are involved in brain cells.
15	Male	25	Right side of head squirms limply. Spine disappears.
16	Male	24	Area about base of nose is stretched. A net-like object moves around in head, occasionally in entire body.
17	Male	19	Chest is hollow with no bottom. Something turns around in hollow chest.
18	Male	19	Abdomen is hollow and gets twisted complicatedly.
19	Male	18	Body spreads limply and hangs down in abdomen and stomach, reaching down to buttocks. Left side of abdomen is clogged and right is hollow.
20	Male	19	Body is loose and hanging from the eye through the waist.
21	Male	26	Muscles melt down from neck to abdomen. Body crumbles and drops down slovenly.
22	Male	21	String is in head and is cut off with a snapping sound.
23	Female	18	Nodule exists in left upper area in head and chest is hollow.

absorbed himself into his studies. His relationship with his classmates deteriorated as his grades gradually improved, and he became concerned only about his student/teacher relationships. About half way through senior high school, he became hypochondriacally concerned with his stomach in conjunction with falling grades, but recovered following admission to a university. As first-year final examinations approached (at 19 years of age), he began to complain of cenesthopathic symptoms such as: 'My abdomen is twisting wildly and feels hollow. The hollowness is obstructed here (throat), squirms here (chest) and here (buttocks), my back feels pulled tight and the left side of my chest is cramped.' The hollowness expanded throughout the space of the trunk from the throat to chest, and back to the left side of the chest and buttocks, but this same space was localized as though by resistance to the expansion. This feeling of resistance was exemplified in the expressions of 'tightness' and 'cramped.' The patient's complaints were described vividly and with a sense of movement in the phrases 'my abdomen is soft and twists', and 'squirms.' In the initial stage of treatment, the patient only complained of cenesthopathic symptoms, but as treatment progressed he developed other complaints such as: 'My very core has been destroyed by all the twisting and squirming of my abdomen. I have no reason to live.'

RESULTS

Clinical statistical characteristics

The onset age distribution was as follows. Onset extends from 16 to 27 years of age with a mode of 19 years, a median of 20 years and a mean of 20.9 years of age [$SD = 3.4$ years, $\alpha_3 \approx 0$, $\alpha_4 < 3$, $\alpha_3 < b_1$ (23, 0.05), $\alpha_4 < b_2$ (23, 0.05)]. These findings indicate that the population distribution of these cases is a near symmetrical platykurtic normal distribution peaking at late adolescence¹⁰ (20.9 years of age) and attenuating bidirectionally towards early adolescence¹⁰ and pre-adult¹⁰ ($P < 0.05$).

The 23 cases included 19 males [82.6% (p: 64.5–93.8% ($P < 0.05$))] and four females [17.4% (p: 6.2–35.5% ($P < 0.05$))], $\chi^2 = 9.782 (> \chi^2_i(0.005))$, $F = 3.8 (> F_{10,38}(0.005))$. There appeared to be a sexual difference related to onset ($P < 0.01$).

The four body parts subject to complaint are classified as the four regions of the head, chest, abdomen and limbs. The regions stressed as 'being always central'⁵ by Dupré and Camus were the head in 19 cases (82.6%), trunk in four cases (17.4%; i.e. abdomen in three cases (13.0%) and chest in one case (4.3%)), and no cases reported for the limbs.

Cenesthopathic symptoms

Characteristics of body parts and physical changes

Complaints of physical changes are shown in Table 1; the characteristics are clear. Complaints include: 'It's hollow' (C.N. 6, 9, 13, 17, 18); 'It's hollow on this side and there's a mass on the other side' (C.N. 7, 15); and the experience of uneven distribution of hollowness and mass with the body divided into left and right sides (C.N. 1, 2, 5) or upper and lower (C.N. 4). Other complaints include 'I have no spine' (C.N. 2, 15); 'The tube is stretched and loose' (C.N. 8); 'I've come unglued' (C.N. 2); 'Collapsing and falling apart' (C.N. 2, 6, 9, 18, 19); 'drooping' (C.N. 19, 20); 'twisting' (C.N. 2, 18); and 'vibrating' (C.N. 10, 11, 12). It should be noted that the body parts in these complaints are stated without regard to anatomical sequence and may be more appropriately called 'functional physical space.' Many patients described various types of 'experiences of hollowness.' In contrast, the complaints of hypochondriacal delusion observed in schizophrenia, which means the decaying collapse of existence as 'putrefying in a recondite body', and becoming inorganic and sandy as 'collapsing in pieces', and which may be mistaken for the experience of hollowness and relaxation in adolescent cenesthopathy, were not encountered in cases of adolescent cenesthopathy at all.

