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Clinical and interventional implications in a chronic evolution. Disorganized schizophrenia

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Abstract:
Background*: Chronic paranoid schizophrenia involves over time moments of emotional decompensation, in which the person in question, overlaps manic coloring over all the implicit symptoms of positive, negative dimensions and disorganization.*
Materials and Methods*: The methods used were the initial psychological evaluation, the progressive one, the structured and unstructured clinical interview, psychoanalytic psychotherapy cure, periodical psychiatric evaluation and treatment monitoring, psychoanalytic interpretations, analysis of transference and countertransference dynamics, the transgenerational analysis, the analysis of his social functioning, psychological monitoring, as well as the psychiatric treatment.*
Results*: The present case exposes the psychiatric pathology of a 56-year-old patient, in whom the disease started around the age of 20, the one in question being partially treated. It presents a multiple fragmentary delusional ideation based on pseudo-reminiscences gathered from memories of his youth and cryptomnesia, along with fantastic and dreamy conspiracies. The shift to the affective pole of paranoid schizophrenia is felt from the joviality and exaltation both ideational and emotional. Social functioning is severely affected, the patient losing the coherence of her actions and actions. To these is added the social dimension of the case, the one in question has lost its home and no longer has a social support network. As defense mechanisms from the primitive psychotic register are involved: denial, projection and projective identification, the cleavage of the Self and the Self, found in delusional fragments, in the delusional idea of denying filiation and in the emotional inversion towards the family.*
Conclusion: *Suicidal behavior sometimes occurs in response to hallucinatory commands of self- or hetero-aggression. The risk may increase, being higher immediately after discharge or in the period following a psychotic episode.*
Key Word*: paranoid schizophrenia; prolonged evolution; positive phenomenology; delusional ideation of filiation; disorganization of thinking; impairment of social functioning.*

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I. Introduction

General data and context of the assessment

A 56-year-old female patient, unmarried and retired (for medical reasons), with psychiatric history had been admitted for five weeks at the moment the interview was taken. She showed up to the emergency ward with the following elements of semiotics: ideational and verbal incoherence, disjointed cognition, visual and auditory hallucinations as well as confabulations.

Given the severe auditory hallucinations, the medical team needed to be on the lookout for patient V.; therefore, her admission to the hospital became necessary. The patient came to the hospital voluntarily and consented to the admission. Nevertheless, she does not acknowledge her previous psychiatric diagnosis.

Regarding her family, it is known that both her parents died, the father in 1992 and the mother in 2008. Also, the patient has two siblings, but further information about their history is not accessible.

V. was married to a man but divorced him in 2001. They have a daughter born in 1987.

The relationship with her family is seriously flawed – she considers her brothers imposters, and she has not been in touch with her daughter for two years.

We presume that Mrs. V. had a miscarriage – possible trauma that further reflects strongly in the patient's symptomatology (taking into consideration the political status of Romania at that time, the communist regime might have forced her into an illegal abortion, or she suffered miscarriage).

Regarding her school record and academic pathway, the patient finished high school in 1975. She took the Baccalaureate a year later – major life event with potential high impact on the outburst of her mental illness.

The patient's disorganized speech reveals contradictory aspects regarding her academic history. On the one hand, she claims that she studied foreign languages at the University of Bucharest. On the other hand, she argues that she used to be a high school student and a third-year medical undergraduate at the same time. These aspects are not possible, neither logically nor chronologically.

The academic aspirations together with the intellectual concerns of the patient (that build up her rich general knowledge) are, at the moment of the interview, the background for her confabulations: she speaks about famous people of the time, such as heads of states – George W. Bush, bishop of Rome – Pope Saint John Paul II, close family relationships with international artists – Richard Chamberlain, Michael Jackson, Julio Iglesias. Furthermore, she mentions having received international prizes for Arts and Journalistic writing – Oscar and Pulitzer. Also, she proudly talks about her collaboration with Leon Levițchi (a famous Romanian philologist).

Spending an important part of her life under a communist political regime, Patient V., like many other Romanians, suffered oppressions. These are possibly actually existing experiences, amplified now, molded into ideas of persecution linked to the presidential family.

