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High Emotionality and Pulsional Substrate: The Transgenerational Aspect in Schizophrenia

Ana Miruna Dragoi[1], Ilinca Vlaicu[2], Amelia Damiana Trifu[3]

[1] Clinical Hospital for Psychiatry "Alex. Obregia", Bucharest, Romania
[2] Faculty of Psychology and Education Science, University of Bucharest, Romania
[3] "Tudor Vianu" National College of Computer Science, Bucharest, Romania

Correspondence: Ana Miruna Dragoi, Clinical Hospital for Psychiatry "Alex. Obregia", Bucharest, sos. Berceni, 8-10, Romania. Tel: +40721427097. E-mail: dragoimiruna1@gmail.com

Abstract
Motivation behind choosing the subject: The present case is an attempt to highlight the affective dimension of a paranoid schizophrenia, ie, the presentation of a patient with a delusion of relationship as a central symptom, as well as the loss of the boundaries of the Ego, but in which the emotional nature of the experiences calls into question the differential diagnosis with affective schizophrenia. Objective: We wish to present the case from a psychiatric perspective, clinical psychology, as well as psychodynamic, this way trying to highlight one's functioning through the main defenses mechanisms used. Hypothesis: Paranoid schizophrenia can overlap high emotionality, lability, the richness of the affective life being supported by the nature of the delusional idea. Results: The patient presents psychotic functioning, in which the oedipus complex, the phantasy sexual abuse, the similarity, the narcissistic binding of the self, and the mother support the delusional idea. One can identify the loss of the boundaries of the Ego, the delusional idea of relationship, pursuit, and persecution, negative phenomenology, matched by masochistic feelings and the need to be rejected, in direct harmony with the incapacity of self-care. Conclusions: The social functioning of the patient is affected by the experience of being driven away, exhibiting self-isolation behavior, loneliness, dromomania, vagabondage, promiscuous sexual life due to mental deficiency.

Keywords: Paranoid Schizophrenia, Fantasy Sexual Abuse, High Emotionality, Masochistic Feelings, Negative Phenomenology

1. Introduction

1.1. General description of the case:

Personal information: A., female, is born in Timisoara, 27 years of age, Romanian nationality, mother of a 7-year-old boy whom she gave up for adoption when he was 6 months old, separated from the Roma father of the child, currently in a relationship with another Roma partner. She states that she worked as a waiter abroad.

Heredo – collateral history: she had primary relatives with psychiatric problems, the deceased biological mother of the patient being diagnosed with paranoid schizophrenia.

Personal history: From the patient's story at the time of admission in the presence of a psychiatrist, she claims her father sexually abused her at the age 16 (there is no evidence to prove the truth of this). She called Child Protection Services, who did not take any action, in this case, the patient claiming that the father bribed the competent legal bodies. She says that while she was a child in his care, he proposed to give her a full-body a massage, concluding that the father wanted to abuse it physically.

As a personal pathological history, we highlight her articular rheumatism arising because of her job as a waiter (done abroad) and maintained by the fact that on her return to the country, she lived on the streets, sleeping on the cement in apartment buildings. Consumption of toxic substances: the patient did not mention anything about consuming toxic substances.

1.2. Personal history

A., born in a city on the Western side of the country, is part of a disorganized family, the natural parents divorced, and she was entrusted to her father because her mother had a psychiatric history, being diagnosed with paranoid schizophrenia. No data is known about the current status of the parents. "The existence of a sick parent causes a 10 to 15% risk of childhood disease. The transmission of disease predisposition is conditioned poligenically and correlates with dopaminergic and serotoninergic neurotransmission. Another role in the person's vulnerability is maternal viral infections in the second trimester of pregnancy. It was found that an important part of those who subsequently get schizophrenia is born (in the northern hemisphere) in January-April "(Nevid, Rathus and Greene, 2014).

She states that the father began to "ruin" her childhood when she was in the second grade. The natural mother suffered a cardiac arrest from which she died. The natural father remarried, noting that at the death of the mother, the two parents were already divorced. The stepmother, according to the patient, is a rhythmic gymnastics coach.

The patient completed 10 classes. "I also know psychology, I have failed pretty much every subject"; "My head explodes as far as I know." There is an inconsistency between the patient saying that she has a lot of knowledge and her grades from school, which do not certify it. The patient confesses that she has had a hard time finishing her high school education, and she cries while recalling that the stepmother was beating her because she was not good at mathematics. Professionally, A. claims that she has been working since the age of 16 as a clothing salesperson.

