

Evolutionary Possibilities of Acute and Transitory Psychotic Disorder

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Personal History

The patient comes from an organised, socio-economically modest family, his father suffering of diabetes mellitus insufficiently controlled therapeutically, because of his own negligence (at present following to be hospitalised, given the disease complications), his sister is diagnosed with malignant melanoma, extirpated, treated and at present relapsed. Heredo-collateral antecedents are apparently irrelevant psychiatrically.

On his professional training, the patient mentions he graduated a Technological High School, followed by one year at the faculty of Chemistry, where he asserts he did not go because the admission was facile, needing only one day to learn together with his sister. Subsequently, he abandons it and goes to a private faculty of tourism economics, in parallel being employed in sales, passing successively through many positions, in some years reaching in a top position in sales management, after the completion of the graduated faculty and a master within ASE.

In 2008, he reaches a high position in the sales company, next to a high financial status, relating also a change of his personality, in this sense asserting: "I was an introvert and an inhibited person in high school, but working in sales I had to open myself and to be very persuasive". On the verge of economic crisis of 2008, he tries to open his own business of footwear, moment when he is accused by the company of unfair competition, he is sued in justice, action charged legally and interpreted subsequently by the patient delusionally. In the period 2008-2011, he works for two smaller companies, also in the sales sector, at approximately one year and a half.

In 2012, he resumes an older passion from adolescence, when he asserts he made a lot of sport (performance football, arbitration courses) and he enrolls to a master programme of management and marketing for performance teams within UNEFS. In 2013, he wins an Erasmus scholarship for six months in Denmark, subsequently

extending his resident status. 2013 is also the year when the patient decreases his socio-professional functioning level, choosing to do housekeeping, between 6:00 and 9:00 in the morning to be able to attend courses.

In parallel with the master in sports, he also attends the courses of another faculty of marketing of Denmark that he graduates. The professional route and the option for the extended student status suggest an Adlerian overcompensation of the modest socio-cultural level from which the patient comes [1].

For seven years, the patient is in a relationship from distance with a judge girlfriend, who, during quarrelling moments, reproaches him the precarious status of the provenience family. During the last three years of friendship, he refuses to have intimate relationships with his partner, asserting an ascetic road, on which he says: "I wanted to see if our relationship lasts without it, to convince myself that after we remove sex, there something that remains between us. It is obviously that I frustrated her too, but also myself, it is normal to be so". He describes this attitude as a "response" to a "tumultuous" period of his past, when, according to his assertions, he had more occasional partners and he enjoyed life (period on which we can infer that it would correspond to the period of financial wellbeing, when it is probable that the patient had a hyperthymic mood for a long time).

In adolescence, he describes an emotionally significant relationship with a girl three years younger, a borderline structure (from the report of events) and who was forced by circumstances to make to abortions at the age of 16 years, approximately, incidents the patient integrates at present delusionally-traumatically and towards which he asserts guilt and remorse (more in the thinking plane than felt in counter transfer).

The first episode of diseases occurred in 2009 and has as possible real trigger the financial failure in which the patient shows

massive negation (“*Me, trauma? No way of such things, I am not the type!*”). The manifest trigger in relation to which the patient develops a “fixation” is represented by an incident potentiated by subcultural beliefs, in which together with his mother and sister buy a bulb from the internet, with the conviction that it has effects of increase of immunity. The patient exposes himself extendedly and at small distance to the ultraviolet rays, developing a non-specific erythema; he interprets delusionally, which subsequently progresses to ideation in the network from the spectrum of relationship and influence, with consecutive change of behaviour. (He wears very thick clothes, he endows his house with specific transparencies and even shutters against natural lighting, and, finally, he refuses to leave domicile of ear of sunrays. He takes interest in the type of radiations the respective bulb could have emitted, he writes emails to NASA, from where he receives a neutral response to which he assigns delusional significance) [2].

During these months, he develops a psychotic episode in which delusional relationship ideation dominates, next to proprioceptive and tactile hallucinations, systematised delirium supported by somato-tactile feelings and fed by coincidences, in parallel being present the negative phenomenology of the socio-cultural activity and self-care deficit type. He undergoes a psychiatric consultation, and he is indicated a moderate medication, after a few weeks the patient presenting a suicidal attempt by ingestion of medicines, affirmatively because of mood change in depressive direction by the exhaustion given by the persistency of hypochondriac delirium.

Disease history

Patient aged 38 years, has psychiatric antecedents recorded within “Alexandru Obregia” Psychiatry Hospital since 2009, when he was hospitalised for ten days for a suicidal attempt by the ingestion of 15-20 tablets prescribed by the psychiatrist, affirmatively for insomnia (“*I took the respective pills. I said to sleep more and I apologized to God. I took them outside, because I did not want my family to see me. I knew I could die. I renounced to fight anymore.*”)

In relation to the present episode (March 2019), he declares that the symptoms started three days before hospitalisation “*with panic attacks and emotional lability*”, exhausted (we conclude) by the psychotic phenomenology at the basis. He comes to hospital voluntarily, travelling emergently from Denmark to Bucharest. During the flight, it is needed that the crew on board content the patient, who was in a visible psycho-motor agitation condition.

