BETWEEN THE DESCRIPTIVE AND THE DYNAMIC. THE STRESS DIATHESIS MODEL AND THE TRANS CULTURAL PERSPECTIVE IN THE PSYCHIC CONDITION. (CASE PRESENTATION)

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Abstract: Motivation choice of research topic: The particularity of this event is that it demonstrates, both in terms of descriptive and dynamic the practicality of the diathesis - stress in the etiology of mental illness, for a young man that failed to adapt to changing socio cultural area, perceived as traumatic to the fragile structure.
Objective: This paper aims to identify biological factors, social, cultural and environmental conditions in the patient's personal history, which had a major impact on his personality structuring and subsequently the development of symptoms of paranoid schizophrenia.
Hypothesis: In the patient's A. case, schizophrenia is installed on a background of schizoid personality, being involved both fragility / vulnerability of the individual and the model triggers stress - diathesis, where a major role plays identity superimposed loneliness abandonment.
Results: The case study highlighted the fissure of the Ego, becoming inept and immature and the existing mental automatism syndrome, characteristic of paranoid schizophrenia. During adolescence, the subject tries to structure more appropriate for social defense mechanisms, being in contact with the world and himself. Such defenses were subsequently lost, as damaged by the evolution of the disease a few years, given the loss of identity security at transmuting into another country.
Conclusions: This presentation demonstrates that in the etiology of schizophrenia, besides the existence of genes involved, an important role has the particular personality type over which the mental illness is evolving, as well as social and environmental factors.

Keywords:*alienation identity, personality structure, mental illness, environmental factors, transmutation and intercultural differences.*

Motto: „...a broken soul which reflects reality is like a broken mirror"

1. Family and personal history:

This case study describes patient A., age 23, unemployed, unmarried, who was brought to the hospital, to the emergency by his aunt, mother's sister, on the grounds that: „ He is in a state of panic, does not talk, refuses to eat and drink ". Admission diagnosis: acute psychotic episode. In the first week, the patient stayed in a room under supervision.

The patient completed a high school with a math/computing profile in Bucharest, in 2008 and took the baccalaureate in the first session. States that did not like to learn, but instead ,, I liked computers, reading and i have a passion for hackers ". Future plans there are not any, but still wants to go to a School of Economics, ,, to open my business. "

He never knew his biological father. He was raised by a stepfather, and when he turned 14 his parents broke up, his mother left to Italy, „to work as a nurse*, because there was a better payment”*. He has suffered a lot because he was left all alone, in one room apartment,

in the capital, when he was only 14. He also had a grandmother somewhere at a countryside, but she did not get involved much in his education or life.

In 2011 he went to Italy, to his mother, where he lived for two and a half years and during this time, has not found any job. He states: *" Because of this I was stressed, I felt the world taking distance, away from me, cold, they do not resemble the Romanians..."*

The first psychiatric hospitalization occurred in 2013 in Italy, where he was brought to the emergency by his mother's fiancee, as having auditory and visual hallucinations: *,, I saw blind people walking and I could hear their voices "; ,, I was playing basketball with imaginary people... I was playing ball in the park with some guys and some voices were telling me to watch women "; ,, I saw a person who was calling me to it, and I did what the voices told me... "; "I saw planes in the sky, when nobody was seeing them...". In the psychiatric hospital in Italy he was hospitalized six weeks, during which he was given haloperidol. After this pharmacological cure gained insight on hallucinations. In the interview, he tells about himself: ,, I was a closed person, not really talking to people... I was like that in the in childhood and did not bother me... "; "I think it all happened because of the stress"; ,Friends were cold,, they were false and posted on facebook bad things about me "; ,, I feel sad, I was depressed and I asked for help. My mother probably knew but could not do anything... ".*

He says that for three days he lost contact with the real world. After a week of discharge, he went to control, at which time treatment was changed: 4 mg Haloperidol Abilify 15 mg due to dizziness and erectile dysfunction. On returning home he discontinued for two months and two weeks ago started the second episode psychosis.

