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Paranoid schizophrenia with florid evolution and complete remission within ten years

Alexandra Geară[1], Raisa Constantinescu-Coban[1], Florin Mititelu[2], Simona Trifu[3]

[1]*Faculty of Psychology and Educational Sciences, University of Bucharest, Romania*
[2]*"Alex. Obregia" Clinical Hospital for Psychiatry, Bucharest, Romania*
[3]*"Carol Davila" University of Medicine and Pharmacy, Bucharest, Romania*

Abstract:
Motivation: *This paper aims to present the case of a patient who in youth showed extensive auditory and visual hallucinations, doubled by phenomenology in the paranoid spectrum of persecution, with the change of behavior in a bizarre psychotic sense, including an attempted suicide under the rule of florid symptoms.*
Objective: *Presenting how guardianship (under interdiction) was used as a formidable tool for the patient in question, who had also reached a high level of pre-morbid functioning (lawyer, family of intellectuals). Consequently, the legislature and its legal connotation, similar to the situation of involuntary hospitalizations, become a handy tool in introducing disease awareness and gaining insight.*
Results: *The case describes in detail the psychiatric examination, the results of a multiphase personality inventory and two projective tools (Luscher and Szondi) - which simultaneously investigate the conscious level, as well as the unconscious level of officials. After about 10 years of guardianship, the patient is functional, with daily self-administration of medication, the present hospitalization being the preamble in order to perform a new psychiatric forensic examination, which would allow the person to be removed from the ban.*
Conclusions: *Schizophrenia, when it occurs at a high level of intellectual development, does not belong to any form of Crown II or III with the involvement of organicity and the predominant expression of the negative area, under appropriate medication, allows resumption of functionality and reintegration into an active social, with capitalizing on the remaining functional potential.*
Key Word*: paranoid schizophrenia, extensive hallucinations, self-medication*

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I. Introduction

Schizophrenia is the most severe psychiatric disorder, located at the extreme end of the clinical continuum where damage is inevitable, this being the B criterion that a mental illness of this nature meets, both in DSM-IV-TR and in DSM-5. Over the years, the social, professional, academic and family functioning of the person in question deteriorates. However, the keystone of psychiatry, the attempt of specialists is to establish a solid therapeutic alliance, based on which to be "pierced" the plate of defenses and, on a serious psychopharmacological background, the person in question to criticize his psychopathological manifestations. From this perspective, there are schizophrenics evolving to deficient and schizophrenics who, in over ten years of medication, lead the patient to a state of disposition located within the wide limits of normality, with the absence of productive phenomenology and possibilities to maintain thinking at an optimal level. , in terms of quality cognitive training and a good involvement of the social support network in patient support.

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

The patient aged 44 is divorced, has no children, and currently lives with his parents. He grew up in a biparentally tense family climate (maintained by the paternal grandparents, concerned about the socio-cultural and low material status of their daughter-in-law's family of origin). The tension inside the family had decreased

with the passage of time and with the appearance of the patient's younger siblings: a brother and two sisters. He says that, as a child, he liked reading (he learned to read before going to school) and that he was such a withdrawn child, that his parents had to encourage him to go outside, play and make friends. He also describes the primary, secondary and high school environment as an aggressive environment because of his school-mates.

The socio-cultural and material level of the patient's family is high, the profession of lawyer being inherited on the paternal line (his father is a lawyer, the paternal grandfather was lawyer) and his mother was a Russian teacher for a short period of time, later she became a notary secretary.

O. graduated the Faculty of Law, University of Bucharest, last worked as a lawyer under the supervision of his father at his office. His father banned O. from professing in 2013, due to the appearance of schizophreniform symptoms: he used to type the claims in court in colored ink and attached them colored clips.

Currently, he presents himself at the Psychiatric Hospital for psychiatric and psychological examination, in order to challenge the court prohibition ordered against himself through civil judgment (issued in 2013), delivered by the District Court of county city, to be analyzed if the cases that determined it ceased.

Known to numerous psychiatric antecedents, the patient is diagnosed with Paranoid Schizophrenia. He presents in neat hospital clothes with preserved hygiene. He is cooperating by answering questions, and his attitude is situational appropriate. Clear consciousness. [1] Mimics and gestures are congruent with the content of the speech. Visual and psychic contact initiated and maintained easily. Low tone and low intensity of voice. Temporo-spatial oriented, auto and allopsychic. The patient understands the given instructions and he integrates properly into the required tasks. Slow working rhythm. Provides strong motivation for performance. Strong impulse control emerges from the way of working. [2]

Denies autolytic ideation at the time of the present examination.

