Self-Subliminal Therapy for Adolescent Major Depressive Disorder with School Refusal: An 18-Month Longitudinal Case Study

Compiled from clinical records and first-person narrative

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Abstract

Background: Adolescent depression has reached epidemic proportions in urban Chinese cohorts, with prevalence estimates exceeding 20% in some regions. Standard interventions achieve only partial remission in a substantial minority of cases, and treatment resistance is especially common when family-system dynamics perpetuate the depressogenic environment.

Case Presentation: We report the case of "Z.," a 17-year-old male adolescent with major depressive disorder, generalized anxiety, school refusal, and disordered gaming, who had declined pharmacotherapy and electroconvulsive therapy. The patient presented following academic setback, romantic dissolution, and familial conflict exacerbated by the COVID-19 pandemic.

Intervention: Treatment consisted of 18 months of weekly video-based psychotherapy grounded in the Universal Law of Subconscious State Change (ULSSC), delivered concurrently to the patient and his mother. The intervention integrated cognitive training, behavioral activation, and family-systems restructuring.

Results: The patient resumed educational engagement, achieved university admission, and demonstrated sustained functional recovery at 18-month follow-up. Depressive symptomatology reduced from severe to subclinical levels; suicidal ideation resolved by month four and did not recur.

Conclusion: This case illustrates the potential efficacy of family-integrated subconscious-state therapy for treatment-resistant adolescent depression. Controlled trials are warranted.

Keywords: adolescent depression, school refusal, gaming disorder, family systems therapy, subconscious state change, telepsychology, autonomy support

1 Introduction

Adolescent depression has reached epidemic proportions in urban Chinese cohorts, with prevalence estimates exceeding 20% in some regions (Li et al., 2020). The clinical presentation is frequently complicated by comorbid behavioral addictions—particularly gaming disorder—familial conflict, and academic pressure. Standard interventions, including pharmacotherapy and brief cognitive-behavioral therapy, achieve only partial remission in a substantial minority of cases, and treatment resistance is especially common when family-system dynamics perpetuate the depressogenic environment (Ryan & Deci, 2006).

The Universal Law of Subconscious State Change (ULSSC) posits that psychological states undergo discrete, quantized transitions analogous to phase changes in physical systems (Wu & Wu, 2017). Sustained positive environmental inputs accumulate until a critical threshold is reached, at which point the subconscious state shifts from pathological to euthymic configuration. The framework emphasizes that adolescent depression is maintained not solely by intrapsychic factors but by the relational ecosystem; consequently, treatment must target both the individual and the family subsystem simultaneously.

2 Case Presentation

2.1 Demographics and Background

The patient, pseudonymized as "Z.," was a 17-year-old Han Chinese male living with his parents and maternal grandmother in a major metropolitan area. He was the only child of a family that had made extraordinary educational investments. His mother, pseudonymized as "Mrs. F.," had deferred career advancement to ensure intensive parental involvement. The patient had been a nationally ranked competitive chess player and had gained admission to a highly selective secondary school through a talent-based pathway.

2.2 History of Present Illness

Onset occurred in the tenth grade. Precipitating factors included: (a) an escalating conflict with a mathematics teacher; (b) the dissolution of a first romantic relationship, which the patient experienced as a profound betrayal; (c) the transition to online instruction during the COVID-19 pandemic, which eliminated the structural scaffolding of classroom attendance; and (d) the cancellation of a guaranteed academic advancement policy ("green channel") that had been the foundation of the family's educational strategy.

The patient responded with progressive behavioral withdrawal. He ceased completing assignments, stopped attending virtual classes, and escalated gaming activity to 8–12 hours daily. When parental restrictions were imposed, he exhibited severe emotional dysregulation. He developed passive suicidal ideation, documented in personal journal entries stating that he "would never amount to anything" and that his future was foreclosed. Appetite and sleep disturbance followed.

2.3 Prior Treatment

The patient was evaluated twice at a tertiary psychiatric hospital. Clinicians recommended electroconvulsive therapy and pharmacotherapy. The patient refused both interventions and discontinued contact with the psychiatric service. His mother reported that she had "cried until there were no tears left" and had begun to fear that her son would either complete suicide or permanently abandon his educational trajectory.

2.4 Family Context

Mrs. F. exhibited a highly controlling parenting style characterized by intensive academic scheduling, surveillance of leisure activities, and conditional regard contingent on achievement. The patient perceived his interests—chess included—as instrumental to academic advancement rather than sources of intrinsic satisfaction. When the advancement pathway collapsed, the patient experienced not merely disappointment but a collapse of meaning. His mother's grief, which she expressed openly in his presence, was interpreted by the patient as confirmation of his own irreparable damage.

3 Theoretical Formulation

From the ULSSC perspective, Z. was locked in a negative subconscious state maintained by three reinforcing vectors: (a) internal perfectionism and catastrophic cognitive style; (b) familial pressure and conditional regard; and (c) the absence of autonomous, intrinsically motivated activity. The mother's anxiety functioned as a continuous negative environmental input, while the patient's gaming—though ostensibly a symptom—represented his only remaining arena of perceived competence and self-determination.