With the naked eye, A. says he does not feel healthy. The Symptoms have returned: *,, I felt that someone controls my mind, I'm in a coma and that the people from the reality they want to harm me, to cut me " ; ,, I Went online, I was in a jungle... I had hallucinations there, online " ; ,, The people i saw were my former girlfriends parents who wanted to kill me because I mistreated them. In high school, I stayed with them and at some point we did not get along anymore. From 16 to 21 years i have been living with my girlfriend, she was a singer. It ended because she cheated, then I went to Italy "..*

A. likes to stay long in front of the computer, where he says he *sees only nonsense: things bizarre, nonsensical, things I cannot say they are really ugly. And on TV, like: ,, The show I like IT speaks nonsense, nonsense... my subconscious was only understanding the nonsense. "*

His mother has always been distant. He also has a step sister, younger, of 17 years old who went with the father when the parents broke up, and she does not keep any contact with the mother, but she visits A. in the hospital.

2. Present psychological examination:

Orientation:

The Patient disoriented in space, auto and allopsychic.

Perception:

* Auditory Hallucinations and / or functional hallucinations (*,,I was hearing the voices, they were telling me to look at the women"; ,,I was doing what that person told me to*

do"; ,,My Subconscient was understanding only stupid things, nonsense from that tv show „I like IT").

* Pseudo Hallucinations, sinestezic Hallucinations = producing simultaneous sensations at the visual and auditory level of the analyzers (*„I saw blind persons walking and I was hearing their voices"; ,,I was playing basketball with imaginary people,, I was playing the ball in the park with the guys and the voices were telling me to look at the women"; ,,I saw a person calling me to it and i was doing what that person was asking me to do"; „I saw planes in the sky, when nobody was seing them.."*).

* Auditory Hallucinations and / or illusions with delirant interpretativity: (*„I Went online, I was in a jungle... ... the people from the reality they want to harm me, to cut me"*).

Attention:

* Insuficient functioning of the attention filtre, leading to delirant interpretativity.

* Hipoprosexie, spontaneous and voluntary, visible difficulties in concentration, stability and selectivity of attention.

Memory:

* Hipomnezie - fixing and voluntary evocation, plus

* Hipermnezie spontaneous regarding dates, facts and events which are brought in the speech, integrated into the delirium. Because the patient is psychotic desorganized, the attention filter does not work properly.

Cognition and Language:

* Ideatic poorness

* Logical speech and systematized.

* Disorders of content: subjective experience of *confusion* (being described as *coma and / or dream*).

* Xenopatic control thoughts phenomena (*„I find that…"*), without being able to specify who directs the subjective reality.

* Delusional persecutory ideation and injury.

* Reference delusional ideation, containing abnormal and increased symbolization.

Emotionality:

* Does not show depression in the manifest plan but the issue centered is latent abandonment trauma.

* He is an empty patient, Flattened, spiritually depleted. It highlights the emotional resonance in all sectors of life interest, up to anhedonia

* Sensitivity to rejection which affects emotional sets, overlapping delusional interpretativity as a cognitive mechanism.

Activity:

* Risk of psychomotor agitation under stress, psychotic changed behaviour, secundary to hallucinations, in the absence of treatment.

Will and motivation:

* Inadequate drives and motivation,bizarre, energy invested

Conscience:

* At some point in time in the disease's evolution, characterized by intense psychotic anxiety, A. prezented a kind of oneroid type alteration of consciousness with depersonalization phenomena and derealisation.

Criticism of disease:

* The Patient has critic over the sickness by aproximately 80 % („*I suspected i had schizophrenia,i read on the internet and i was afraid of this"; „When i stopped the treatment, i began to hear voices again but they were not talking to me..."*).

3. Diagnosis of the syndrome: mental automatism syndrome („*They all want to hurt me from outside"*) = is characterized by pseudohallucinations, delusional relationship ideation and xenopatic influence, and is the quintessence of paranoid schizophrenia.

Mental hallucinations, pseudo-hallucinations and psychomotor hallucinations were synthetized in the mental automatism syndrome, in which, the primary elements are: the Eului fissure, thinking strangeness, and the Ego no longer assigns certain feelings over its own individuality. At A. We can rediscover multiple phenomena that asociates ideatory automatism: emotionally (feelings imposed), volitional (imposed acts) and visually (images shown to the patient). Considered as the core of chronic delusional psychosis, the mental automatism syndrom causes delusional persecutory and prejudice ideas and it is structured around the patient's belief that thinking is no longer its own.

Diagnosis:

AXIS I: acute psychotic episode of paranoid Schizophrenia.

AXIS II: schizoid personality disorder type.