V. then stems the flow of abuse that she suffered and vividly describes being physically hurt – these claims are also delirious ideas of persecution.

Regarding the patient's career, the interview reveals a proven fact: V. started working (in an employment record book) ever since the 4th of October 1976, as a technical designer (fact confirmed by legal documents). Now, the patient is retired for medical reasons and has a health insurance.

Psychiatric History

Taking into consideration the patient's psychiatric interview as well as previous medical data, the apparent onset of her Schizophrenia can be identified around the age of 18-19 years old, while V. was a senior high school student. The triggering event might be a possible academic failure, which led to her taking the Baccalaureate a year later than she was supposed to. On this ground, she was not able to get into University as she wished.

Another highlight of the current psychiatric interview is V's narration about her assumed time as a medical undergraduate: she describes being an intern and dealing with the most difficult cases at a Psychiatry hospital in Romania. A plausible interpretation for these statements is the patient actually reckoning her first psychiatric admission.

Also, there are medical documents attesting that in July 2011, V. was admitted to a Psychiatry hospital in another town, after the police found her exhibiting a bizarre behaviour at the train station. She was found on a platform, cursing people at random and being aggressive towards the others.

V. denies having ever been admitted. At the moment of the interview, we estimate that she was at her fourth psychiatric admission.

II. Material And Methods

In the present case, the methods used were the initial psychological evaluation, the progressive one, the structured and unstructured clinical interview, psychoanalytic psycho-therapy cure, periodical psychiatric evaluation and treatment monitoring, psychoanalytic interpretations, analysis of transference and countertransference dynamics, the transgenerational analysis, the analysis of his social functioning, psychological monitoring, as well as the psychiatric treatment.

III. Results

Perception

Literature emphasizes that pseudo-hallucinations are characteristic signs for Schizophrenia[1,2]. We identify these pathological phenomena also in the case of patient V.

Pseudo-hallucinations ("psychic hallucinations" or "non-psychotic hallucinations") are perceptions without receptors, not projected on the outside, but rather happening in-side the body ("in the head", "in the mind", "in the soul"). Although they do not trace the physiological sensory pathway, they belong to somebody exterior (they are exogenous).

In Mrs. V's speech, we remark multiple semiologically meaningful statements: "To lift my spirit, I always (ask) << Chocolate, tell Mom what you need to say>>, <<Mom, tell them everything, tell them that I am alive >>. And I know that he is alive". This is a dialogue that the patient holds inside of her with a phantasmal child, Chocolate, that she never actually found and whose birth was never registered. The pseudo-hallucinatory feature of these perceptions is accentuated by the patient's belief that they do are real– that her son exists, that he is alive and well.

Mrs. V then points out that she is married to Richard Chamberlain: "While dealing with amnesia, I was subconsciously talking to him and telling him all my sorrow (...) Voices are not heard in the head; there, we have only a gelatinous matter with many gyri and nothing can be heard there – they are heard in the soul".

We daresay that this interior voice is in fact the voicing of patient's thinking that tried, at that time, to make sense of her suffering.

On the background of her thinking, troubled in its entirety, V. attributes this echo to a significant person in her life – the husband – that she endows with an extraordinary care that he presumably has towards her, all the time, from a distance: "I haven't seen my gentleman for a year and a half (...) he brings me everything I need".

The patient's narrative also provides clues about experiencing visual hallucinations in the past. Mrs. V. talks about the phantasm child that he loved chocolate even before he was born: "When I was offering him chocolate, he liked taking it in his tiny hand." What is more, at the time and place of the real daughter's birth (validated through an inquiry), she describes auditory and visual hallucinations that she holds on to: "Chocolate was screaming in the new-born ward. He was screaming and he was right – I cannot forget him – Chocolate was thrown next to the window and his sister was thrown near the door". This pathological phenomenon is in sync with the patient's persecution delirium about the hospital where she gave birth. She vividly narrates that her surgeon was "a butcher" and the rest of the medical staff were "ignorant <<îngălați>>" (a neologism) that they "slaughtered her".