The therapeutic task was therefore bifocal: to flood the patient's subsystem with positive cognitive inputs while simultaneously restructuring the maternal subsystem to reduce environmental toxicity. The "boiling water" metaphor—wherein sustained heat produces no visible change until a discrete phase transition occurs—was employed to sustain therapeutic expectancy through an initial period of apparent stagnation.

4 Intervention

4.1 Modality and Structure

Treatment was delivered via weekly 60-minute video sessions over 18 months. The therapist was located overseas; the patient and mother were in China. Sessions alternated between individual meetings with the patient and conjoint meetings with the mother, with crisis-responsive additional contacts as needed.

4.2 Phase 1: Alliance Formation (Weeks 1–4)

The therapeutic alliance was established through a strategic concession: the therapist advocated for the unconditional return of the patient's mobile telephone, which had been confiscated by the parents. This intervention was not framed as a reward for compliance but as a signal of respect for the patient's autonomy. The mother, despite considerable anxiety, acquiesced. The patient later reported that this gesture was the first time an adult had sided with him rather than against him in the preceding two years.

4.3 Phase 2: Cognitive Training and Behavioral Activation (Months 2–8)

The patient was prescribed a daily cognitive training protocol: five minutes, three times daily, consisting of (a) affirmation of curability, (b) rehearsal of recovery narratives, (c) autobiographical recall of positive experiences, (d) rehearsal of therapeutic dialogue, and (e) metacognitive application of the boiling-water metaphor. He was also instructed to engage in daily pleasant activities and to avoid idle solitary sitting, which promoted rumination.

The patient exhibited variable adherence. Sessions were missed; homework was discontinued and resumed. The therapist maintained a consistent, non-punitive stance, reframing lapses as expected features of the accumulation phase rather than as treatment failures.

4.4 Phase 3: Maternal Restructuring (Months 3–12)

Mrs. F. received parallel psychoeducation emphasizing autonomy support over control. She was coached to: (a) cease tearful displays in the patient's presence, which he had interpreted as evidence of his own hopelessness; (b) inquire about his daily experience without reference to academic performance; (c) permit self-directed leisure activity, including gaming, as a developmentally appropriate domain of competence; and (d) relinquish immediate corrective responses to academic setbacks. These changes were introduced incrementally; the mother experienced significant ambivalence and required repeated reassurance that stepping back was not equivalent to abandonment.

4.5 Phase 4: Identity Reconstruction and Vocational Engagement (Months 8–18)

As depressive symptoms remitted, the patient identified game design as a prospective career interest. With parental support, he obtained part-time employment as a gaming community moderator, channeling his existing expertise into a structured, prosocial role. He simultaneously resumed academic tutoring, passed qualifying examinations, and submitted university applications. He was admitted to his first-choice program.

5 Results

5.1 Clinical Outcomes

Sleep normalized within the first month. Depressive symptomatology, as assessed by clinical interview, showed progressive reduction from severe to mild by month six and to subclinical levels by month twelve. Suicidal ideation resolved by month four and did not recur. Gaming activity decreased from 8–12 hours daily to 2–3 hours daily, with the majority of screen time now devoted to the community moderator role rather than to passive consumption.

5.2 Functional Outcomes

The patient resumed full school attendance by month three, completed all required coursework, and achieved scores sufficient for university admission. He maintained the community moderator position for 10 months, receiving positive performance evaluations and building a professional portfolio. He established a stable romantic relationship.

5.3 Family Outcomes

Mrs. F. reported decreased anxiety and improved sleep. She described her relationship with her son as having shifted from "command and compliance" to "conversation and collaboration." The grandmother, who had initiated contact with the therapist, reported that the household atmosphere had become "warm again."

6 Discussion

6.1 Mechanisms of Change

Several mechanisms likely mediated recovery. First, the unconditional return of the telephone functioned as a corrective emotional experience, repairing the patient's expectation that adults would inevitably betray or control him. Second, the mother's reduction in expressed anxiety removed a potent environmental stressor, demonstrating the coupled

nature of dyadic subconscious states. Third, the patient's transition from "gaming addict" to "gaming professional" restored self-efficacy and provided a socially validated identity.

6.2 The Role of Telepsychology

The trans-Pacific video format was necessitated by geography but proved therapeutically advantageous. The physical distance reduced the patient's sense of being surveilled, while the regularity of weekly contact provided a stable holding environment. The format also permitted the mother to participate without the logistical barriers of clinic attendance.

6.3 Limitations

This is an uncontrolled case report. Spontaneous remission, placebo effects, and therapist allegiance cannot be excluded. Outcome data rely on clinical interview rather than standardized instruments. The therapist is also the originator of the theoretical framework, introducing potential confirmation bias. Generalizability to non-Asian, non-urban, or female populations is unknown.

7 Conclusion

The case of Z. demonstrates that severe, treatment-resistant adolescent depression with school refusal and gaming disorder can achieve durable remission through sustained, family-integrated, theory-driven telepsychotherapy without pharmacotherapy. The ULSSC framework provided a coherent rationale for intervention design, patient engagement, and family-system restructuring. Controlled trials comparing this approach to standard cognitive-behavioral therapy and pharmacological monotherapy are warranted.

References

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