AXIS III: No informations.

AXIS IV: Lack of job, reduced social support and the presence of the disease.

AXIS V: GAFS at the present time = 35.

Diagnosis diferentiale princeps:

* **Schizoaffective disorder.** It differs from paranoid Schizophrenia by the way the symptoms are developing. According to DSM IV, there must be an episode of affective coloration, in paralel with the acute phase symptomes and the affective symptomes are present in most of the disturbance. Also, the criterion of halluciantions in the past for at least 2 weeks, in the absence of affective symptoms must be met. In the case of A., in his history we could not identify episodes of at least 2 weeks in which only disposition was alterated, without psychotic features overlap. In addition, **mental automatism syndrome** is typical of paranoid schizophrenia.

* **Delusional disorder.** It differs from paranoid schizophrenia by better functioning at a socio-professional level. In delusional disorder, hallucinations are rare, and when there are usually there, there are auditory and consistent with the delusional theme. In addition, the A.'s personality is far too modified, unstrucured to be a delusional disorder.

4. The results of psychological tests and interpretations:

4.1.The tree test

* Little tree feeling insignificant, loneliness;

* No roots repressed sexuality and repressed drives;

* The absence of the ground fear of libidinal fixation, tendency towards instability;
* Grass prevails concealment;
* The absence of leaves (only4) interior vacuum;
* Vague lines uncertainty, lack of energy;
* Opening the trunk in the crown hyperexcitability with explosive tendencies = risk of acting out;
* Directioning branches up reality testing is low, hyperexcitability;
* Crown with closed structure introvert, closed itself, isolated;
* Branches of unique line emotional retardation, regression;
* Leaves altered in branches (all 4) failure in achieving trends;
* Branches with closed extremities resistance to receive and losing energy (accumulation and explosion) = mismanagement of libido;
* Tilting the crown to the right trend towards the future and repression of the past;
* Crown sharpened to the right aggression (organic, aquired or accidental);
* Enhanced peaks anxiety.

4.2.Test of the face:

* No eyebrows denots conflicts in this region of the head;
* No ears possible auditory hallucinations;
* Nose with highlighted nostrils primitive rage, unsophisticated, aggression;
* No chin weakness feelings, especially in social relationships;
* Slightly oval face, sensible, aesthetic indicates feminity;
* Vague, with omissions face withdrawal from social relationships, to be „out of time";
* Mouth in the cupid curve aspiration to youth, adolescet impulses;
* Breakthrough eyes exaggerated alert status in relation to the world, meaning the paranoiac side; suspiciousness towards the other's reasons or behaviours; increased risk for visual hallucinations;
* Long genes + long hair on the forehead sign of feminity in man;
* Tear in the left eye indicates the wish of controlling the suffering.

4.3.CAQ Personality Inventory:

Emotional warmth (A = 1) individual score very low suggesting a sindrome of a „ psychotraumatized child", indicating history of poor interpersonal relationship. Extremely low scor at this scale indicates a pathological avoidance of the others;

Intelligence (B = 2) low rezolution abilities; intelligence below average;

Emotional stability (C = 1) high level of anxiety, stress intolerance, inability to make use of the internal resources, high blood pressure;

Dominance (E = 3) the patient can not protrude, „closing up itself". Hostile and aggressive feelings can erupt unexpectedly, as typical passive-aggressive pattern;

Impulsiveness (F = 2) non expansiveness, internalization of internal conflicts. Correlates with factor A = 1, claiming a pathological avoidance of others and contributing to the patternul of depression in the latent phase;

Conformity (G = 4) denotes un weak SuperEgo. Correlation with A = 1 and E = 3, indicaing inability to adaptto the group norms;

Eccentricity (H = 3) A. would not feel comfortable in the spotlight and has difficulty in making decisions;

Sensitivity (I = 4) denotes affective flattening;

Suspicion (L = 3) low degree correlates with C = 1 and explains rather indifference towards the environment and towards itself, and poor perception and lack of interest for reality.