Family Medical History: affirmative - "My maternal grandfather had cirrhosis... he worked at a pub and used to drink in there"

3.1. Psychiatric evaluation:

Perception: denies qualitative and quantitative perception disorders at the present time, but the presence of commentative auditory hallucinations is mentioned in the previous [3], which he considers as a hearing sensitivity inherited from the paternal grandmother.

Instinctual life: Psychotically motivated autolytic ideation in the past - "I had a fight with my father and I became aggressive... someone knocked on the door and I thought it was the police. That's when I thought I should climb from the balcony to the gas pipe that my brother used to climb when he was coming home or going out and didn't want our parents to catch him. I tried to get out by the gas pipe and broke my leg. Then the neighbors called the police and I found out that initially it was the postman who knocked at the door, not the police as I thought."

(According to O.'s parents, it comes out an attempt of O. to commit suicide, they confessed as well O.'s non-compliance to medication, professional banning him being seen as a sure way to compel the patient to accept medication and get better. Also, the parents claim a considerable degradation of the patient about 7-10 years ago, but after the constant follow-up of treatment, the one in question had a favorable evolution).

Attention: without clinically significant changes in prosexic function.

Memory: hypomnesia of fixation and evocation of certain data, with un-selective hypermnesia for other subjects that have a particular significance for the patient being related to important events of his past.

Evaluation of intellectual level and efficiency: O. mentions the presence of idiosyncratic thoughts and associations in which alternates the obvious connection or logical relationships between ideas with causal synchronicities that he interpreted prevalently ("I felt that my ex-wife was cheating on me."; "After graduating, I began to be obsessed with the idea that my destiny is written."). At the present moment, the patient's discourse is spontaneous, with lexical and notional volume according to the instruction level and the provenance environment, logical and coherent, centered on the need for intellectual activities (reading, poetry writing, increased interest in completing psychological tests) and the need to activate professionally. School evolution suggests a level of intelligence within normal limits. Thus, intellectual efficiency is at the level of average intelligence. Also, the patient is currently capable of both concrete thinking and operating with abstract ideas and does not present difficulties in making elementary mathematical calculations. [4] The critique of the disease is partially present, as O. considers the diagnosis of Paranoid Schizophrenia as no longer being in accordance with reality, but admits the undoubted presence of the disease in the previous.

Affectivity: playful, positive and serene disposition, slightly blunt affect, low tolerance to frustration.

3.2. Psychological tests:

3.2.1. Projective exam:

1. Elective projection (Luscher):

· Desired objectives / Behavior dictated by the desired objectives: The patient needs a quiet environment, wants to relieve stress and avoid conflicts. He strives to control the current situation and problems, acting with caution. He shows emotional stability and is attentive to details.

· Behavior according to the existing situation: He's impulsive, he's irritable, he's got to control his desires and actions. They dominate him, the one in question not giving sufficient consideration to the consequences of what arises from stress and conflict. Cooperates well with others and is capable of team work. He needs a personal life with mutual understanding and the resolution of disagreements.

· Retained characteristics / Inappropriate behavior for the existing situation: He tends to insist on the realism of his goals and pursues them with a fierce exclusivity, even though circumstances may force him to compromise. He has very demanding standards regarding the choice of life partner.

· Rejected or repressed characteristics / Charged characteristics of anxiety - physiological interpretation: The inability to maintain sensitive relationships in the desired conditions generates stress.

· Rejected or repressed characteristics / Features loaded with anxiety - psychological interpretation: He needs a partner with whom to fully share an atmosphere of serenity, without tensions, but his own constraint to demonstrate his individuality determines him to adopt a critical and assertive attitude, which creates an imbalance and results in alternating periods of close ties with lax links. [5] Thus, the ideal of serenity and tranquility in the couple cannot be achieved. He imposes considerable restrictions on its instincts, despite the urge to satisfy its own natural desires, considering that this demonstrates its superiority and rises above the common category. He manifests discernment, critical spirit and originality, good taste and ability to discriminate. These qualities combined with the patient's tendency to form his own points of view, allows him to judge things by himself and to express his own opinion with authority. He enjoys originality, ingenuity and stability, searching associations with people of similar tastes with whom he could share his intellectual interests.

Conclusion: Intellectual or aesthetic discrimination.

· Current problem / Behavior due to stress: He seeks admiration and appreciation from others and seeks this by creating close and quiet relations based on mutual respect.

