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Interpretative process - from utilization of predominant to psychotic decompensation

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Abstract

The present study expounds a transgeneration pathology, both sense psychological metaphorically and translation of certain genetically pulsation and biologically charge, which marks the personality of the next generation. The study wishes to bring in to focus a case of depressive decompensation with interpretative phenomena, in a climate of psychological and physical overload and based on a frail personality structure, which is having as a first outburst a behavioral act with negative consequences. Method: psychiatric assessment, tracking longitudinal the evolution of the case, family dynamic study Results: Shows the thin line between: normality and interpretative paranoiac personality structure

Keywords: dissociation affects the situation, structure sensitive –interpretative, transgenerational trauma, structural ambivalence, relation naivety / lack of reality testing

1. Introduction

The present case analyze a couple who has a pathological function, being composed of two former abandoned children; each of them remained within an immature stage of psycho-emotional development, partners who react different at environmental stressors. Regarding the patient (the young mother), the question is if a psychotherapeutic treatment is adequate for this episode, or it is imposed also a psychiatric medication. Emphasizing the thin line between: normality, interpretative paranoiac personality structure, introversion, high functionality in cognitive-

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2. Method

The interview was conducted as OPD recommends: “exploratory approach, in order to gather factual information” and “a dynamic approach of the relationship, based on pure psychodynamic attitude”.

1. Patient:
1.1. 28 years old, female, married, a two years old child; born and raised in a rural area / presently she is living in an urban area
1.2 University education, masters degree, post-graduate; quasi-constant professional performance
1.3 Never hospitalized in a psychiatric hospital
1.4 Patient lives with her husband and their child; she has a sister who lives in the same city

1.2 Family Psychiatric History:
2.1 There are no known diagnosed cases in the patient’s family
2.2 The patient affirms that her mother supposedly suffers of a mental illness and she need diagnosis.

3. Premorbid personality:
3.1 She comes from a rural area, from a family without financial resources.
3.2 She had no family support during school, patient states that had to fend for herself.
3.3 Her husband has the same family background.
3.4 Determination to obtain financial comfort, perseverant in achieving professional goals.
3.5 Social immaturity
3.6 The relation with her partner is one marked by norms and regulations, following a predetermined pattern.
3.7 Going on demand psychotherapy session prior to give birth (in VIII month of pregnancy), being terrified by the idea “I will die giving birth”.
3.8 Postpartum, returns to the personal analysis sessions

4. The context of the incident and the case process – acting out as a pre-psychotic mark
4.1 The two year old child ingested a poison (Verde de Paris)-Insecticide.
4.2 The situation required hospitalization. The first 24 hours his condition was critical. He was maintained in hospital for three days the child and received intravenous and specialized treatment (antidote type)This was followed up and he was subsequently kept under observation for another 14 days.
4.3 The child is brought to the hospital by the parents.
4.4 The father (patient husband) had taken at this poison home and it was placed in a suitcase with various bottles (medication, shampoo, etc)
4.5 The child comes in contact with the poison while he was home with his parents. They left him unattended whilst they tried to lay a carpet.
4.6 The child had previously played with the poison, two days before incident, because “he learned to play with the Nurofen bottle, pretending to drink it until the last drop”. Then, the mother asked him to put it back for the reason that “it belongs to daddy”.
4.6 The suitcase in question (in a side pocket had the poison vial) was used by the child to play as a toy when the patient had works to do: “I gave him the suitcase to play with, when he was nervous and I had to work.”
4.7 The suitcase in question (which had a side pocket holding the poison vial) was used by the child to play with as a toy when the patient had work to do: “I gave him the suitcase to play with, when he was nervous and I had to work.”
4.8 The mother states: “I didn’t ask myself what is in the vial”; “I didn’t think that my husband could have brought home poison”; “We established not to use the poison (Verde de Paris)”
4.9 The child has drawn their attention by coughing, he was found with the vial in his hand and then the father decided to take him to the hospital.