Body parts related to physical change and feeling of insufficiency

As treatment progressed, patients complained of a feeling of mental insufficiency closely linked to the complaints about body parts. This advanced stage of treatment is reached after about 3–5 years. One patient initially made repeated and persistent physical complaints such as 'My spine is gone; I have no center', and as treatment progressed he began to complain of a feeling of insufficiency in his existence (lack of mental support for self) through his complaints of lacking a physical center (e.g. 'Since I have no center, I'm collapsing' and 'Because I have no center, I'm not human' (C.N. 2)). Other patients complained of feelings of physical change such as 'My head and torso have separated with a snapping sound', 'Even when I think and have a purpose I cannot act. I cannot act unconsciously, and my body will not move unless I make sure of each action' (C.N. 4, 21). Feelings of physical change relating to relaxation such as 'slackness', 'I've come unglued', 'falling apart' and 'drooping' correspond to mental laxness (C.N. 2, 6, 8, 9, 18, 19, 20). Other patients suffered from an unstable imbalance and complained of the existence of a mass, or uneven distribution of hollowness and mass. Some examples include 'It's hollow on

this side and there's a mass on the other side', and 'My swollen stomach is divided into two halves that twist and turn to the left and are blocked at the pit of the stomach.' A labile instability was also reported (C.N. 1, 7, 15, 19). One patient suffered 'mental hollowness' and complained of a 'hollow chest' (C.N. 17). Another patient was influenced and shaken by his surroundings and complained of 'feeling vibrations in my head' (C.N. 10). In adolescent cenesthopathy, body parts perceived as having physical change are important not only in terms of localization,⁵ but are also closely related to feelings of mental insufficiency.

Bipolarity of cenesthopathic symptoms

Cenesthopathic symptoms in adolescent cenesthopathy have distinct boundaries and are vividly descriptive with a sense of movement. Although such symptoms appear superficially disordered, they can be arranged between two poles under close observation. One pole has a tension element, as when complaining of 'being cramped', whereas the other pole has a looseness element, such as 'coming unglued.' For example, one patient said 'I am loose and drooping from my eye to my waist, with my eyes hanging down' and posed as though holding up his eyes with both hands during the examination. This patient complained of cenesthopathic symptoms such as 'I am unglued, loose and drooping' and 'I am lifted up from legs and buttocks, my groin is cool and I feel good' (C.N. 20). What is more worthy of note is that these two poles are 'antagonistic.' That is, on one hand are the cenesthopathic symptoms of looseness such as 'coming unglued', 'falling apart' and 'spreading hollowness.' On the other hand, one observes the opposite cenesthopathic symptoms of tension such as 'stiffening versus loosening', 'lifting versus drooping' and 'condensing versus scattering.' Even the complaint of 'twisting' is antagonistic to the 'body divided into left and right sides' and to 'becoming wildly chaotic' (C.N. 18, 19). Looking at all cases, there were many complaints of 'cramping', which expresses an antagonism to 'relaxation and looseness.' The two types of cenesthopathic symptoms comprising relaxation and tension are closely linked to the progressive course. For example, one patient made complaints such as 'It's mushy from here (right temporal) to here (neck, shoulder and back)', 'It's pulled tight and clinging' and 'My spine is gone.' This patient speaks figuratively of an amoeba-like movement of 'mushiness' and refers to it as a movement condition, whereas he refers to the 'stretched and clinging' state as a stationary fixed condition. He says, 'These two feelings go back and forth in intensity, but I like the fixed condition as being more relaxed.' Thereafter, he says, 'I've gained

confidence because my missing spine is back' and, at the same time, the body parts he complained about were reduced to the right side of his head, although the predominance of the tension-type cenesthopathic symptoms such as 'cramping' continued (C.N. 15). The cenesthopathic symptoms that are observed in schizophrenia, including symptom-deficient-type schizophrenia, which have unclear boundaries, lack movement and may be vaguely described as 'scattering', 'transmitting', 'flowing' and 'running' were not encountered in cases of adolescent cenesthopathy.