Attention

According to Predescu (1976)[1], attention disorders are not specific to schizophrenia and usually derive from other disorders. However, at the level of prosexic function, we notice that the patient has hyperprosexia under the ideational content of persecution and grandeur. Related to an episode nearing the onset of her illness, M.B. says in the inter-view: "I was on hunger strike because in apartment 84, I was treated like a slave by Ceausescu's servants", "My cousins of royal vine revolted against the inhuman treatment I was subjected to", related to a colleague who helped - and in whose arms he fell, he remembers that he called her "Poor Princess". In our interpretation, it is possible that all these details captured so well by the patient are part of the picture of a first psychotic episode spent near the actual onset of her illness.

Thinking

From a thematic point of view, schizophrenic delusional ideas come together around two major themes - persecution and grandeur. Among the persecutory themes, the most common are: persecution, poisoning, mental destruction, murder, jealousy, illness. The overestimation of one's own person within the delusion of magnification is more often manifested by delusional ideas of invention, political, mystical, erotic[1].

The MB patient cognitively presents qualitative (content) disorders, which take the form of both expansive delusional ideas: filiation, "Pope John Paul II, my godfather," "George W. Bush adopted me," " Michael Jackson sang with me for decades, from 1968 to 2010, we knew each other for a lifetime", "On my birthday (Michael Jackson) he was the first and did not come alone, but with Pope Julio Iglesias, who also baptized ",“ Pope Julio Iglesias invested heavily in me, first and foremost in law "), erotomaniac ("Richard Chamberlain is my husband"), as well as delusional depressive ideas: persecution (A murderer paid me he hit me in the head with a hammer and while I was fainting, he raped me"," CR hated me to death "," I was tormented"), of grandeur (" I received the hardest homework and the peak, I solved "," For everyone success, I received a house and a car (...) I did not have time to live in my Oscars, Pulitzer Prize "). These delusional ideas are permeated by the patient's entire personality, her values, and the entire motivational and affective system, including ideals and conceptions of the world and life. The delusional images and feelings evolve as a whole, forming a whole world that starts from people in reality (significant close people - A. and F.B., the patient's real parents, D.L., siblings, including well-known public figures). Such delusional ideas are a symptom of rank I for schizophrenia, they form a broader structure that presents a certain logic and internal consistency for the patient[3].

We also notice the idea of reading thoughts ("Listen to my thoughts"), which the patient would have acquired after a head operation performed by a paid assassin. Mrs. M.B. she thus feels a degradation of her own mind barrier, so that everyone in the world around her can have access to what is going on inside her mind.

Memory

In terms of memory, we notice as symptomatology the alienation of memories: "Was I hospitalized in Brașov? Another lie. " By believing that the events experienced do not actually belong to her, the patient denies her own identity, while also refusing her psychiatric diagnosis.

In terms of qualitative disorders, we report the patient's pseudomnesia. Thus, she relates in the psychiatric interview several scenes that have in the foreground Chocolate, the ghostly child: "I went to the

confectionery once a week and talked to him in English - the confectioner was outraged by this", "The baby he took me nicely by the neck, and with his right hand, when I took her by the hair (the nurse) I put her down. Chocolate was happy, he gave me a smile ". The patient also talks about her wedding to Richard Chamberlain in Madrid, remembers details about her godfather Julio Iglesias, reports that her husband, "my beautiful" was at the Vatican.

From a quantitative point of view, we identify hypermnesia in the speech: "all my documents remained in apartment 84 on X road".

Language

As Predescu[1] mentions, the content of language can become metaphorical, leading to the creation of new words. These neologisms give the impression that they are elaborated by the patient in order to be able to express the special, completely new feelings that appear during the schizophrenic process. In the case of patients with schizophrenia, neologisms have a certain meaning, which gives them some persistence. Thus, in the case of patient M.B., the use of the neologism "angled" is noticed, which fuses the name of the city of Galați, with the word "frozen", to give a new meaning. As I quoted from Predescu, the neologism constructed by Mrs. M.B. reflects a particular experience that is not in Romanian, being possible that this word also reflects its attitude towards the city of Galati. The only memory evoked in the speech related to this place is the opening of the Galati Iron and Steel Works, which also overlaps with the delusion of persecution related to the Ceausescu presidential family: "they didn't even give me a cup of water".