Imagination (M = 3) A. is a conventional person and correlating with G = 4 express relational rigidity and thinking;

Insight (N = 6) patient hardly expresses feelings, but not totally inhibated by rules and standards; minimum *ordine* in thinking and self control ; naivety;

Insecurity (O = 4) correlates with N = 6, A. Not bond by standards and with others;

Radicalism (Q1 = 1) denotes aggressiveness and desire for autonomy. Correlated with E = 3 expresses high risk of outbreak of hostility after interiorization conflicts;

Self-sufficiency (Q2 = 3) social introversion; with low scores in A = 1 and F = 2 highlights pathological withdrawal;

Self discipline (Q3 = 1) increased anxiety, weak sense of self, low self esteem; with Q4 = 7 indicates compulsive excess, rezulting in obsessional behaviour, bad prognosis in the long term evolution of schizophrenia;

Tension (Q4 = 7) anxiety, frustration, need to receive support from others;

Hypochondriasis (D1 = 8) shows concern for the body dysfunction, accusations are nonspecific clue to schizophrenia.

Suicidal Depression (D2 = 7) indicates rezidual depression post psychotic episode evolution of schizophrenia; There are selfdestruction thoughts, but will not be put into act (supported by down score D3 = 5).

Agitation (D3 = 5) patient with average externalizing behaviour;

Anxiety Depression (D4 = 10) specific apsychoti anxiety score of satelite schizophrenia. Rarely A. Speaks his mind, lacks self-confidence, dreams about dangerous situations. He is confused and incapable to cope with sudden demands;

Depression with low energy (D5 = 7) sadness, fatigue, anhedonia;

Guit and resentment (D6 = 9) patient has nightmares in which he feels abandoned by others; more resentment than guilt, fear of abandonment;

Boredrom and withdrawal (D7 = 7) feeling that life is meaningless and dominated by social withdrawal; correlates with Q2 = 3;

Paranoia (Pa = 9) high score indicates paranoid Schizophrenia (associated with suspiciousness and a sens of injustice and persecution). Not to be confused with L = Intolerance.

Psychopatic Deviation (Pp = 2) much lower score, supports the diagnosis of schizophrenia, to the detriment of any other diagnostic that could suggest disharmony type of personality pathology;

Schizophrenia (Sc = 7) correlates with D7 = 7 indicates tendency to social withdrawal. With A = 1 indicates low level of afectivity. Score above average indicates thet he feels rejected, shows derealisation sensations and hallucinatory experiences;

Psihastenia (As = 8) means and supports obsessional behaviour and tendency to express his efforts to oppose A. xenopatic control;

Psyhological Inaccuracies (Ps = 8) indicates presence of feelings of uselessness, autodevalorization, distortion in selfesteem apreciations; correlates with D2 = 7;

4.4.Test Szondi:

Suggests the profile of paranoid Schizophreni and the presence of dissociation syndrome.

p8 h7 manifest (foreground)

s5 d6 k6 sublatent (possible aggression to outsource in the future)

hy1 m4 e3 latent

p8 h7 foreground highlights the **paranoid dimension**, superimposed on imature structure, which tries to overcome its condition through pathologic mechanisms. It describes a personality with touches of feminity, needs to receive and provide tenderness

S: +!!, - signifies psychological female sexual constitution, with uncounscious inversion/sexual purpose;

P: 0, - means operation on projective mechanisms = suspicioousness, senzitivity, senzitivity to rejection, anxiety related to own image in the eyes of the others;

Sch: 0, - means Ego regresion towards amagical *Ego*, dominated by projection mechanism;

C: 0, - means detachment from the world, solitude, loss of value in objects.

5. *„I feel I have no future".* Psychodinamic explanation of the case.

General operationdoes not meet expectations, without medication A. Can not function.Much of the Ego is centered on defense (Freud,A,1936).A. Is empty, flattened, having so imature and ineficient mechanisms, the ego breaks and everything goes out of him (*„they do" / „they put me to do" / „ they tell me how to behave"*).

Dynamics of psychological problems and conflicts is very important in understanding the symbolic significance of the symptoms (Rosenfeld,H,A,1950). His internal experience is all confusion and overwhelming sensory input, and the defence mechanisms is Ego's attempts to cope with particularly intense emotions There are 3 major primitive defences interfering with reality testing:

- **psychotic projection** to the outer world he awards his internal aggressive, sexual, chaos and confusion sensations, not recognised as emanating from within; the boundaries between internal and external experience are confused. We can say that the major defence is the projection of emotional erotic experiences in the auditory hallucination's contents.
- **reaction formation** transforming an idea or impuls in the opposite;
- **psychotic negation** transforming unclear stimulation, that are confusing the patient in delusions and hallucinations (Gabbard,O,G,2014).