Two and a half months after the divorce she went abroad to work. She spent two and a half years in Italy, two months in Austria and another few months in Cyprus and Greece. Asked by the psychiatrist if she worked in Germany, the patient completely denied it (in a strange way, suggesting an illogical construction). She worked as a waiter, the fact that she is convinced to have caused rheumatism, at the time of the talk saying she cannot work and that she will want to work as a housekeeper in the future. She says that she has worked without a contract abroad and that she is currently receiving a disability pension.

Since returning to the country she has been living on the streets, she does not keep in touch with her biological father. She feels alone, which is something that eases the appreace of an illness. She meets another Roma person with whom she is in a relationship. She claims she loves God and has no close friends. She is interested in the zodiac and thinks she can recognize the month in which one is born depending on their voice. She tells the psychiatrist that she is born in November, and when affirmatively answered, the patient says she could tell from the voice.

The future plan of the one in question is to engage as a housekeeper, continuing her relationship with her current boyfriend, whom hse met two months ago and who says, "he is like a child, he only talks stupid things, and he marvels at everything."

1.3. Case history

The first admission to psychiatry occurred when the patient was 23 years old, two and a half years ago at the time of the presentation. She motivates admission by returning to the country and not feeling alone in the house: "That is how my illness began!" She states that she has had at most four psychiatric admissions and that "she has never heard voices."

At age 16, when she was at the Child Protection Services to denounce her father for physical abuse, she was not consulted by any psychologist or psychiatrist. Then the father would have defended himself in front of Child Protection Services by saying that a doctor had told him that at the age of five, the daughter would be triggered by the mother's inherited illness. Child Protection Services have taken no action in relation to the denunciation made. This is the moment that causes the patient to split from the family (currently does not keep in touch with them).

While she was being monitored by a psychiatrist, she was prescribed Haloperidol. As the patient says, this medicine did not do well because it caused micturition difficulties. "Haloperidol is a classic neuroleptic, which works by blocking subcortical D2 dopaminergic receptors and noradrenergic α2 receptors. Among the main positive effects, we mention: reduction of productive symptomatology, diminishing psychomotor agitation, and psychotic anxiety. To break down the positive symptoms, the therapeutic algorithm proposes the administration of a one classical neuroleptic with increased potency - Haloperidol, 5-20 mg/day, along with a classic low potency neuroleptic - Clopromazina, 300-1000 mg/day (Trifu, Udangiu, and Tilea, 2013).

At a previous admission, in another psychiatric hospital, she was diagnosed with paranoid schizophrenia. She received Risperidone as a medication, which made her sick. Later, it was changed with Haloperidol and Olanzapine to relieve the negative symptoms. Diazepam was prescribed, but she does not want to take any medications with a miorelaxant effect because she believes they make her faint. The reasons for the admission show the presence of erotic delusion symptoms. According to Kay and Tasman (2006), atypical antipsychotics have been reported to be more effective than those typical for treating schizoaffective disorder. Olanzapine is more effective on psychosis, mania, and depression. "This class of atypical antipsychotics acts on all types of symptomatology: positive, negative, depressive, cognitive, without determining the extrapyramidal side effects of classical neuroleptics. Rarely, adverse reactions may occur. "(Trifu, Udangiu, and Tilea, 2013).

Case history: The current boyfriend of the patient claims that he gave her a plane ticket to her hometown and that she had refused it. He is concerned about the condition of the patient and the fact that she is angry. From what has been said, we can conclude that the lover's involvement is the emotional support A needs.

The reason for the current hospitalization: The patient was hospitalized nonvoluntarily following psychotic manifestations, mentioned both in the grounds of admission and in the examination of the present mental state.

2. Materials and methods

Initial psychological evaluation, as well as the progressive one, the structured and unstructured clinical interview, the life map, psychoanalytic psychotherapy cure, periodical psychiatric evaluation and treatment monitoring, analysis of transference and countertransference dynamics, psychoanalytic interpretations, explanatory models of psychodynamic orientation, patient reporting to his own unconscious, the analysis of his social functioning, the study of works, the transgenerational analysis, psychological monitoring and psychiatric treatment.

