THE CORRELATION BETWEEN UPROOTING AND THE ABUSE OF SUBSTANCES. SOCIO CULTURAL ENVIRONMENT CHANGE AS A TRIGGER FOR PSYCHIC CONDITION

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Abstract:Research motivation: Drug use started to be more and more socially tolerated nowadays, fact which can be supported also by the increased permissive legislature concerning the emergence of legal recreational drugs in many European countries. For this reason, the current case study represents an opportunity to observe the effects varied drugs intake on a long period of time.
Objective: The current work aims to draw a profile of a substance induced Schizophrenia, in rapport to the prevalence of a philosophical charged speech, occurring in a 31 years old patient.
Methods: Psychiatric evaluation, psychological evaluation at the moment of hospitalization, also during, projective exam (Szondi test – destiny analysis), the identity loss perspective when changing socio-cultural environment.
Hypothesis: We suspect that the patient was affected by abusive and long term drug use, which determined the occurrence of a schizophrenic type of psychic disorder, a major role played by the fact that the patient spent ten years out of the country, trying to adapt to many cultures.
Results: The case study shows the profile of a drug abuser, highlighting an immature personality with dis-adaptive defense mechanisms as rationalization, intellectualizing and identity loss, in his journey through many countries. Based on the elements obtained through investigation we defined the current condition episode and its possible evolution in time.
Conclusions: We confirm the specialty literature studies that states that in the case of excessive and long termed substance intake, the level of co morbidity is high, with co existent psychiatric disorders. In this case, the psychiatric disorder was influenced also by the patient's family history, as well as by social and environmental factors.

Keywords: ***psychic condition, substance induced schizophrenia, social and environmental changes, cultural uprooting, loss of personal, family and national identity.***

The patient, B., aged 31, was committed to the Sapunari Psychiatric Hospital 5 months ago, prior to this having spent 1 month in another hospital.

1. Psychic state examination

1.1. The patient's personal history

B. comes from a family of 2 children and an average socio-cultural level. He lives with his parents who spend 9 months working and living in Germany, the remaining time being spent at home, in Romania. In Germany, B's father works in washing machine repairing centre and his mother at a fast food. B's relationship with his parents is not an harmonious one. He tells how his mother, when he was a child, used to tie him to a radiator as an extreme punishment for his running off from home. On the other hand, he says of his father that he was the one who urges him to be honest, just and fair. In B's vision, his sister has all her wishes fulfilled as he thinks she is daddy's favorite.

B's sister is the first member of the family to leave the country, now residing in Spain with her husband. The tense relationship with the other family members is noted throughout

the evolution of B's life story. Following the behavior change due to drug use, B starts to steal things from the house to sell them, so managing to get money for his drugs. This does not pass without a trace in B's conscience, manifesting feelings of guilt and criticism over the act of stealing from his own parents, accusing even suicide thoughts.

From the age of 8 until 21 years old, student at a sports school, B is a member of a soccer team. At 21 he suffers a leg injury, which causes him to stop from his sporting life. It is when he does drugs for the first time and decides to leave the country.

1.2. School history

He first attended primary school and then high school, taking the baccalaureate exam, without caring to know the results. Leaving his country of origin and boasting a high level of adaptability, B manages to learn by himself the languages of the countries where he settles (Spain, Germany, Belgium, Holland), allocating a specific teaching to every place. In the case of Germany, according to B. , work civilizes.

1.3. Work history

In the professional area the patient did not meet difficulties, always managing to find a job, in all the countries he has been to. He said that in Spain, "society helps you to advance", comparing with the difficulty in adapting to the Romanian working environment "here, as you rise a little, they knock you in the head". Despite the ease to find jobs, the patient's story reveals multiple jobs. This aspect must be investigated extra to discover what determine these often changes, because we can obtain information about the patient's capacity to adapt to hierarchical structures, the presence of toleration to frustration and assuming responsibility.

1.4. Present social circumstances

At the moment, the patient has a disorganized family environment. The patient's role in the family is very poorly drawn as he has a tensed relationship with all members. Despite his sister's help he got when he first tried to work abroad, at the moment, due to some theft suspicions and the patient's frequent drug related fights, she is no longer in touch with him. Concerning the relationship with those he lives with, there is a confusing situation in terms of the fact that B says he's living with his parents, while they are home only 3 months a year, the rest of the year working in Germany.