Depersonalization symptoms

'Feeling of incomplete control'

The depersonalization symptoms accompanied by a sense of insufficiency found in adolescent cenesthopathy are experienced in the area of a patient's own feelings such as 'I cannot move without consciously thinking and being aware of every action' (C.N. 21) and 'I cannot control my own feelings because they are really unsettled' (C.N. 5). Another area relates to the connection between the patient and the outside world such as 'I'm clearly separated from my body and the real world. I cannot focus attention on the subject I'm working on' (C.N. 3) and 'When connections cannot be made logically one by one, they just fall apart' (C.N. 22). Another area relates to the patient himself, as in 'I have no center' (C.N. 5, 18). These experiences, however, differ from the feelings of alienation and unreality that are usually emphasized in depersonalization. Depersonalization symptoms in adolescent cenesthopathy relate to an insufficiency of self-control such as 'Since I don't have the strength to oppose outside pressures, my mind will become distracted and my body [will] become hollow unless I consciously restrain myself' (C.N. 6). Thus, these symptoms are appropriately called 'feelings of incomplete self-control'.

Complaints related to incomplete control of interpersonal distance and experiences mistaken for schizophrenic experience

Depersonalization symptoms, which are similar to those in social phobia (i.e. frequent fear of interpersonal relations), are the subject of complaints over the long term, including 'I don't blend in on different occasions, so I'm the only one who stands out' (C.N. 6, 23) or 'I feel like I'm floating away whenever I talk to people' (C.N. 1). These patients live out a vividly competitive relationship (i.e. an unmerciful relationship in connection with their fear of being overawed by and simultaneously becoming estranged from others), and

resist pressure from others. An example of such a complaint is 'I don't have the strength to resist my surroundings, so my mind is taken away even though I exist' (C.N. 1). Behind depersonalization symptoms in adolescent cenesthopathy is a feeling of insufficiency in interpersonal relationships. Mixed among these complaints are experiences very similar to those of schizophrenia such as 'When I listen to others talking, my own feelings are used up' (C.N. 3), 'My personality becomes separated from me when I'm in large groups' (C.N. 1) and 'I'm always tossed around by my surroundings' (C.N. 10, 11, 12). Complaints such as 'For a moment his mind enters mine', which can be mistaken for a schizophrenic experience such as 'blowing-in-thinking' or being 'made to feel an experience' are called the 'transfer' or 'trans-enter experience' as distinguished from schizophrenic experience.

Functional insufficiency

We frequently hear complaints of physical functional insufficiency (e.g. 'The muscles are all melted from my neck to my abdomen and they sit so heavy in my abdomen that I can't concentrate on my work' (C.N. 21)). The patient feels that his physical changes are the origin of this functional insufficiency, and that this feeling is responsible for his state of dissatisfaction with self. In contrast, many complaints are closely related to a feeling of incomplete self-control such as 'I'm a klutz because my head is hollow' (C.N. 23). These complaints are just a somatized form of a deep feeling of incomplete self-control and, as such, are suitably included in that category rather than under physical functional insufficiency.

Strangeness of behavior, way of communication and thought

Strangeness of behavior

Patients vigorously complain of subjective pain related to the change in parts of their bodies, but one must not overlook the objective strangeness, unnaturalness and lack of skill apparent in their behavior, gestures and actions. For example, one patient who complained, 'My face is crushed by a feeling of pressure and there is a mass in my head', walked with fearful little steps, stiff shoulders and little hand movement as if to confirm each step (C.N. 7). Other patients said, 'I've lost my balance' and strangely twisted the upper half of their bodies (C.N. 2, 6). Another patient complained, 'I'm hollow and drifting into the air' and 'I have a mass that makes me heavy so I can't move quickly.' This person walked with deliberate steps and legs wide apart (C.N.

18). The patients who complained, 'I have no spine' and 'I am loose and drooping from my eye to my waist, and there is no space between my legs' waited for their interviews by lying on a sofa in the waiting room (C.N. 15, 20). The sheer strangeness of behavior in adolescent cenesthopathy as a whole produces feelings of tension in patients accompanied by conflict about controlling their body. It should be mentioned in passing that the sense of decaying collapse without intertwining over the situation in bizarre behavior of schizophrenia was not recognized in any cases of adolescent cenesthopathy whatsoever.

Strangeness in communication

Strangeness has also been observed in interviews. One patient who complained, 'I can't control myself; I don't know moderation' spoke constantly and ignored the therapist or remained silent during the interview (C.N. 5). Another patient who complained of being unable to get himself together repeatedly asked the therapist to explain the meaning of the question (C.N. 3). We observed many patients who described their condition while gesturing with their palms first held flat, then on the vertical, or seeming to write on paper to make the therapist understand, which indicates their difficulty in grasping the matter under discussion in interpersonal exchanges (C.N. 1, 3, 5, 18, 21, 23).