2. Szondi Pulsion Test (Destiny Analysis):

The results obtained

· S = h+s+, h0s+: The expression of passive sexuality and inclinations towards feminist subordination, with reversive elements towards men (he cooperates strongly with the clinical psychologist, asks for daily psychological testing, he is very polite saying "Good evening, Mrs.!" every time he meets the clinician psychologist on the hospital's hallways). [6] He manifests an artistic perception ("I like reading, I read since i was a kid."; "I write poems about how I feel... and philosophically themed poems too." "I like classical music"; "Do you have any psychological tests with colors and sounds?") and paranoid symptoms focused on avoiding tension ("I do not like conflicts at all and I avoid them as much as possible!"). h+ and s- factors suggest the patient's tendency to renunciation, passivity, refuge in the past, artistic sensitivity, while the factors h0 and s+ scored in the second application of the Szondi pulse test emphasize the presence of aggressive behavior, tension, fantasy-sadistic with instinctual-erotic dominance, associated with the anxious tendency of self-blaming.

This association (h0, s+) expresses the patient's attempt to put the outside world under his domination with aggression under the cover of tenderness and charm. According to the association of these factors, the patient fits in the typology of "the sentimental executioner" (the mask of a tender and sophisticated man, which hides brutality) and whose activity - liveliness, energy, active spirit - is coupled with infantile tenderness. Thus, the fusion between aggression and childish activity is suggested. Pathology: Unsolved Oedipus, preaponeurotic marginal immaturity. [7]

· P = e0hy-, e0hy-!: As evidenced by the P-axis, the patient exhibits selective stability in relationships - preferring the usual; has high attention and increased concentration capacity. Anxious symptomatology.

Manifested impulsive trend, with possible directly active reactions. He seeks to understand himself by reason and is anxious not to be known as he thinks he is - he perceives himself as being stupid, ugly, homosexual, etc. Complexes of inferiority, feelings of guilt, sensitive relationship anxiety, anxious scruples, sensibility of paranoia offensive, eventually paranoid schizophrenia.

Factor hy = -! : Excessive bashfulness, the repulsion of showing off, the presence of an imaginary, unreal world. Severe moral censorship (of an external nature) - more common profile in prepuberty, in homosexuality, in fantastic pseudology, rarely in conversion hysteria.

· Sch = k+!p±, k±p±: Ideative intellectual identification with the author-like, through obsessive projection impulse. Anxious symptomatology. Excessive functioning of the inhibitory mechanisms, generating persistent strain, affecting the sphere of emotional relations and phenomena of emotional masking, which is felt

critically, with all the ecstasy of intuitive thinking and desire to accommodation. The conflict of anxious attachment and self-assessment is accompanied by tachycardia. The profile expresses the Self that accepts (introjection), femininity, the Abandoned Self, introjecting. He fights against the state of abandonment introjecting (k ±) the image of the abandoning partner. He is, however, able to take the first step towards the adult Ego. [8]

The disturbing antagonisms at the periphery of pulsional life are restored inside the Ego, where they are resolved. The Self that can prevent catastrophes. Forced adaptation. The self that uses all the brakes has to survive a catastrophic panic, which never leaves the classic phobic. [9]

Factor k = +!: Selfishness, egocentrism, autism, narcissism, imaging, introjection, the self that takes position and adopts formal logic, rational thinking; Frequent profile in the period of "pouting" - "ideal of possession": "Here's what I want to have!"

· C = d-m0, d0m0: Conservative attitude towards world objects. Focused attention, restrained. Difficulty adapting to new, attachment to everything that's old. Perseveration (the patient completes the CAQ test for two hours minutely, without pause, hardened), stubborn, stingy, pedantic.

Infantile relations with the outside world and its objects. Dominated by the pleasure principle. The desire to stay always around the mother or her representations. Attention and infantile curiosity. Pathology: Pseudo neurotic marginal immaturity - the infantile desire to sit in the mother's lap. Labile and easy to seduce in relations with the environment, oriented (infantile) polymorphic interest, extremely curious. Hysteroid symptomatology.

3. Clinical Analysis Questionnaire CAQ – standard form:

Part 1:

· Emotional warmth (A=7): the patient wants to get involved in different relationships, to express his feelings.

· Intelligence (B=9): has an above average intelligence, is capable, resourceful and logical.

· Emotional stability (C = 5): high level of anxiety, inability to use resources, increased tension.

· Dominance (E = 4): the patient is uncertain, reserved, hesitant in taking an initiative.