3. Results

3.1. Examination of the present mental state

Clothing: Neat at the time of the interview. A. lived and slept in the staircase of apartment buildings for a while. She mentions that during that period, he was the first time she was dirty. Now she likes to be clean and says the

nurses are stubborn and do not let her wash. Activities such as washing follow the negative phenomenology, the patient realizing that he has come to live on the streets without the possibility of washing, and is now compulsively trying to change this. As a treatment, Olanzapine, which she says works well, works on negative symptoms. She began to analyze the fact that washing had become a ritual. This behavior leads to regression in a symbolic sense, just like the kindergarten children who follow exactly the phrase I have to do this. By the action of washing, the one in question assures somehow that she will never live on the streets again. She finds a connection between the current moment and the childhood: "They cannot stand me sweaty and dirty"; "When I was young, I often changed my intimate lingerie and washed often."

Spatio-temporal orientation: appropriate. "Orientation is the capacity of a person to adapt or integrate into all situations of life, general or particular, in relation to time, space, and his own person. Orientation is a mental aptitude related to thinking, memory, learning, and consciousness "(Enăchescu, 2005). In other words, following the findings at the time of the clinical interview, the patient did not draw attention to an indicative dysfunction in space and time, which determines us to mark this observation as a positive aspect in the evolution of the disease.

Perception: As an affiliation with the diagnosis of affective schizophrenia, we sought to find out if A. has any kind of hallucinations or pseudohalucinations. In order to establish the existence of such a perception disorder, we make a review of the meaning of the terms. „Hallucinations - defined by Ball and H. Ey - are perceptions without an object to be perceived. " A first classification distinguishes the following types of hallucinations: psychosensory, hallucinations, psychic hallucinations. Psychic hallucinations or pseudohalucinations are defined by G. Petit as "aperceptive self-representations, characterized by incoercitivity, automatism, and exogenity" (Trifu, 2015). The patient denies the existence of perceptual disturbances in the past, but currently says she "does not hear voices, nor does she see unusual things," and "has no other disturbance on this level."

Thinking: It is disorganized, the discourse does not have a natural flow, and the weakening of logical associates can be observed - jumps from one idea to another. At the time of the consultation, the speech seems coherent, while the patient still denies hallucinations. "The degree of cognitive deficit seems to be strongly associated with the degree of severity of negative symptoms, such as disorganization. The use of atypical antipsychotics improves motor function (motor speed, reaction time), especially Olanzapine "(Kay and Tasman, 2006). During the dialogue, delusions of sexual nature (centered on intimate life) can be observed, and the patient said that she was a victim of sexual abuse by her father. She claims that "at the age of 16 he wanted to massage my bottom", the father is characterized by this as being able to persuade and manipulate: "He can deceive people." A. finds a similarity between the jealousy manifested by the father and that of the former husband.

Talking about another episode, where someone wanted to kill her in Italy by running her over with a car, she concludes that "men are envious of women, in the way they look." A. presents disguised pseudohallucinations, but consistent with delusional, paranoid convictions, delusional ideas of persecution and grandeur: "People follow me, they are curious because I am good and nice, I am not bragging"; "I'm good with psychology." Other types of delusional ideas encountered in the patient's speech: of reference ("They are watching me with the world's eyes, I am not saying I do not like it! They are all attentive to me!"), the phenomena of listening to thoughts ("I have no intimacy, they listen to everything that I speak, they stop when I pass by and listen to me! ") delusional ideas of persecution:"They bother me at work! " The delusional ideas of grandeur are not consistent with the patient's mood. Allport - "I am me, what is not me, maybe other mes, maybe, but for myself I'm non-me" - describes very well the integration of the patients' dissociated parts, some are integrated, and others are not. Pathology defies the area of thought, but it is not experienced with joy (the verbal and nonverbal levels lead to depression, there is a division between the area of emotion and thought). "The delusional ideas of persecution are common but not specific to schizophrenia. Uncommon, but with greater diagnostic value, are delusional ideas of relationship and control, as well as those of possessing (mastery) thinking. "(Gelder, Gath, and Mayou, 1994).

The patient feels disorganized, says, "I have beautiful eyes, but they look empty," which is a characteristic of psychotic eyes, a sign of schizophrenia, emphasizing the dimension of flattening. In popular interpretation, the eyes are the mirror of the soul, which causes uncertainty in the perception of personal identity in this patient's case.