Strangeness of thought

In adolescent cenesthopathy, many instances have been observed wherein abstract content is caught concretely (e.g. 'cavity' for 'hollowness' (C.N. 6, 9, 13, 17, 18) and 'spine' for '(support) column' (C.N. 2, 15)). These relationships are readily understood by inserting 'as if.' For example, we can understand 'I have no spine' as experiencing a lack of mental support 'as if' he lacked a spinal column. The complaint of 'my head is hollow' expressed by one patient corresponds to an expression such as 'my mind is blank, and I can't think clearly' (C.N. 1).

Tendencies of personality and interpersonal relations

(i) Intellectual impairment was not observed in all cases. (ii) The personality as a whole tended to be timid and reverse-assertive persistent, and resembled the personality tendency of sociophobes. (iii) None of these cases belonged to a category of specific personality disorder or their mixed type. (iv) Tension-type symptoms in interpersonal relations were observed in all cases before onset of cenesthopathic symptoms. (v)

There was a tendency to avoid difficult interpersonal relations through an excessively adaptive ‘as if’ lifestyle to conform to expectations and win praise from others (C.N. 18, 22) and a ‘competent intent’ lifestyle through absorption in studies, work or sports (C.N. 21, 23). This last tendency may be an important factor in delaying the age of onset of adolescent cenesthopathy compared to the case of social phobia.

DISCUSSION

Structural analysis of cenesthopathic symptoms

To assist in the management of the descriptive and phenomenological level of the various cenesthopathic symptoms encountered, we would like to emphasize the utility of the following viewpoints: (i) The bipolarity of ‘relaxation-type’ and ‘tension-type’ cenesthopathic symptoms; (ii) antagonistic rivalry between both poles of cenesthopathic symptoms; and also (iii) bidirectionality comprising ‘centrifugal’ and ‘centripetal’ directions producing these polarities of ‘relaxation-type’ and ‘tension-type’ cenesthopathic symptoms; and (iv) the ‘dialectical’ relationship between these two directions. For example, the relaxation-type cenesthopathic symptoms (e.g. ‘being loose’) can be understood as maintaining equilibrium with the centrifugal directionality predominant in the dialectical relationship between the centrifugal and centripetal polarities, whereas the tension-type cenesthopathic symptoms (e.g. ‘tight’) can be understood as maintaining equilibrium with the centripetal directionality predominant. The dialectic of centrifugal and centripetal directionalities basically allows cenesthopathy to exist as itself, and the body parts have clear boundaries in adolescent cenesthopathy and are typically vividly described by a sense of movement.

Psychological particularities in adolescents and specific symptoms mistaken for schizophrenic experience

Adolescent cenesthopathy can be summarized in the following three points. (i) Patients with adolescent cenesthopathy are not only preoccupied with simple physical change, but also suffer a feeling of mental insufficiency due to their sense of physical change; (ii) The feeling of mental insufficiency seen in adolescent cenesthopathy is related to the hollowness and uncertainty of the patient’s own existence (self-existence); (iii) Strangeness of thought has been observed and is believed to be an important factor in transforming the feeling of mental insufficiency into strange physical experience.

Psychological particularity in adolescence

The hollowness and uncertainty of self-existence and the insufficiency of self-control have the following aspects: (i) the difficulty for patients to be themselves; (ii) the difficulty for a patient to accept him/herself in relationships such as between the patient and outer-operating objects and people, or between the patient’s own intentions and actions; and (iii) the difficulty in resisting pressure from others in interpersonal relationships. These types of insufficiency are common to the feeling of insufficiency in social phobia, and are particular feelings of insufficiency in adolescence related to uncertainty or missteps in earning a place as a member of society. In contrast, the feelings of insufficiency suffered after 40 years of age are concerned with threats to an already established foundation of social existence, such as the feeling of insufficiency shown in cases having an onset peak in this time frame among those having a sensitive delusion of reference.¹³ We regard adolescent cenesthopathy as a specific pathological state in adolescence, which manifests in cenesthopathic symptoms, feelings of insufficiency and depersonalization. Furthermore, the distribution curve of age at onset of adolescent cenesthopathy indirectly supports our contention that onset is concentrated in adolescence. One reason that we selected cases with onset prior to 30 years of age, besides Kasahara’s assertion,¹⁰ is the tendency of the age of onset of adolescent cenesthopathy to be delayed.

