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The pathology of cognitive and language disorganization – between hysteric dissociation and schizophrenic split

Ana Maria Draguta\textsuperscript{a}, Isabella Danalache\textsuperscript{b}, Marina Goanta\textsuperscript{c}, Simona Trifu\textsuperscript{d}

\textsuperscript{a}University of Bucharest, Faculty of Psychology and Educational Sciences, Bucharest, Romania
\textsuperscript{b}University “Spiru Haret, Faculty of Psychology, Bucharest, Romania
\textsuperscript{c}University of Medicine and Phaemacology “Carol Davila”, Bucharest, Romania

Abstract

We present a patient without hospitalizations in psychiatric facility or treatment for more than ten years, which made possible the expression of rich symptomatology, especially in the disorganization sphere. A detailed description of the symptomatological pallet, from the level of the main functions and mental processes: perception, cognition and language, quantitative disorders in the field of linguistic, removing the signifier from the signified, involving the use of proximate genus and shifting from the abstract meaning of the words into the concrete, which lowers cognitive function, exclusively at a particular level and simplistic operationalization and conceptual impoverishment (along with emotional impoverishment).

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1. Introduction

What sometimes appear to be just misinterpreted gestures of a persona and just because it’s a little odd, the other tend to judge it as an ill person, regretfully its hiding a truth a lot darker.

How can we tell the differences between a very religious person and a psychiatric patient with religious delirium and how can we be sure that a person has a psychiatric problem just because it has a lot of debts?

* Corresponding author.
E-mail address: simonatrifu@yahoo.com
Delivering an efficient care requires that psychiatrist and mental health workers, including social workers – have to know exactly what is their role within the health system and what to do as a first person in contact with a potential psychiatric emergency. (Clinical Manual of Emergency Psychiatry, 2010).

Psychiatric hospitals are designed to be safe settings for intensive mental health treatment including observation, diagnosis, individual and group psychotherapy and medication management. In patient treatment should be part of an overall plan of care, a coordinated effort between the individual, the family or other supporters, the inpatient treatment team and outpatient service providers (Anitei, 2010).

2. Case details

The present case came in our emergency room as a social case, a women with some behavioral dysfunction, many financial issues, during the initial admission she present different symptoms, from high interpretativity to different illusions. During the initial interview it was highlighted some very intriguing facts like: the first symptoms were around the age of 25 year old, her son was admitted also in a psychiatric hospital, she was supported financially by her father and food was provided by a neighbor.

After several clinical interviews the mental state of the patient start to shapes as a paranoid schizophrenia, which has the first outburst more than 20 years ago. During this period of time the patient had lived in her own apartment with her son, in the first few years she was able to support herself and her child, but as the disease developed she loses the social skills, the ability to work and the contact with the real world.

Patient is female, 45 years old, divorced, unemployed and lives with her 25 years old son. She was hospitalized for fragmentary delusional ideation, blunting of emotion, dissociation, auditory hallucinations, patient shows a trend of disorganization on the level of thinking, on certain topics (subject of the changed religion), speech became incoherent, with a tendency to be vague and digressive: “They all swooped upon me with the idealization change”; “Someone has accumulated me in a particular state, they have assimilated me in these changed pathology”; “I have been optimized”, meaning “relativized by someone”.

Her life story can be an argument for the psychiatric diagnostic: finished high-school, starting working at a very important telecommunication company, with a job of a relative importance, after the new technology take place of the old one, the computers become a very important help, she decided to live the company because “I was not able to learn how to operate a computer, in fact I never try because I think there are not good for people”. After she quit her job, hers husband decided to divorce her, after only 5 years of marriage and they had at that moment an infant baby. After the divorced she moved to another city, where she bought an apartment, she starts to work briefly in a pastry, a shop and other small jobs, during all this time she become extremely religious. The moment of social services intervention was when the neighbors call the police because she put a table on the hallway and start praying for an entire day on top of the table, standing on her knee.

The Psychological examination reveals the following:

Observations:
- the patient is dressed in a hospital outfit, relatively untidy;
- incoherent regarding the theme discussed, with a tendency of disorganization;
- insufficient cooperation due to the cognitive disorganization (this creates the feeling that she does not always understand the interlocutor questions);
- responses latency;
- spatially oriented
- slight disorganization in the life personal history;
- perplexity notes;
- environment dissociation sensation.

Perception:
- she has imperative auditory hallucinations (voices that make her perform different actions);
  “the voices are small”;
  “these are from some and others, they are loose to get me lured in”;

she hears the voices "on the skin and on the walls";
,,they tell me that they will assimilate me”;
,,the voices tell me that they attack me, that they will make me, that they will mend me... they hurt me...”;
,,they have an interest, they want me to make them enticements projects, as they came out today”;
,,some and others play them for me, special assimilations of these, bad’

- possible auditory hallucinations at the time the interview (which can justify the answers latency and perplexity notes);
- possible defense behavior during examination (shaking head).