5. Mental status

5.1 Perception: The patients do not present qualitative modification of the perception, neither in hers history or currently. It is noticed a discreet irritability and a decreased in sensorial thresholds. At olfactory level, she identifies correct the smell of the dangerous substance, but cognitively she can’t translate accurate the message suggested by the sensorial area (!).

5.2 Attention: spontaneous and selective hyperprosexia, with voluntary hypoprosexia

5.3 Thinking: quality disorder ◊ persecutory ideation with prevailing intensity, influential ideation and mystical ideation. Interpretativity: “there are given to us all kind of tests that we need to overcome”; “from the second day in our house, my mother started to think negatively and we had a fight. She wanted to help me, but beyond her willing, it was not good what was going on...But she is not guilty.”; “We must avoid ours mothers...we are weak and they disturb us, we act differently, they pull us down...”

5.4 Memory: no pathological alteration.

5.5 Affectivity: emotional impoverishment, raging to indifferentism and athymhormia, emotional inversion towards the mother, bundled with delirious interpretativity persuasion and modifications subsequent decisional: “I must avoid any relation with my mother”; “I behave really well in the hospital, I didn’t get depressive...”; significant decrease of emotional resonance, with laying at stake of cleavage and dissociation mechanisms related to the incident which took place and her child.

5.6 Instinctual life: substantially diminished, in all the areas of compulsion manifestation.

5.7 Volition: motivational and volitional retard, attitudinal pessimism: “In the hospital I was optimistic, but since I came back home I am less connected to what’s happening to me...”.

5.8 Affectivity: loss of interest in all useful social activities, including the scientific (in which she was previously involved), post-partum social isolation, inability to fulfill the mother status and professional rigors in the same time, social immaturity – relational. Narration in a superficial register, demonstrating maladaptive coping: “We were lucky that the doctors have been real, as if we were doing part of a movie...”; “I was not able to persuade D. to eat in the hospital, he react just like home...”; “I wished to be like other mothers from the park, to have somebody to replace me in this role...because can no longer cope...”.

5.9 Consciousness of the disease: patient did not consider that she suffers form any psychiatric illness which require medication treatment.

6. Primary diagnosis conform DSM IV

Axis I – Delusional Disorder Persecutory Type

Patient experience delusional ideas and high interpretativity related to the relationship with her mother, respectively the mother in law: “I concluded that our mothers don’t love us. I thought that his mother is a loser, which have only negative thoughts and if we meet, something bad will happened to us. But now, I can say the same thing about my mother – she is also a loser, with negative thinking; therefore to be avoided, because we are influenced!”
It is noted an excessive analytic thinking, loss of contact with reality in vital area sectors, significant modification in areas like ability to anticipate the consequences and own decision, inability to efficiently translate sensorial information.

Presents also, delusional ideation mystical type, according to high interpretativity regarding common life events, which she assigns a particular meaning, living subjective sensation of waiting for a waiting. Psychotic intensity of guilt feeling: “I worked on New Years day which was also Sunday!”.

**Axis II**: Schizoid Personality Disorder, lack of emotional engagement (including family), absence of any friend or other persons important in life of the patient, affective detachment – towards to the child also, no interest in any type of activities, social isolation, tendency to analytics, choosing a profession according with this way of being, pre-morbid characteristics from the area of interpretativity, suspiciousness, sensitivity and high analytics.

**Axis III**: Do not present any medical condition

**Axis IV**: Absence of psycho-emotional comfort in her family: “There is no communication!”; economical challenges: natural family with low resources, the couple lived in a dorm room, after that they moved in a rental apartment living under difficult circumstances (cockroaches); social inadequacy, lack of social relationships, isolation after she gave birth.

**Axis I – Major Depressive Disorder with Psychotic Features**

This prime differential diagnosis is considered because the patient shows depressed mood, fatigue and low energy, guilt feelings, excessive concern about relation with her mother, pessimism, loss of pleasure and interest, thoughts and emotions instability.