The patient was reserved in clearing weather hid had friendships at the moment. Still, base on the information gathered from his past, we can deduct that he has the capacity to form social contacts and tie relationships, but these seem not to be functional, as he is the one to bring up the lacking equilibrium and reciprocity problem in relation with his friends.

1.5. Forensic history

For approximately 10 years, the patient used various drugs ("anything I could grab" – ketamine, heroin, marijuana, hashish, legal drugs, LSD, pills, stamps, ecstasy). At the moment he does not wish to take hardcore drugs, as he feels those had a negative influence on him ("I got toast"). Still, he remains undecided about marijuana, oscillating during the interview between quitting or not.

On the background of drug use, there have been run-ins with the law as well. In Holland, after taking ketamine and the drug's effect being so powerful, he loses the notion of reality, doesn't know who he is anymore, where he is and asks help from the police, while in

Germany he is arrested for drinking. Also his parents asked for a restraining order concerning him. But have now withdrawn it.

1.6. Prior medical history

The only mention in the patient's medical history is his leg injury that had led him to leave the soccer team he was a part of.

Pre morbid personality:

In the context of the pre morbid personality, we noticed in the patient: addictive tendencies, unusual experiences ("I liked getting lost" – age 7) and a dis harmonic personality structure.

Acute condition:

The hospitalization was not voluntary after B., searching for some money to buy drugs, finds and disturbs his sister's parents-in-law in trying to convince them to lend him money. They called the police and had him committed.

The patient seems to be aware that he s suffering from a psychic condition ("I'm a little weird, I have a sort of philosophical thinking"), but as a part of the symptomatology, he uses some interesting words to describe the state, as "schizoid-free" and "schizoid-joy".

The patient is optimistic about the evolution of the condition presenting his future plans – starting a family and finding a job abroad. During the clinical interview, he comes back to his present state saying "I've recovered. I'm on the brink of despair".

Heredo-collateral psychiatric antecedents and psychiatric history:

The psychic condition debuts in 2007 with a hospitalization that the patient believes was caused by a acute chaotic episode, its trigger being "losing love", breaking up with his girlfriend, that is. During the second hospitalization, the patient gets the schizoid-affective disorder diagnosis. The patient does not agree with the diagnosis saying that he could not communicate clearly what he felt, for that reason stating that his correct diagnosis is "schizoid-free".

The problems in the psychic disorder sphere are not limited to the patient alone. The mother is presented by him as a schizophrenic, the first episode being his birth ("she jumped to their coller"). He also recalls of a memory when he was 16 and his mother was running around the house pulling her hair.

2. Psychic exam

Even from the beginning of the examination, it is quickly shaped that the patient's universe is centered on philosophical principles, as the quest for freedom idea, the time concept, the problematic of divinity, these concepts having a pervasive effect over all the functions and psychic processes, including personality. The philosophical universe is very emotionally charged, as one of the favorite subjects B chooses is expressed this way: "Freedom is above love". The world of philosophical quests seems to be ever expanding, fact that is supported also by the patient's intellectual initiatives – "I've worked for time, to understand it", "I've read philosophers of which you haven't even heard of". All the while, the patient declares himself a mentalist ("I've worked a lot mentally", "the mentalist sits and thinks a lot about freedom") and an avid consumer of philosophy, being taught by a friend that after he uses marijuana to read philosophy. Also, he says that Emil Cioran is funny and that he offered him an important lesson: "I've learnt from there to suppress". The world the patient

created is not safe from day to day threats – "Routine binds you, that's why you are not free". Although the patient has invested a lot of effort into building and maintaining this world, he did not do so in order to isolate himself from the outer world, but invented new words, through amazing associations, in order to explain it and present it to others in a authentic as possible manner. Therefore the patient presents himself as a schizoid-free individual who wants to attain schizoid-joy. The divinity problematic is solved fairly easy through borrowing the conclusion many philosophers reached so far – "Conclusion: God does not exist". In this search, the patient approaches also the conscious, unconscious and subconscious mechanisms – "you can create a little gateway between conscious and subconscious". Not even the body is ignored in this quest, presenting the perspective: "The human body – these energies that pass … waves… sensors. When your ear is ringing it's actually a wave". Still it seems that this continual wave has been abandoned, at the moment the patient describing himself like this: "Now I am a simple person that wants to find a girlfriend".