Since she was hospitalized and her boyfriend is visiting, she does not like to be kissed by him because other patients and nurses are envious, considering she will be "punished" with pills. This type of prevalent interpretation is also supported by the patient's exaggerated belief in the zodiac and the search for explanations and meanings of a philosophical nature in the mythological dimension. Finding coincidences and offering hidden meanings to banalities of life (for example, interpreting the fact that she was born on the same day as her son and believing that people in Scorpio's sign have problems with the nasopharyngeal region) leads us to see a destruction of personality and at the same time the presence of an inferiority complex. Patient beliefs can be interpreted as defense mechanisms, which can protect and help to deal with their own disorganization.

Memory: There are no significant changes, but memories seem to have no coherence through a chronological prism. We can not say at the moment about the type of memory dysfunctionality, but we suspect that this chronological discrepancy in remembrance may be a kind of paramnesia. According to Kraepelin, "Paramnesia is characterized by evoked deteriorations in terms of reality from a chronological point of view. These are divided into two groups: disturbances of immediate memory synthesis, also called memory illusions and disturbances of remembrance of past or allomnesia." (Trifu, 2015). "In schizophrenia, orientation is normal. Disturbance of attention and concentration are frequent and can cause apparently evocative impairment, although memory is unaffected. Sometimes the so-called delusional memories appear. "(Gelder, Gath, and Mayou, 1994). The patient has a moderate concentration and attention deficit disorder, and the psychiatrist has to ask the same question before receiving a response repeatedly.

Affectivity: Affective flattening in regards to her parents and her own child is noticeable. She behaves as if she were not a mother. The attitude that masks the complex of inferiority leads to a defense mechanism that aims to cancel the state of fact, a mechanism that fails at the time of the consultation. "Anomalies of mood are common and consist of three main types. First, persistent abnormalities of mood, such as anxiety, depression, irritability, and euphoria. Second, a flattening in affectivity, sometimes known as affective flattening. This essentially consists of a marked and persistent emotional indifference or diminished emotional response. Third, the incongruity of affections. Here the emotion is not necessarily diminished, but it does not match the mood that would normally be expected. For example, the patient can laugh when she talks about mourning. It is often considered that this third anomaly is characteristic of schizophrenia, although many disagree with this view. "(Gelder, Gath, and Mayou, 1994). "Affective disorders are usually associated with pathological changes in the sphere of motor activity and ideative. They are extremely varied and show differences when it comes to the age of the patient. "(Enăchescu, 2005).

Interpersonal relationships: Low ability to initiate and support social engagement. The sickness was apparently caused by loneliness and the fear of abandonment: "I have no one to love me." When she returned to the country, she felt the lack of emotional support, resorted to various defense mechanisms, and built a psychotic delusional bubble. The tendency of social withdrawal has led to the development of abstract concerns, such as philosophy, astrology (recognizes the person's zodiacal sign), the attribution of exaggerated importance to signs and coincidences.

According to Kay and Tasman (2006), it is not uncommon for patients with schizophrenia to be depressed (especially patients with a history of high pre-morbid function) or indifferent, seeming to have no emotional response to a particular situation. A. does not show deficiencies in the initiative, motivation, or in terms of executive functions. She has increased interest in continuing the relationship that she is in today. She is geared towards finding a stable job as a housekeeper.

3.2. Psychological tests

Elective Luscher projection:

Desired Goals / Behavior Dictated by the Goals:

Look for a relationship that is affectionate, to give her fulfillment and happiness. She is capable of a strong emotional, but sterile enthusiasm (To mine a rey ryp !!!), more form than substance, without a finality concretized in action, enjoying a state of fact, without substance. If necessary, she is willing to adapt to make the affective connections she desires (to mimic relationships, schizotypal structure, who once learned patterns of a

relationships). She wants the same consideration and understanding on the part of others. She moves easily and quickly to anything that stimulates and activates her. She is concerned about intense things, either erotic stimulation or something else. She wants to be seen as an exciting and arousing personality that impresses and thrills others. She uses intelligent tactics to avoid jeopardizing the chances of success or to make others trust her. She performs robotically what she is told, mimes hysteria to have the attention of others.

Existing situation / Behavior dictated by the existing situation:
Engage promptly in things that enable her to stimulate or excite, activate. She transmits intense sexual fantasies. She strives to be cheerful and pleased (mimics a role in the same robotic manner). Deeply, she is not sure of herself, and she is looking for stability, emotional security and an environment that will provide her with more comfort and fewer problems, but can not and does not want to make an effort to do so.