6. Etiological Assumptions:

In paranoid Schizophrenia there is no single etiologic factor. The most widely used is the diathesis-stress (DSM).

After Freud, „the royal road" to the uncounscious is the nonverbal language. Early attachment relationships are internalized and submitted as implicit memory. Difficulties related to early attachment and oedipal complex (Freud; Deleuze,G&Guattari,F,2008) crossing malfuncion affected the patient's menalizing ability (Sugarman,A,2006). A. could not manage any internal conflict. With a biological father he never met, raised by a step father until the age of 14 (in that point his mother divorced), abandoned in a one room apartment in the capital, neglected by parents, he developed a huge trauma on abandon dimension (Eigen,M,2001). Thus, as a teenager, he restrained thinking and did not dare to imagine what may be in the mother's mind. This defensive reaction affected his mentalizing ability.

There is a specific biological vulnerability (diathesis), a fragility triggered by psychosocial stress and social environment. Factors that loaded the diathesis: first, the abandonment trauma, then his departure in Italy to his mother. Socio cultural factors include: family, religion, customs. A. Proved to be more troubled in a new culture than in his culture of origin (Deleuze,G,2008). The loss of love objects, ethnic values, native language and home environment leaded to a phenomena of „cultural shock", which severely compromised the identity and self-esteem of the patient and precipitated a „process of mourning" (Halperin, 2004).

Axis IV of the DSM requires consideration of stressful factors in diagnostic evaluation. These events that precipitate an episode of the sickness are of vital importance for both descriptive and dynamic diagnosis. Great attention is essential in this case, because the patient can distort memories of the time of the stressors appearance, in his attempt to explain retrospectively the disease or the problems, as an external event. A stressful event, apparently minor can have great significance for the patient, causing major impact over his functionality.

All this can lead to symptoms of schizophreniform color, in which psychodinamic thinking, familial early relations were disrupted, social inhibition is pervasive, and social needs are repressed, to remove aggression.

We support the aspects of a classic psychosis, evolved with expressed confusion at a productive level, dellusional and hallucinatory, with control from outside of phenomenology and not directly, through an disorganized behavioral act.

More psychopathic deviation score dropped to (Pp = 2) indicates Schizophrenia (and not a personality disorder), and the highest score Paranoia (Pa = 9) claims paranoid form of this disease and evolution marked by suspiciousness and feelings of injustice and persecution.

Score very low on emotional stability scale (C = 1) maintains the high level of anxiety (linking with D4 = 10), stress intolerance, inability to use their resources, high blood pressure.

The patient internalize internal conflicts (Impulsiveness F = 2), closing up ,, itself " hostile and aggressive feelings can burst unexpectedly, as is typical pattern passive - aggressive (dominant E = 3).

7. Conclusions :

Personality tests applied reveal schizoid personality with passive - aggressive tendencies, overlapping paranoid schizophrenia. There is an endogenous background, over which disrupted family relationships early led to pervasive social inhibition of the individual

(which supported the CAQ scales scores: D1 = 8; D2 = 7; D4 = 10; Pp = 2 ; Pa = 9). A very low score factor = 1 „ child expresses psychotraumatized syndrome ", directing us toward a pathological avoidance of others.

The maximum score in Anxiety Depression scale (D4 = 10) adjacent psychotic schizophrenia suggests the anxiety adiacent to schizophrenia, which loads the risk of suicide. Patient lacks self confidence, dreaming about dangerous events, it is unable to cope with sudden request. Clinically, presents a modification of consciousness close to the type oniroid, confusion of thought, which alone calls „ coma ", " dream " and spoken of that combining visual hallucinations and delusions, disorganized psychotic experiences of depersonalization and derealisation phenomena, xenopatic control of thoughts („ I find that... "), delusional persecutory ideation („ will kill me...") and damage, but without knowing who controls his subjective reality. Corollary, appears symbolization.

It highlights a splitted Ego, a weak sense of self with the compulsive and obsesionality, failed attempts to mantain internal control in its own self, that strives hard to oppose xenopatic control (Q3 = 1; Q4 = 7). Exhaustion leads to social withdrawal, which superimposed to inferiority complex and low self esteem,leads to affective flattening, anhedonia and social functioning impossibility.

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