2.1. General description

2.1.1. Presentation (looks)

The physical outlook and clothing are cared for, the degree of cleanliness is satisfactory.

2.1.2. Behavior and manifested psycho motor activity

The patient is awake, alert and responds normally to stimuli. The patient has a neutral attitude towards the examiner, his focus being raised by the high number of students in the room, with whom he tries to establish contact and normalize his behavior.

He has mobile facial expressions, accompanied by a lose pose, poor gestures and a maintained visual contact. His psycho motor activity is incongruent with the optimistic mood he tries to present about his future. He keeps saying that he will get a job at a catering form and that he will find a girlfriend.

2.1.3. Attitude

The patient's attitude during the clinical interview varied. At first, he had an arrogant attitude, sometimes defiant, clearing as he found out that the room was fool of psychology students, that this is a subject he knows very well, that he even took an exam at a psychology faculty impersonating a friend. Still, during the examination it was obvious the profile of a seductive patient. According to the book "Clinical psychiatry pocketbook manual", the seductive behavior has different meanings for different patients and can be explained as a defense mechanism to feelings of inferiority, a casual way of interacting with those around or even an unconscious way to keep control over an anxiety causing situation (Sadock & Sadock, 2001). We suspect that this patient's behavior can more likely be explained as a defense mechanism to his feelings of inferiority, because all throughout the interview, B. tried to show that despite him having radiated 14 grades, he holds knowledge from very many fields and that he is better prepared than the audience. At the same time, another consequence of his seductive behavior is the fact that his psychic condition is very well masked, managing to instill in others the feeling that his manifestations are strictly the effect of long term drug use, effects that cease him as soon as the drugs would exist his system and in no way a psychic condition.

2.1.4. Perception

At the moment, the patient does not accuse any disorder in the perception sphere.. Still, during those 10 years of drug use, he mentioned various perception disturbances as audio and visual hallucinations ("I see sounds and I hear colors") . Also, the patient told that under LSD effect he could see the way his friend's thoughts left his mind.

2.1.5. Language

From the formal education point of view, the patient is at a medium level with only 14 grades completed; his language is elevated, but charged with slang and English words or even bizarre ones, invented by the patient – new words ("schizoid-free" and "schizoid-joy"). These invented words are used by the patient to better describe himself in the closest manner to his reality. During his speech, we notice slight verbose and a tendency towards slippery ideas, the patient passing from one topic to another fairly easy, with sometimes shallow, random or surprising associations of ideas, but the ideas maintain their associations and he eventually returns to the main theme.

At the level of expressing thinking disorders, we notice the patient's answer tangently, especially for close end questions.

2.1.6. Thinking

Despite the fact that the patient has an average formal schooling level and a poor socio-cultural environment, his intellect is above the average.

The patient's thinking is disturbed by excessive preoccupations and thought processes in a speech with a tendency to lean on philosophy, centered around the prevalent idea – "Freedom is above love".

Other noticed characteristics in thinking level are represented by fragmentation and weakening of associations, which imply a thought logic progression disorder, the patient passing from describing the perils of everyday life routine to the definition of the term mentalist. When he was asked closed end questions, he would answer them, but later on would manifest a thinking blockage, every time accusing that he would not remember what he was saying or was about to.

2.1.7. Affectivity

The patient shows affective ambivalence in rapport to his family. His affectivity is marked by partial flattening, which can be explained as an effect of the condition's existence, of medication or the relation between both. During the clinical examination, the patient proved emotionally stable, meaning no sudden experience modification, but showing constricted emotions.

Instinctual life

The instinctual life does not show significant touch.

2.1.8. Attention and orientation

Attention does not prove significant concentration, stability or selectivity disorders. The patient is time and space oriented, self psychic and allo-psychic.

2.1.9. Memory

The memory shows a slight hypo mnesia, a difficulty in evoking certain situations in his life story, that the patient is aware of: "sometimes I forget what I'm saying".