As mentioned in the literature[4], the language of the patient M. B. has a tangential character, noting frequent jumps from the concrete to the metaphorical. Her mind always goes tangent, the answers to some questions are not direct. Also, the patient's speech contains many details that she considers really relevant, even if in reality they are not: "all my documents remained in apartment 84 on X road", "Room 8", "I have worked at the TIMB Installations Trust from October 4, 1976 to February 2012".

The use of diminutives, for example "bumpy", "beautiful" is also typical of the language of schizophrenia. In addition, we notice the presence of soliloquy regarding language disorders in the case of schizophrenia, the patient addressing her phantom child: "Chocolate, what do you say?"

Although the method of investigation chosen for the analysis of the case of Mrs. M.B. is the interview, we note that the patient mistyped the last name of her phantom husband (Richard Chamberlain). We can consider this as a manifestation of the cognitive destruction of the patient.

Affectivity

The case of Mrs. M. B. has a peculiarity, namely - the expansive coloring in the affective plan. The patient does not show affective indifference, which results from the negative symptoms of schizophrenia, nor from affective ambivalence or lack of affective correlation with feelings. She creates vivid images for everything she tells - the birth in a hospital with poor hygiene, the smile of her son and how he conveys in his soul that he is well and still alive, as a child falls in love with the goodness of her husband (Richard Chamberlain).

Regarding the qualitative changes in terms of affectivity, the emotional inversion is obvious. According to Predescu[1], this is closely related to the loss of sympathy for family members and the lack of emotional relationship. Patient M.B. he has negative emotional reactions to family members, especially brothers: "Some impostors were not my brothers. I did research - they only came to me to eat and drink ".

The patient denies her parental parentage: the phrase "called F. B." invokes non-belonging to the maternal role of the natural mother. The delusional ideas of denial of parentage ex-tend to the father, whom she presents as her adoptive father.

Psychodynamic perspective on the patient's symptoms

Among the psychiatric symptoms analyzed previously, we notice the existence of a phan-tom twin sister, about whom the patient speaks: "I have a twin sister who looks exactly like me; she is the client of several psychiatric wards". It is remarkable that the patient M. B. endows this mirror of hers only with traits that she considers negative - addiction to sub-stances, mental illness, unacceptable erotic feelings.

From a psychodynamic point of view, the term splitting refers to the separation of aspects of the person and is often associated with denial and projection[5]. The patient M. B. denies her diagnosis and through all this, she reflects the unacceptable in herself in another duplication of it.

This phenomenon of twinning[6], in the case of Mrs. M. B. is built on the background of a contradiction between behavior and values. Thus, the patient at-tributes the consumption of alcohol and nicotine to the twin sister because her Supra Ego (which manifests itself in the form of hallucination related to her husband) would not al-low such behavior: "If the father of my children came and saw me that I put my hand on a cigarette, it

would give me a look that would freeze my hand. The sister has them with drugs. Could I do this during pregnancy? Not. She's addicted. "

Projection and denial as defense mechanisms, also described in the literature[7] are activated in the patient in question and in other circum-stances. We distinguish in her speech the episode of the meeting with Elena Ceaușescu. The discussion between the two, in the patient's projective vision, took place at the request of the First Lady: "Elena Ceaușescu invited me because a colleague wanted to marry a stranger."

Against the background of an unstructured thinking, a delusion of grandeur is built, meant to overcompensate both the fact that the parents were ordinary people and the fact that due to the probably early onset, the patient did not have access to a professional career she dreamed of. The delirium does not stop at the delusional experiences (wedding in Madrid with Richard Chamberlain, the embrace of Julio Iglesias, expertise in medicine, law and Turkish-foreign languages), but it transcends them, integrates them and organizes them in an entire inner world. In this dimension, M. B. is married, has children and is supported even today by Richard Chamberlain, Julio Iglesias is her godfather, who sup-ported her in realizing her potential throughout her life: "I learned Arabic to find my child. Leon Levitski, before the University of Bucharest, told me that I have to do what others have not done".