Retained characteristics/behavior inappropriate for the existing situation:
She feels she can not do much about the problems and difficulties that exist today and that she has to deal with things as they are, in the best possible way. She senses that she does not receive what she deserves (sensitivism, sensitivity to rejection, which she projects in others and in the way she asks her father to relate to shame and to experiencing shame as well as experiencing humiliation). She feels she is not well understood and not properly appreciated. She feels compelled to conform while she does not participate emotionally in close relationships. She has reached the stage where they need to comply is a pleasure and wants to give the current boyfriend the same mechanism to function.

Characteristics repressed or loaded with anxiety / Behavior dictated by repressed characteristics:

Physiological Interpretation:
Susceptibility to external stimuli.

Psychological Interpretation:
She wants to overcome her own sense of void (emptiness) and fails to make the most of every opportunity offered to her. That's why she pursues her personal goals with a strong intensity and is ready to mimic profound participation. She feels fully competent in any field she is going to engage in, although sometimes others think she's too involved in everything. The need for control exists, using the denial mechanism: Do not believe how much I like control. She is on the paranoid side, the situation in which she lives sustains his development on the dimension of sensitivism (I am not good enough and how to make myself accept this).

The current issue, stress-induced behavior:
She wants to achieve a stable and quiet situation (after having gone through all the other desires of the type I want the symbolic phallus from my father to protect me, I got the abuse, I want the phallus from my ex-husband, I got abandonment, I want to feel accomplished by having a child, but I was forced to give it for adoption), allowing her to escape from the anxiety that prevents her from getting all the things she wants. She has structural anxiety that prevents her from heading into the situation.

She is afraid she can be stopped from doing the things she wants. This will make her use her own personal charm to convince others, hoping that it will make it easier for her to achieve her goals.

Szondi pulsion test:
s4e5d6
k1p1
h0hy0m0

Cd + pulse class: latent researchers and seekers. Rivals with anyone who has or has had success. She is ready to change love partners often, as well as the workplace; often changes her center of interest. The cause of this eternal rivalry probably resides in the hypertrophy of the primary ideal represented by the person which embodies success (perhaps one of the parents, together with k +). This eternal rivalry makes the subject unstable and unfaithful to the "object." The pulsating danger is conditioned by the lack of satisfaction of the need to

conquer the primary object. Subjects are permanently searching for the lost object. The need to cling to the primary object is spasmodic and impossible to satisfy. There is an exaggeration of the value of the lost object, the subject being tortured by its ideal image. The return of aggression to her own person, the need for tenderness cannot be satisfied. If the socialized subject has the need to conquer the object in a latent state, we have before us the "eternal rival" or the "humanized subject and willing to renounce."

d6e5s4 - debilitating decompensated asteno excitatory structure.

k1p1 - The abandoned self has taken inside it the object that caused its sadness. The abandoned (passive) dualist partner tries to get out of the awkward situation he is in, either by transforming into the Ego the object of inflationary aspirations or by having possession of it, or by searching for a new object and living in such a narcissistic prophecy to the dualistic union.

h0hy0m0 - incest, abuse, homosexual pulsion, hysterical structure.

S = +, -: passive, feminine sexuality, which abandons herself. "Artistic" perception. Ancient (Hellenistic) humanization. Humanized subjects are devoured by the inner fire of their spirit. Waiver, passivity, retreat in the past, artistic sensitivity.

h +: individual tenderness in relation to one person; the need of femininity; maternal instinct.

s-: chivalrous spirit in relation to the community; civilizational spirit; return of aggression to herself; inactivity; masochism

P = + -, -: isteriform obsession, close to panic. An Abel that lets feelings accumulate (because it does not have discharge valves). The pre-illness fobic.

e ±: ambivalence: Do I have to be an angel or a demon? Abel or Cain? Good or bad? (e +: inner censorship, ethical scruples, desire to be Abel,

e-: accumulation of brutal feelings: anger, hatred, desire for vengeance, jealousy, desire to be Cain).
hy-: shyness; repulsion to getting attention; imaginary, unreal world; severe moral censorship (of an external nature).