2.1.10. Condition criticism

The patient shows a partial criticism of his condition (I'm a little weird, I have a more philosophical thinking"), describing himself through new words: "Schizoid-free"/ "schizoid-joy".

2.1.11. Social functioning

The patient completed 14 grades and gave his Baccalaureate exam, but does not know the result. For 10 years, no matter the country he was in, he always managed to find himself a job. At the moment he is committed for a prolonged stay and is following psychiatric treatment. There is the potential of social reintegration, but a problematic aspect which must be closely monitored is his indecision to take marijuana in the future. If he decides to take it up again, there is the risk of falling in the circles that offered him access to hardcore drugs. This way, his capacities to resist temptation are at risk, because by retying the knot with the people he used to do drugs in the past, it's possible to be confronted with cheaper drugs or easier to find than marijuana, his life history demonstrating that, faced with a choice, he would opt for the most accessible drugs, in terms of availability and price.

3. Szondi pulsations test results – Destiny analysis

The pulsational structure

Hy3 p3 d3

S2 e2 m2

K1 h0

In the manifested plane, we have the predominant occurrence of the hy factors, p and d, showing the need to show off, to emphasize himself, of personal and object acquisition, of going in their search.

In sub latent plane, the s, e and m factors appear, indicating aggressive, sadistic, masculine, paternal, activity, virility needs of accumulating brutal affects like fury, cholera, revenge and security.

The profound structure, made up by the k and h factors, indicate, needs of tenderness, maternity, passivity, feminine needs.

From a factors perspective, the structures appear:

* the S vector: h- / s-: The structure is part of the unreal category, of spiritual love, indicating a desire of idealistically intimate connections, through a totally humanized sexuality, non-reality, "tight", positivist reason, hyper intelligence, rationalism; beings of judgment, positivist, hyper intelligent, rationalistic. Isolated from the real world and spiritualized, he totally suppresses his sadism.

* the P vector: e+/hy0: The structure is part of the restless category, anguish states, anxiety, panic, phobia, indicating a simple fear towards certain elements(IE.: fire, water or before certain situations: height, abyss, closed rooms (claustrophobia), large spaces (agoraphobia), animals (zoo phobia), certain people, etc. Classical phobia: the uni-tendency of good intentions.

* the Sch vector: k-/p0: The structure is part of the juvenile Self, inhibited, realistic, who fights against taking conscience, against threatening needs. It is the Suppressing Self; the Self does not see that the pulsional threatening needs deviate conscience. The incapacity to form an objectified ideal. The Self that rejects, that cannot identify itself (obsessive and hysterics).

* The C vector: d0/m+: The structure is part of the happy connections, based on the principle of pleasure, indicating mature relations of the adult with the world, good attention. The subject is not looking for new objects, but clings to old ones with solicitude. The fear of losing the object. Anxious clinging.

4. **Diagnosis and treatment**

Diagnosis

Axis I – substance induced disorganized schizophrenia (main diagnosis, presently in remission due to hospitalization and medical treatment)

Axis II – antisocial personality disorder (criminal acts – theft, arrest; his parents restraining request, overlapped with the conflictual family history).

According to the DSM-IV-TR diagnosis criteria, B's clinical picture is drawn around schizophrenia. The patient shows the following characteristic symptoms: disorganized speech (frequent derailing or incoherence), strongly disorganized behavior and negative symptoms (emotional flattening). At the same time, from the patient's life history a social and functional dysfunction is evident. At 31, B isn't married and tells of a life limited outside the family, accusing that there is no balance and mutuality in his friendships. Also, he has an extremely varied work history, passing through numerous work places. 6 months after being committed, the patient still shows residual signs of his condition – weird beliefs ("I worked for time, to understand it"), negative symptoms (emotional flattening). B's case is not a mood or schizo-affective disorder, because, at the same time with the active phase symptoms, there was no major depressive episode, no maniacal episode, and not a mixed one. Furthermore, the disorder is not due to the direct physiological effects of a substance or general medical conditions.