In order to a meaningful discrimination it is necessary to rigorously establish the temporal sequence between mood swings in depressed sense and over adding the delirious interpretativity.

**Psychotics features**: interpretativity, mystical and prejudice ideation: “By our acts and thoughts we have brought this misfortune”; “We worked in the New Years day, which was also Sunday…Monday we wanted to work again, but the accident happened…”.

**Axis I Factitious Disorder not Otherwise Specified**

Considering this differential diagnosis is argument by patient inaction, in the moment she notice that in the bag, which is used by her son as a toy, it is a new bottle/vial.

Patient states that she smelled a pungent smell like gasoline, when the child opened the receptacle.

She put back the bottle/vial in question, without taking any action and after few days she let the child to play again with the bag unattended: “I give it back again, he was alone, I was in the hallway…then I don’t know what he did, but if he had swallowed it all, he would not have lived…I ask him repeatedly how much he drunk and he told me that only a drop…”

**Axis I Paranoid Type of Schizophrenia**

This diagnosis can be valid given the significant impairment of social function of patient, in conjunction with delusional ideation and interpretativity “disturbing socio-professional functionality, (…)) subjective discomfort”

F.Tudose, C.Tudose, L. Dobranici

We support a Delusional Disorder rather than a Paranoid Type of Schizophrenia:

- preserved core personality coherence
- absence of mental automatism syndrome
- absence of hallucinations or pseudo-hallucinations
- functional in professional area (mathematics)
- personality structure inclined to hyper-analytic, suspiciousness and sensibility
- presence of depressive features, secondary of operating a long period of time in delirious register.
This differential diagnosis can be considered starting from the major defense mechanisms of type cleavage and dissociation, superimposed to a high intellectual level of patient, as well of family dynamics of this dysfunctional couple, found into pathological symbiotically registry, with severe impairment of the reality perception and absence of emotional resonance ability.

First reaction of the patient was to scold the child who coughed because of the toxic substance, drawing the attention of the husband, who recognized the substance and they took the child to the hospital: “He heard me arguing D, he came in to the kitchen and we decide to go to see a doctor!”

She sought medical attention and received it: “I asked the doctor who took care of him, if the hospital has the best toxicologist in the country, if the organs will be affected and she replied in a harsh tone, that is a life and death problem”; “The doctor, which was also the hospital manager, decided after five days, that it’s better to stay at home”.

Patient ignored the locomotor and cardio-vascular issues of her son after the ingestion of poison: “I consider that’s what made their mark on what had happened”.

7. Prognostic
Patient refuses medical help, including abandoning the personal analysis / therapy sessions. Under these circumstances, without therapeutic intervention, the probable evolution will be negative.

8. Unfavorable prognostic features:
8.1 Premorbid personality has dominant features from schizoid spectrum, favoring the decompensation to Axis I in delirious register.
8.2 Heredocollateral background.
8.3 Social and interpersonal deficient function.
8.4 The presence of intensive prevalent ideation – delirious and interpretative.
8.5 Absence of social-family support.
8.6 Hospitalism / side benefit of the disorder (unconscious experience, present as follow: by using signs and symptoms that may draw the attention from others, absence which she has always suffered)

Cumulative trauma concept makes its presence in the patient dynamic of life, through its inability to function at optimum parameters, in social and maternal registry, being dominated by: psychotic fragility, suspiciousness, sensitivity, interpretative. The case implies a careful management of situation in the couple dynamics and also involving the competent authorities regarding the child issues.

As a final conclusion we can state that our patient is fully disconnected in relation with the poisoning incident and in relation with her life. Also, as everything in patient life is xenopatic, she doesn’t know any other method to ask for help but in what it seems to be like deus ex mahina. From an explanatory perspective, her gesture represent has not poisoned the child but the mother has poisoned her.

References