Sch = +, + -: The self which accepts through femininity, abandoned ego. She is fighting the feelings of abandonment, (k +), the image of the abandoning partner. The first step towards the adult Ego. Good prognosis.
k +: the ideal of possession: "Here's what I want to have!"; The self which takes a position; selfishness; egocentrism; autism; narcissism; imaging formation; introjection; formal logic; rational thinking; frequency in "bad moods" in depression.

p±: one of the tendencies rises to consciousness, the other remains unconscious;

C = +, + -: Searching for a new object, although still clinging to the old one. Infidelity in relationship, bi-objectual. Depression. Attention is directed to several directions, but it is immature.

d +: tendency towards depression (d + / k + / s-); searching for a new object; the need to purchase object values; greedyness; the tendency of rivalry; (waste);

m ±: ambivalence: do I have to detach myself or continue clinging to the old object? Crisis of connection; unlucky connection and without joy. Clinically: Appears in obsessive neurosis and depression.

3.3. Establishing the diagnosis

Paranoid schizophrenia - The patient has previously been diagnosed with this type of schizophrenia. It is worth mentioning that her mother also had the same type of mental illness. A. claims that the first hospitalization took place at the age of 23, not mentioning when she was diagnosed. Currently, she continues to have delusional ideas of persecution and delusional interpretations (paranoid), but they are not predominant. The ICD 10 Criteria for Paranoid Schizophrenia are: The presence of persecutory auditory hallucinations frequently; The existence of paranoid delusional ideas; The manifestation of a tense and cautious behavior, marked by exaggerated suspicion. There is no predominance: incoherence, weakening of associations, disorganized speech, or flattened affection.

In the present case, A. partially and tangentially fulfills these characteristics. The difference between depression (as an episode in an affective schizophrenia) and paranoid schizophrenia is that paranoid schizophrenia contaminates less in countertransference than in depression. It is possible that the part of the abuse is a fixation to the paternal image (she does not say that someone else tried to rape her, there is no evidence attached to the file). The jealousy intensifies the pathology: "I received a yellow tulip from my father," which suggests the originally planned Oedipus desire, then transformed into affective inversion, which in turn migrates to pathological incest. The patient wanted to physically separate from this relationship (by distance and choosing to go abroad) but could not separate from the psychologically.

There is also the dimension of humility ("she is submissive and docile in front of men"). Having been sent away from home, she has three possibilities: either she struggles or succeeds (resilience), or becomes a homeless person, the latter being the choice the patient made. This amplifies her anger and revolt, feelings which she has developed over time with men. Paranoid schizophrenia is characterized by a lack of initiative, which A. does not feel, as she intends to get a job and continue the relationship she has at the moment.

Affective schizophrenia - reviewing the current psychiatric, we opt for this diagnosis - given that our attention is attracted to the way the patient associates her illness with loneliness, attributing it a dispositional causality. Although studies have shown that the risk of developing affective schizophrenia is minimal, given the mother's diagnosis of the paranoid schizophrenia, we consider the depressed mood of Mrs. A. when she returned to the country, incongruent with the delusional idea of grandeur.

Fear of abandonment and loneliness depress the patient, reducing her interest and energy to stabilize psycho-emotionally. She refuses to contact the father and flattens affectionately. From what she has said, one can notice the victim-aggressor game in which A. is the injured party, and the two male figures (father and former husband) are "aggressors." It is worth noting the affective inversion directed towards the father and the attribution of pathological jealousy to him, a fact supported by the interpretation of the yellow tulips received at the wedding, as a symbol of jealousy.

The DSM 5 diagnostic criteria for schizoaffective disorder are:
A. An uninterrupted period of illness in which major dispositional episodes (major depression or anger) coexist with A criteria for schizophrenia (delirium, hallucination, disordered speech, abnormal psychomotor behavior, negative symptoms - alogia (speech poverty), (anhedonia lack of pleasure), lack of willingness to form social relationships (asociality), lack of motivation. Major depressive episodes should include criteria A1: depressive disposition.
B. Hallucinations or delirium for two or more weeks in the absence of major episodes (depressive or manic).
C. Symptoms that meet the criteria for the major disposition are present in a large proportion of the total duration of the active and residual portions of the disorder.
D. Existence of major dispositions which are not an effect of substance use (e.g., abuse of substances, drugs) or other medical conditions. On the basis of the presence of criterion C, diagnosis is differentiated between schizophrenia and schizoaffective disorder, and based on criterion B, and differentiation is made between schizoaffective disorder and depressive or bipolar disorder.

An argument in favor of criterion B is supported by the fact that when returning to the country, the patient realizes that she is alone (separated from her husband, does not keep in touch with her father, and the child was given up for adoption). This situation makes her "ill," although she reminds us that in Italy she had been

followed by known and unknown people because she is a good person ("Everyone is following me around in order to listen to me!"), the persecution and grander delirium being present ever since A. was abroad.