Statistically, one of the most often met co morbidities associated to schizophrenia is substance use. Still, considering B's lifestyle, we emit the hypothesis by which the substance use was a trigger of the condition. From his life history, we hear that there is a case of schizophrenia in the family, the patient's mother, which might bring in the genetic predisposition to this disorder. Still we believe that the extremely orderly structured lifestyle of his teens (soccer practice twice a day from 8 to 21 years of age) kept his pulsional energy under control, re rooting it towards sporting activity. But with the stopping of this activity, on the background of substance abuse, the vulnerability towards this condition was amplified into manifestation. More accurately, we consider that his frailty, in the absence of prolonged hardcore drug use, would not have been sufficient to trigger the condition. We believe that prolonged substance abuse is the reason for the occurrence of the psychic condition, and the family histories have had the role to influence the type of manifested psychic condition.

According to DSM V, the patient holds the criteria for a substance induced mental disorder. Precisely, the manifestation of the disorder meets the clinical picture significant to schizophrenia. From the patient's history, it is evidenced that the disorder developed a month after the substance intoxication, the drugs he used (hashish, marijuana, ketamine, heroin, LSD, Legal drugs, stamps, pills, ecstasy) being capable to produce this mental disorder. Still, we believe that the disorder is not better explained through an independent mental disorder, and this is not manifested just in a delirium.

Treatment

Based on the comparison between the clinical interview performed at the moment of the hospitalisation and the one 5 month after, we notice the effect of the prolonged stay through the decreased level of dissociation and fragmentation. At the initial evaluation, the patient has a hard to follow speech that alternates between contents, dreams, bizarre statements far off reality check like "This glass is a glass", while at the moment, although his speech maintains a tendency towards philosophy and one for tangentially, still has a higher level of structure.

5. The psychodynamic perspective over the case

5.1. Primary defense mechanisms

In the book "The Ego and the defense mechanisms, Anna Freud presents the way of action in intellectualization. Due to the emergence of libidinal action, the Self becomes more intelligent, developing interests in the intellectual sphere. Namely, the adolescents which, according to Bernfeld, go through a "prolonged puberty", have an insatiable desire to approach abstract topics, to turn them upside down and talk about them. Many of the friendships tied in youth are based on this desire to debate with others and to meditate about these topics. The sphere of these abstract interests and of the problems the young try to resolve is very large. The themes are those like living free or married; philosophical problems like religion or free thinking and various problems of political nature like revolution or submission to authority. The theme of friendship in all its forms is also debated. This is also B's case, who presents a speech centered on philosophical principles, like the idea of the quest for freedom, the time concept, the divinity problem. Therefore, the whole clinical interview represented to the patient the opportunity to describe his intellectual activities in various areas.

In completing the picture created by the subject's intellectualization, in the patient's case we observe also the isolation of the affect through the separation of the idea of freedom from the feeling of love, the latter being inferior. At the same time, at the level of the patient's speech, we can observe rationalization as well, by the making normal the idea of drug use, with the purpose to make it into a socially acceptable behavior, the subject trying to obtain the tacit support of the audience about the use of marijuana. In this situation, the rationalization mechanism is doubled by humor, which although it may seem as a mature form of defense, the patient's case is used for avoiding certain subjects or reducing the inner tension in the case of some difficult subjects, to make them seem unimportant.

5.2. Immature personality

In the analysis intervention, one of the patient's characteristics that became obvious was that of a immature personality. According to Allport's theory, in the case of the immature personality, "The Self has limited borders, does not involve in activities, does not participate in an authentic way, eventually only physically, but not psychologically". The patient realizes a clear distinction between the physical and mental work. "Their emotionality is loud / unbalanced; we see lashes of anger and passion; they do not resist frustrations, welcome them with aversion; are accusing and self accusing", respectively in B's case the powerful emotional reaction he had in the moment of the separation from his girlfriend from Spain (2007 – his first psychiatric hospitalization). "The reflection of reality is modified and adapted to the tendencies and personal fantasies" (the patient's attempts to normalize drug and alcohol use). "They are affected, they "pose", seek to leave impressions, possibly different, contrary

to their real ways of being" (the seductive attitude towards the public). In a descriptive level, immature personalities are seen as self-centered, closed, possessive, suffocating, exclusive (they believe that only they have lived a certain experience, seek to be loved, but cannot give love). They act with hesitation, fluctuating, depending on the situation, surroundings. Still we need more investigative approaches to confirm the hypothesis by which B holds all the characteristics of a immature personality. (Zlate, 2006)