‘Trans-enter’ experience

The trans-enter experience is an experience ‘as if’ the patient’s hollowness and weakness of self-existence is taken advantage of, and can be understood by inserting ‘as if.’ Trans-enter experience is closely related to the difficulty the patient experiences in being him/herself. In contrast, schizophrenic experience such as ‘blowing-in-thinking’ and artificial experience are based on an anastrophic structure,¹⁴ in which experience starts from a transcendental point over self and is manifested in the patient’s body as the activities of imaging and thinking, whereas the origin of experience is within oneself in adolescent cenesthopathy.

Hiding of ‘as if’ thinking

Strangeness of thought in adolescent cenesthopathy originates in a condition wherein the ‘as if’ is hidden behind the experience, and can be readily understood by inserting ‘as if.’ The hiding of ‘as if’ thinking is paired with the ‘aiding of “as if”’ in which patients can just begin to describe strange experiences, such as ‘I feel as

though I'm looking through a thin film' seen in depersonalization. Strangeness of thought in depersonalization and adolescent cenesthopathy have a commonality related to 'as if' and accompanied by a difficulty in verbalizing experience. There is a possibility that the strangeness of thought found in adolescent cenesthopathy may belong to the same type of thought disorder as is found in depersonalization.¹⁵ Attention-concentration disorder in adolescent cenesthopathy is an impairment related to an unevenness in the activity flows,⁸ and is one type of disorder of distractibility.¹³ In contrast, in the thought disorder of schizophrenia, a metaphor such as 'as if' is not formed, but only experienced on the literal level. Moreover, attention-concentration disorder in schizophrenia carries a sense of indifference; the associations are interrupted, incoherent and dynamically feeble.

Psychopathology bordering on the other conditions

Non-schizophrenic pathology

Adolescent cenesthopathy has a commonality with sensitive delusion of reference¹³ in that the patients lament that they cannot control their own body, which is burdened by an insufficiency of self. These pathologies differ in whether or not the changed body is related to self. Similarly, adolescent cenesthopathy has commonality with depersonalization in that: (i) there is competitiveness within the patient himself;¹⁶ (ii) there is a structure in which the self is preoccupied with its own body similar to a tendency for convulsive self-observation¹⁷ in which the acting self intensely regards itself; and (iii) the patient has difficulty grasping the essence to behave skilfully in both situation and scene,¹⁸ although these pathologies differ in formed symptoms. In contrast, insufficiency related to self-existence in adolescent cenesthopathy is very similar to the 'loss of natural self-explanatory comprehension'¹⁹ in symptom-deficient-type schizophrenia. Surely, patients with these two pathologies commonly share the particular crisis in adolescence of missteps in gaining their footing in society at large. However, although patients with adolescent cenesthopathy become transfixed on 'individual occasions' resulting in difficulty being themselves, patients with symptom-deficient schizophrenia drop out from the 'absolute commonness' to transcend 'individual occasions'.

Endogenous-juvenile asthenic insufficiency syndrome

This syndrome²⁰ is very similar to adolescent cenesthopathy.²¹ However, although the strangeness of

thought and attention-concentration disorder in adolescent cenesthopathy differ from those in schizophrenia as previously described, Glatzel and Huber regard the weak concentration observed in this syndrome as a schizophrenic thought disorder.

Delusional Disorder, somatic type (DSM-IV) and Monosymptomatic Hypochondriacal Psychosis

Adolescent cenesthopathy is not to be classified as [297.10 Delusional Disorder, somatic type] even if one is sure that it is based on some bodily modification derived from a cenesthopathic somatic experience, as it is not a somatic delusion of being ill or deficient. In contrast, Monosymptomatic Hypochondriacal Psychosis (MHP) has an infestation group category including 'coenaesthopathia',²² signifying some cenesthopathic somatic experience or supposed form of existence. However, there is, as yet, no clinical entity for an independent category applicable to adolescent cenesthopathy patients.

CONCLUSION

Adolescent cenesthopathy is compared to schizophrenia, including symptom-deficient-type schizophrenia, depersonalization and sensitive delusion of reference. The dialectic competitiveness in cenesthopathic symptoms, feelings of incomplete self-control within the self of the patient and the hiding of 'as if' thinking are regarded as being different from schizophrenia. This pathology is called adolescent cenesthopathy in light of its psychological peculiarity in adolescence, which manifests in cenesthopathic symptoms, feelings of insufficiency and depersonalization.