Attention:
- difficulty with concentration, stability and selectivity of attention;
- spontaneous and voluntary hypoprosexia;
- insufficient functioning of the attention filter function.

Memory:
- fixation and retrieval hypomnesia;
- marked dissociation on a cognitive and emotional level, with the inability to recall significant events from her personal life history (she refuses to remember why she divorced, why her daughter changed her religion).

Cognition:
Quantitative:
- circumstantial speech;
- tangential responses;
- bradypsychia.
Qualitative:
- fragmentary delusional persecution ideation;
- disorganization at the topic level and at the sentences level;
- outlines the mental automatism syndrome (xenopathic influence)
- ,,,They untied me, they squeezed my immunidivity bad”, meaning ,,They squeezed my strength and took my immunity.”;
- breaking the unity of the Ego, she does not understand anymore that the decision-making power belongs to her.

Language:
- multiple active neologisms, that describe bizarre particular states;
- quantitatively she sketches an ideations dam phenomena;
- neologisms are present;
- breaking the signifier from the signified: ,,I live with someone of mine, with a relative.” ,,What kind of relative?” , “A being...”;
- use of diminutives: ,,I live with someone of mine, with a little relative”;
- use of words with changed meaning;
- divesting the words of their abstract meaning of and their use in the concrete ,,I went from the orthodox religion to catholic in pure”, meaning in ,,good faith”;

Affectivity:
- blunting of emotion;
- feeling of perplexity;
- dissociation;
- athymia.

Volition:
- aboulia
Instinctual life:
- basic impulses preserved;
- diminished maternal instinct.

Activity:
- is limited to self-care activities
- significant decrease of the social useful efficiency;
- Athymhormia / emotional indifference, that leads to a decrease resonance with the surrounding situations, with an inexpressive faces, blank looks.

Personality and disease awareness:
- massive dissociation, going to the outline of depersonalization;
- disorganized psychotic personality
- lack of criticism or lack of awareness of the disease

She was diagnosed according with the DSM IV standards of diagnostic for psychiatric disorders. Schizofrenia is one of the complexest mental deasise, one of the most important caracteristic of its being imparing of the whole personality, acting by the destructuring the mental awareness (thinking, perception, affective, volitive, etc). It manifact through „great heterogeneity of symptoms, but also evolutionary-prognosis, which partially explains therapeutic failures recorded.” (Udristoiu, 2010)

The differential diagnosis for schizophrenia represents the biggest challenge for a clinical psychiatrist and “unfortunately, there is no laboratory test for schizophrenia.” (Schizophrenia Biopsihosocial, 2009). The diagnostic is made only after an examination of the person’s history, family, current symptoms, previous unusual behavior, professional performance and any other information that a clinical psychiatrist can use.

Axis 1 – Paranoid Schizophrenia
Our patient has the symptoms described in DSM IV for paranoid schizophrenia:
- imperative auditory hallucinations
- visual hallucination
- persecutory delusion
- high interpretativity of real life events
- low social functionality
- emotional impoverishment
- no disease awareness

Axis 2 – Because of the intensity of schizophrenia symptoms, no other personality disorder could be identifying at this moment.

Axis 3 – no medical condition known at this moment
Axis 4 – Lack of family support, no social and material stability. Her son was also hospitalized for psychiatric problem. Her father, the only financial supporter, is a very old person and lives in another city then her. She has no other living relatives or friend who can offer her the comfort that she needed.

Axis 1 - Undifferentiated schizophrenia
Pronounced negative symptomatology, dominated by apathy, avolition, speech becomes more unorganized, with loss of intrinsic power and consistency, in such a way that present symptoms are found almost in all areas (hallucinations and delusions).The patient meets from the criteria A for schizophrenia (APA, 2013), the following conditions:
- hallucinations: visual and imperative auditory
The over 20 years of untreated schizophrenia left a very important mark over the entire functional life of the patient, reducing her ability to relate to other people and to correct interpret the basic information’s form daily life.

In this moment it’s very important to get involved not only the medical care system, but also the social care who needs to make sure that the patient get the correct treatment, that the patient is not abused by others and monitor the disease evolution.

For a scientist’s fascinating to observe how a mental patient can hide behind a different type of unusual behavior the actual symptoms of a illness as Paranoid Schizophrenia. We can’t be sure, but probably the first episode was around the age of 24, when she quit her job because of computers and her husband divorced her because of suddenly religious behavior. During more than 20 years of illness, she was able to take care of her sick son, committed him in a psychiatric hospital, working and having a relatively regular social life, even she was considered by some people odd.

The ability to conceal the disease is the one aspect that intrigue and make her case so special. What part of her helped? the personality? the Intelligence? or a more cruel aspect of life – the indifference of the family, friends and neighbors regarding her health problem, or maybe the shame to admit that in their family it is someone with mental issues.

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References