"A person diagnosed with the schizoaffective disorder should have an uninterrupted period of illness (diagnosis of schizophrenia) during which, at some point, he has specific symptoms for major depressive episode diagnosis, manic episode or mixed episode" (Kay and Tasman, 2006).

According to criterion C, if disposition symptoms are present for a relatively short period of time from the total duration of the active and residual phases of the disorder, the diagnosis will be schizophrenia, not the schizoaffective disorder.

In the case of schizoaffective disorder, workplace and social function are often affected, but they are not a stand-alone criterion, as with paranoid schizophrenia. The same happens with the self-care process, which in the schizoaffective disorder makes the negative symptoms less severe and less persistent than those encountered in schizophrenia. A. No apathy in the register of speech (allogony), but lack of pleasure (anhedonia) is felt. This defied the field of thought, and no action can be experienced with joy. These things mark a discrepancy between what the patient thinks and what the patient feels. Lack of desire and inability to form social relationships (asociality), along with a lack of motivation (avulia), are often associated. A. Demands the continuation of the relationship she is currently involved in and is expected to work. At present, difficulties in self-care are not present (due to treatment), this symptom not being a diagnostic criterion.

According to Carpenter et al. (1988), an additional distinction is needed in the case of negative symptoms. "The authors have noted that certain forms of social withdrawal, flat emotionality and apparent poverty of thought may, in fact, be secondary to anxiety, depression, environmental deprivation, or the effect of drugs, and these manifestations should not be labeled as negative symptoms because they have a short duration and are secondary. "(Gabbard, 2007).

"To the extent that the disease exhibits symptoms for depressive disorder and schizophrenia, theoretically one of them offers a relatively better prognosis of schizophrenia and a poorer prognosis for depressive disorder. The following variables are unfavorable to predict a prognosis of schizoaffective disorder: a poor premorbid history; an insidious debut; absence of precipitation factors; a predominance of psychotic symptoms, especially negative or deficit; debut at an early age; a non-remic cycle; family history of schizophrenia. "(Kay and Tasman, 2006).

Many patients diagnosed with affective schizophrenia are also diagnosed with mental disorders, particularly with anxiety disorders and substance abuse, and none of the two disorders are present in A.'s case (DSM 5, 2013). Affective and emotional disturbance is evident when the patient recalls when she gives her baby up for adoption: "I was not even allowed to hold my baby for the last time ...", the mechanism put in play is probably dissociation. According to Freud's theory, "schizophrenia is characterized by the dis-investment in objects" (Gabbard, 2007), whether it is aimed at withdrawing emotional investment or whether the social retreat is targeted. At the time of the consultation, A. appears as if she were not a mother. Although psychiatric diagnosis at first admission is paranoid schizophrenia, we consider that at present, the case is more structured in the area of emotional schizophrenia.

4. Discussion

4.1. Defense mechanisms

In Vaillant's view, defense processes are intended to regulate and maintain mental homeostasis. Depending on the context that requires adaptation, he classified "defenses" into 4 categories: "psychotic (delusional projection, distortion of reality and psychotic refusal); immature; neurotic or intermediate; mature "(Vaillant, 1977).

In case of patient A, we identified the following defense mechanisms: the dissociation of the representations from affections ("I was not allowed to walk my baby for the last time with the stroller"), psychotic denial (although she claims she wants to see her hometown, when he receives a flight ticket from her boyfriend, she

vehemently refuses to leave. An explanation would be that she associates her native hometown with the trauma of abuse and her accused father, which is why she secures herself using different mechanisms of circumvention). The psychotic patient's unconscious is close to "the surface," so we can easily see the Oedipus complex, the cancellation of the generation gap, the gemelarity, functionality based on the similar and identical, along with the denial of the reality of time ("I was born 300 years ago"). Sexual abuse in the childhood is fantasmatic, and the use of the projective mechanism is found. The patient's emotions are "visible," and key places are easily identified, such as "church," "jail," "being locked in a house." We note the masochistic feelings ("I wanted to be their slave"), as well as the dromomania generated by the inner tension and the unknown motivations ("I wanted to take the train, to go somewhere").

A. works on delusional interpretation and coincidence, along with childhood nostalgia. Masochist conduct is found in the use of the verbs "swear," "take advantage," "cry." The emotion of separation denied at the time of the event, returns as a boomerang with the appearance of a schizophrenic form of affection ("I was not even allowed to take my baby for a walk with the stroller. And it was the last time ...").