As a peculiarity of the patient's affectivity, we notice the metaphor of the duplication of significant people in her life, a mechanism developed in our opinion against the back-ground of her fear of not losing them. Thus, the biological parents are doubled by the adoptive parents, the godparents are two very well-known people, when her real child was born with whom she has not been in contact for two years, another child was born, undeclared, who still speaks to her in soul.

IV. Discussion

The Common themes of dissociative disorders are the difficulty of integrating past memories with self-awareness / identity and immediate sensations, as well as control of body movements. Indeed, they are considered psychogenic as origin, being associated over time with insoluble problems and troubled relationships. However, this category of dissociative disorders includes only situations in which physical functions are under voluntary control (ICD-10). Dissociation is characterized by the overlap and interference of states that can manifest as inner voices or by symptoms of passive influence[8].

From our point of view, patient M.B. it retains a certain sense of identity, projecting into another person only a core of characteristics considered negative. Through this phantom of the mirror (I have a twin sister; she looks exactly like me), the patient uses dissociation as a defense mechanism against an accumulation of traumas suffered, which she could not manage in their time. However, the patient does not allow herself to be dominated by the phantom twin personality, but rather projects it only outside her. Therefore, we choose the diagnosis of Schizophrenia.

Patient M.B. presents at the time of the interview two major diagnostic criteria for schizophrenia: delusional ideation (with particular themes of grandeur and persecution), dis-organized discourse with tangentiality against the background of an essentially disturbed thinking. Also, in the patient's hospitalization record we find auditory hallucinations, as another feature of schizophrenia (hallucinations being a major psychiatric reason for hospitalization).

According to the DSM-V[9], schizophrenia lasts for at least 6 months and includes at least one month with active phase symptoms. From the data collected, it appears that patient M.B. had the probable onset of the disease more than 35 years ago. At the same time, the interview through which we identified the patient's symptoms took place approximately 5 weeks after hospitalization, with antipsychotic treatment after which the patient did not recover completely.

Although several neurotransmitter systems have a role in the complex pathology of schizophrenia (synaptic availability of dopamine, glutamate metabolism and nicotinic activity)[10], modulation of dopaminergic signaling is considered the basis of pharmacological treatment of the disease[11].

The Pharmacology Treaty coordinated by Brunton[11] states that for schizophrenia and schizoaffective disorder in particular, the goal of antipsychotic treatment is to maximize functional recovery. This can be done by reducing the positive symptoms and implicitly decreasing their influence on the patient's behavior, but also (with a most modest impact) improving the negative symptoms and remedying the cognitive dysfunction.

The treatment is also applied in the acute phase - where the goal is to reduce agitated, disorganized or hostile behavior, but also in the maintenance stage - for stable patients, starting with the application of neuroleptics (for the antipsychotic effect). First, medicines can be used to reduce delusions and hallucinations (eg chlorpromazine, haloperidol, fluphenazine). Antipsychotics are divided into conventional antipsychotics (neuroleptics), mentioned above, and atypical antipsychotics that can be administered to the patient to relieve positive and negative symptoms and to improve cognitive impairment (eg Risperidone, Olanzapine, Ziprasidone, Clozapine). Anti-noradrenergic and antidopaminergic drugs may be used to relieve psychomotor arousal and agitation (eg Diazepam, Alprazolam, Clorazepate). It is necessary to consider the adverse effects of

each class of drugs and along the way to arrive at the administration of those that work best for the patient. In order to monitor the evolution of the treatment and the degree of functionality of the patient, clinical psychological examinations are required by applying sets of clinical tests at certain time intervals. Another useful recommendation would be to go to therapy sessions to help her build a new functional world and in accordance with external reality, but especially to accept the disease and understand the importance of treatment.

In the case of the patient, the risk of suicide seems to be low, because she does not have suicidal ideation and has no depressive symptoms.

V. Conclusion

Suicidal behavior sometimes occurs in response to hallucinatory commands of self- or hetero-aggression. The risk may increase, being higher immediately after discharge or in the period following a psychotic episode. The degree of danger seems to be low because the delusional ideation is rich, but it is recommended to monitor the patient.

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