· Impulsivity (F = 4): interest in relationships, but avoids exhibitionism, tempers enthusiasm, prefers classical music, is reserved.

· Conformism (G = 8): person with a higher degree of conformism; correlation with factor A denotes the potential for adaptation to the group's norms. He's a persevering being, respectful to the authorities.

· Eccentricity (H = 6): while high-score individuals are typically adventurous and energetic, the patient gets a slightly lower score than the average for the H factor, which demonstrates an anxiety characterized by a slight tendency towards withdrawal, towards isolation and avoidance of the spotlight.

· Sensitivity (I = 7): dependent person who feels an acute need for security, wanting the protection of his close ones. He prefers the use of reason — rather than force — to achieve certain things and show the preference for literature, compared to mathematics.

· Suspiciousness (L = 6): he is a suspicious, critical, slightly irritable person, and has a tendency to blame the ones close to him.

· Imagination (M = 8): the score obtained on the M-factor is slightly below the average and indicates the patient's tendency to intellectual efficiency and concern about the problems of this area.

· Perspicacity (N = 10): the person in question is a sophisticated person, does not easily express his feelings, diplomatic, polite, prefers to keep his problems for himself.

· Radicalism (Q1= 4): person who leans to the usual ways of solving problems, believes that society should keep its traditions, needs to be accepted as a leader to solve the group's problems.

· Self–sufficiency (Q2 = 7): prefers loneliness, does not feel comfortable in crowds.

· Self–discipline (Q3= 6): presents the anxiety pattern, tendency to compulsion and slightly obsessive behavior.

· FB = 0: There are no negative distortions.

· FG = 1: The positive distortion score is statistically insignificant.

Part 2: Clinical factors

· Hypochondria (D1= 4): the patient is less depressed and concerned about body dysfunctions than the average.

· Anxious depression (D4= 8): he feels that those around him are disinterested in his problems, tendency towards depression.

· Guilt and resentment (D6= 6): he perceives that he has done something unforgivable, he is self-critical, he blames himself when something goes wrong, he has nightmares in which he feels left by others.

· Boredom and withdrawal (D7= 7): the tendency to social withdrawal, feels happy alone.

· Paranoia (Pa = 6): feelings of injustice and persecution, jealousy, criticism.

· Psychopathic deviation (Pp = 4): inhibited both by physical danger and pain and by the criticism of society. While high scores on factor Pp appear as narcomania and antisocial personalities, low scores appear in neurotics, schizophrenics and alcoholics.

· Schizophrenia (Sc = 6): above average score, the patient feels difficulty in transposing his ideas into words, he feels strange impulses, he feels that the world is not sympathetic and he considers himself rejected by people.

· Psychological inadequacy (Ps = 8): devaluation, personal ineffectiveness. According to the score obtained on the Ps factor, the patient considers himself "useless". There are distortions of reality in the area of self-assessment.

IV. Conclusion

The personality profile of a patient with an intellectual level before the onset of schizophrenia, with a structured and harmonious personality (positive prognostic factor), who altered his capacity of social functioning in the first years of the disease, through the subjective feeling of not understanding what is happening and of being aerial, phenomenology boosted by both the productive dimension of the disease and the negative and disorganization. [10] The ban functioned as the critical Superego and the patient's "auxiliary brain", which helped him in correctly testing reality and maintaining social support. Under medication and the increase of compliance, auto lithic concerns have been reduced, which in young people with high educational level results (and) from psychological reactive depression diagnosis. [11] The one in question is currently operating at a lower level than the highest level previously attained – the infantilization dictated by the prohibition contributing to this aspect. While the parents are ambivalent towards their own son's possibilities, he presents a "mosaic" of feelings and emotions, with maximum and unexpected developments in certain cognitive areas and banal mis-meanings in simpler spheres. [12] From the emotional point of view, the emotional inversion and suicidal concerns disappeared, the patient is inserted into the environment, with hope and faith in the future, with a moderate potential of inner tension, which responds unfavorably to the increase in the dosage of medication. A certain dependence on parents is maintained, combined with the nostalgia of the profession at the other time. [13] We are considering a significant period of time to re-habituate "life on his own", in order to be able to make other pertinent decisions regarding his future, the one in question having a social support network. At the present time it is in complete remission for several years, with minimal atypical residual symptoms, visible exclusively by informed specialists, with increasing the existential drive, insertion in reality, use of mature mechanisms of type: rationalization, intellectualization, humor, activism, involvement in family relations, options for future plans. GAFS -65, PANSS -76

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