Currently, incestuous feelings are transformed into affective inversion, while A. lives in a laundry place inside an apartment building in a desire for self-punishment: "They chased me away, but I stayed there, I slept on concrete." Thoughts dissipate, while the whole emotional and ideological flow is disorganized. A. says, "I did not have the disease anymore, and I felt very lonely," an authentic fact both in real and in metaphorical terms. A. Fears of transmitting the transgenerational pulsation potential with a genetic impact: "Since I was 5 years old, I was told that my mother's inheritance would be triggered."

Over the years, there have been times when the patient's symptoms had a higher somatic resonance, and she experienced generalized anguish as well as periods in which she interpreted deliciously any minimal change in her inner world: "My eyes change for good, otherwise they look empty "; "They do not follow me because of the men, but because of me, others are very curious about me, watching me with the eyes of the world"; "I'm not saying I like it, because I do not have intimacy; they listen to me". She receives suggestions easily, living in an immature world with a tendency to philosophy and inclination to "learn at the college of life." One can identify the loss of the boundaries of the Ego as well as the delusional idea of relationship: "I do not feel followed, but naturally followed, that is, in my intimacy"; "The idea is that they don't follow me too much, they talk about the past."

A. raises anything ordinary to philosophical rank, the speech becoming generalized and absolute, while even the memories are disorganized. She is concerned with morality, as well as provoking envy in others and receiving her punishment. She takes everything personally, fighting for survival. She unconsciously seeks for "bruises" and "pain," while from a psychiatric point of view, negative phenomenology is very present.

She is depressed, suspicious, without criticism of the illness, with fleeing ideas and the disorganization of thought, delirious interpretation, delusional ideation of persecution. She associates emotional lability that determines in the counter transfer the experience of being impressed. On her own loneliness, she has a sexual perspective due to mental deficiency. She never received family support and has a paranoid view on it. The imaginary sexual abuse centered on the Oedipus complex pushed her to masochistic feelings in her relationship with her first husband, later in Italy and Cyprus, leaving the impression of having been sexually used. The option of spending time with gypsies seems to be a choice of sexual potency and the potential of desire.

A.'s acute need for money can be interpreted as a profound demand to know how much she is worth, which has led her to overcompensate financial issues throughout her life. The present episode occurred on the background of fatigue and inability to contain. "I remain alone" brings together the punishment with the sadness. A. has the intuition of being beautiful, as well as the intuition of attraction feelings which he generates and attracts envy. We ask ourselves in whose head the incest really is, while A. runs away from the family to repeat the survival and to realize the self-fulfilled prophecy of being schizophrenic, like her mother. The one in question did not have her father, so she linked him to herself for life, to a fixation that in return, has a void and emotional flattening of the current state. Sometimes she seems manipulative in her desire to obtain approval and affection, to have them in order to be emotionally nourished.

4.2. The diathesis-stressss model

Diathesis is loaded by the genetic vulnerability of the patient for developing schizophrenia, having a similar case in the family, her mother. Having the background of stressors (environment, biological factors, social factors), diathesis activates and leads to the expression of a clinical nature.

4.3. Conclusions and prognostic factors

The patient presents the consciousness of the disease and accepts the diagnosis of paranoid schizophrenia (diagnosis at first admission, which was subsequently preserved). She can have a good prognosis because she shows compliance with treatment on the background of a good therapeutic alliance, motivation to increase her income, and has emotional support from her boyfriend.

It seems that Olanzapine (atypical antipsychotic) has worked well in relieving negative symptoms and has acted on the ability to care, increasing the social adaptability of the patient concerned. In the case of A., psychosocial interventions would be useful to help her train her abilities and solve her conflicts.

"Patients with schizoaffective disorders have a better prognosis than those with schizophrenia of other types and less well than patients with mood disorders. Schizoaffective patients respond more frequently to lithium and have a lower probability of deterioration than patients with paranoid schizophrenia. The treatment suggested by the two psychiatrists is to administer antidepressants or anti-manic drugs as well as antipsychotics to control acute psychosis "(Kaplan and Sadock, 2001). Another view of the effectiveness of Litium in affective schizophrenia is directly proportional to the inclination of symptomatic manifestations, so that: "The more the patient's symptoms resemble that of affective disorders, the lithium is more effective" (Trifu, 2017).

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