REFERENCES

1. Watanabe H. Cénesthopathie. In: Matsushita M (ed.). *Encyclopedia of Clinical Psychiatry VI; Somatoform Disorder. Psychosomatic Disorder*. Nakayama-shoten, Tokyo, 1999; 195–208 (in Japanese).
2. Huber G. Die cönästhetische Schizophrenie. *Fortschr Neurol. Psychiatr.* 1957; **25**: 491–520 (in German).
3. Tsunoda M, Kurati M. A case of cenesthopathia showing high perfusion in thalamus by ¹²³I-IMP SPECT. *Seishin Igaku* 1992; **34**: 423–425 (in Japanese).
4. Kojima D, Endo S, Akiyama M, Takagi H, Mori T, Kuraoka Y. Therapy of cenesthopathia. *Clin. Psychiatry* 1986; **15**: 45–52 (in Japanese).
5. Dupré E, Camus P. Les cénesthopathies. *Encéphale*. 1907; **2**: 616–631 (in French).
6. Baruk H. Le sentiment de la personnalité — La dépersonnalization et la cénesthésie. *Ann. Med.-Psychol.* 1951; **109**: 393–407 (in French).

7. Watanabe H, Aoki M, Takahashi T, Oiso H, Murakami Y, Matsumoto Y. 'Coenästhopathie' in Adoleszenz — Wahnhafte Erlebnisse in der Adoleszenz. *Seishin Igaku* 1979; **21**: 1291–1300 (in Japanese).
8. Watanabe H. Cenesthopathia. **In:** Shimizu M (ed.). *Today's Therapy of Neurosis*. Kongo-Shuppan, Tokyo, 1987; 219–228 (in Japanese).
9. Ulzen TP. Pimozide-responsive monosymptomatic hypochondriacal psychosis in an adolescent. *Can J. Psychiatry* 1993; **38**: 153–154.
10. Kasahara Y. Today's pathological phenomena in adolescence. **In:** Kasahara Y, Shimizu M, Ito K (eds). *Psychopathology in Adolescence*. Kobundo, Tokyo, 1976; 3–27 (in Japanese).
11. Kretschmer E. Moderne Probleme der psychotherapeutischen Methodik. **In:** Kretschmer W (ed.). *Psychiatrische Schriften*, Springer, Berlin, 1974; 140–145.
12. Phillips KA, McElroy SL, Dwight MM, Eisen JL, Rasmussen SA. Delusionality and response to open label fluvoxamine in body dysmorphic disorder. *J. Clin. Psychiatry* 2001; **62**: 87–91.
13. Kretschmer E. *Der Sensitive Beziehungswahn*. Springer-Verlag, Berlin, 1950.
14. Conrad K. *Die Beginnende Schizophrenie*, 3rd edn. Georg Thieme Verlag, Stuttgart, 1971.
15. Tucker GJ, Harrow M, Quinlan D. Depersonalization, dysphoria and thought disturbance. *Am. J. Psychiat.* 1973; **130**: 702–706.
16. Meyer JE. Studien zur Depersonalisation I. Über die Abgrenzung der Depersonalisation und Derealisation von schizophrenen Ich-störungen. *Mischer Psychiat. Neurol.* 1956; **132**: 221–232 (in German).
17. Schilder P. *Selbstbewußtsein und Persönlichkeitsbewußtsein*. Springer, Berlin, 1914 (in German).
18. Janet P. *L'évolution psychologique de la personnalité*. Maloine, Paris, 1929.
19. Blankenburg W. *Der Verlust der natürlichen Selbstverständlichkeit, Ein Beitrag zur Psychopathologie symptomarmer Schizophrenien*. Ferdinand Enke Verlag, Stuttgart, 1971.
20. Glatzel J, Huber G. Zur Phänomenologie eines Typs endogener juvenil-asthenischer Versagenssyndrome. *Psychiatr Clin.* 1968; **1**: 15–31 (in German).
21. Takahashi T, Oiso H, Aoki M, Watanabe H, Matsumoto Y, Fujita O. Phenomenology on a type of endogenous juvenile asthenic insufficiency syndromes. *Jpn. J. Adoles. Psychiatry* 1992; **2**: 103–118 (in Japanese).
22. Reilly TM. Monosymptomatic hypochondriacal psychosis; presentation and treatment. *Proc. Royal Soc. Med.* 1977; **70** (Suppl. 10): 39–43.