5.3. **The psychodynamic perspective over substance abuse**

Vaillant noticed that people that use multiple drugs are more susceptible to having had unstable childhoods, more predisposed to use drugs as self medication, for psychiatric symptoms. Initially the analytical interpretation of any substance abuse was a regression to the oral stage of the psycho sexual development, but it was replaced by an understanding of drug abuse as more likely defensive and adaptive. More than that, at the moment, the addictive behavior is seen as a reflection of a deficit in the capacity to take care of oneself, as a self destructive impulse. This modification of the capacity to take care of oneself derives from early development disorders, which lead to an inadequate internalization of parental figures, leaving the dependent person without the self protection capacity. In comparison with people with alcoholism, the people who use drugs have a higher chance of developing significant co existent psychiatric disorders. In an epidemiological study that did interviews on 20.291 people, the people who used drugs had a co morbidity rate of 53%. The patient falls into these statistics, suffering from drug abuse as from schizophrenia.

Therefore the majority of individuals with addictive drug use, present a fundamental alteration of their judgment on the perils of drug abuse.

During the clinical interview, the patient recollects his mother's methods of preventing him to run from home, by tying him to the radiator, the patient saying that "he enjoyed getting lost" – by the age of 7. At the same time, the patient's childhood was not authentic, having to follow an extremely rigorous and intense soccer training program twice a day, between the age 8 and 21. Therefore, we can emit the hypothesis that the parents – child relationship deserves closer investigation, that is tracking the method and the time allocated to relations in the family.

5.4. **The psychodynamic perspective on schizophrenia**

Freud was convinced that schizophrenia was characterized by dis-investing objects. In the Freudian vision this dis-investing concept could have been used to describe the detachment of emotional or libidinal dis-investing from the intra psychic representations of the object or to describe social withdrawal from real people in the environment. More precisely, Freud defines schizophrenia as an answer to frustration regression and intense conflict with others, postulating that the patient's investing, being later reinvested in the Self or Ego. On the other hand, Harry Stack Sullivan considered that the etiology of the disorder results from precocious interpersonal difficulties, especially in the child – parent relation. Frieda Fromm-Reichmann underlines that the people with schizophrenia are fundamentally loners, who cannot overcome the fear and mistrusts in others, caused by the sad experiences in their life. The patient recalls scenes from his childhood with his mother tying him to the

radiator, not to escape home, as he now declares that "he loved getting lost". More so, knowing that during childhood and adolescence the patient follows an ample sport training routine twice a day, is worth taking into consideration as a possible insufficient family relations, reported to the emotional needs of a child growing up.

5.5. **Therapeutic approach**

The high level of co morbidity associated to drug use creates varied problems in any case treatment for addicts. Most experts agree that the presence of other psychiatric disorders in relation with drug abuse, constitutes an indication for including individual psychotherapy as a part of the treatment program. The importance of the psychotherapeutically intervention was underlined also by Harry Stack Sullivan, who dedicated his life to treating schizophrenia, conceptualizing the treatment as a long term interpersonal process, which tries to approach precocious interpersonal problems (especially in the parent-child relation). More than that, Vaillant noticed that those who took multiple drugs are more predisposed to benefit from psychotherapeutically efforts which approach their underlying symptomatology and pathology (Gabbard, 2007).

In a therapeutic process with B, it would be indicated that in an initial phase to work on the education, more exactly the therapist must explain how experiencing unpleasant feelings leads to drug abuse in the first place. Afterwards, the patient must be helped to contain and tolerate his affects, so that he may be able to replace actions, such as his drug use, with terms which would describe his inner states and adequate actions for their expression. The specialty literature states that the need for drug is for users an expression of pulsation. Therefore, psychotherapy should focus on helping the patients resist that craving, while they examine the consequences of its gratification. With this purpose, the therapist can assist the patient by identifying the feelings and desires that occur in the therapy session and focusing on identifying an adaptive method of expression.

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