From the patient’s accounts, we find out that the psychosis pushed him to this direction, taking the form of some imperative voices with mystical-divine character, during the current episode obliging him to leave the domicile from Denmark, to throw the key of his apartment in which he was living and to go in the search of the nearest church, where to take off his clothes to see God: “*I thought I had to be naked, in my purest form*”. The patient interprets the key finding in the place where it was thrown as a sign he acted correctly listening to the voices: “*God left the key there, it is clear that this was meant to do. Therefore, the key would not have been in the same place!*”. Upon the remission of symptoms, the patient

“resumes” the hallucinations inside his being, calling them “*my consciousness, not an external voice*”.

Examination of the present psychic state

Remarks: The patient is conscious and cooperating, tranquil from a psycho-motor point of view, with a hypomobile facial expression of beatitude (in the absence of an adequate stimulus) and fixed gaze. He is oriented to time and space, auto- and allo-psychically. His posture is neat, with preserved hygiene. The speech is slightly incoherent, tachypnea is noticed, with jerky voice. Psycho-verbal contact is achieved easily. Throughout the medical interview, the patient keeps tightly in his hands an icon.

Perceptions: From the sphere of quantitative disorders, we identify a hyperesthesia focused on tactile sensorial register. From the sphere of perception, the following are recorded as qualitative disorders:

- **imperative auditory hallucinations:** “*It told me that I must go to church. The voice was telling me: Throw the key and go to church! I believe it was God and he was sending me there for my sins.*”;

- **pseudohallucinations:** “*The voice was as a inner process for my sins*”

Attention: Voluntary hypoprosexia is acknowledged, with spontaneous hyperprosexia, insufficient functioning of attention filter, and difficulties of concentration, stability and selectivity of attention.

Memory: A selective hypermnesia is present, with extraction of certain data, facts and events integrated in an interpretatively delusional way. The patient fixes and retains elements that present a “significance” that contributes to the augmentation of his delirium: “*I bought a bulb from the internet. I was very cold and there was written that the bulb cleans the air within the room and it is beneficial for breathing. I felt my teeth are drying [...] I could not leave the house. I was feeling more and more the heat on my skin.*”

Thinking: Analysing the central cognitive function of psychic life, we acknowledge both quantitative disorganisation disorders, and qualitative ones, subsuming psychotic thinking. The ideo-verbal flow is accelerated, with flight of ideas and speech sliding, which is focused on marking content (professional failure, abortions of his former life partner), intercalating sometimes with hypermnesia for non-significant details and incapacity to differentiate the general essential. Weakening of logical associations is noticed with sliding from one real plane to the metaphorical one. We also note the existence of circumstantial discourse and tangential responses (to the question: “*How did you reach to the psychiatry hospital*” the patient answers: “*The symptoms continued until July. A friend recommended me a psychiatrist to be able to sleep*”).

In addition to quantitative thinking disorders, we also draw the attention of the qualitative ones:

- **Delusional ideation of follow-up, persecution, and damage,**

carried out on the background of a basal suspicion: *“In Denmark, one shall find out of my failure in Romania. And when one shall hear there on my trial, nobody will employ me”, “I feel followed-up.”*

- **Mystical delusional ideation:** *“At church, during the last years, I was praying only for others, because I did not consider myself important. I was saying the names of the persons I know and after that, I was praying for all beings on Earth. I felt better during praying.”, “I pray 6-7 times a day.”*

- **Delusional guilt ideation:** *“I have two children with whom I am not in a relationship because my girlfriend underwent abortion when I was 18-19 years old. I feel guilty because I didn't even care.”*

- **Somatic delirium:** *“My physical pain started because of the ultraviolet bulb... I felt my teeth are drying. I slept with it and when I woke up I had the eyes swollen, I was red on my throat and on my face, I was a little tanned.”*

- **Delusional interpretativity:** *“At the conference of Denmark, I had the impression it is spoken about me”*

- **Ideation of xenopathic control [3]:** *“It told me I must go to church. I was told: Go there. Throw the key and go to church! I believe it was God, who was sending me to Church for my sins.”*

Affectivity: Patient's mood is marked by anguish with psychotic roots, described by the person in question as *“a triggering of panic, fear, anxiety”*. Affective flattening is acknowledged, with hypomobile facies and reduction of body language [4].

Activity: He presents low useful yield: *“I could not leave the house”*, and throughout the last years he did not carry out any socially useful activity because, wanting to stabilise in Denmark, he learnt the language and he was permanently in contact with an adviser who had as purpose to facilitate his social-professional integration in the environment from there. He asserts that loneliness and the lack of a job affected him significantly, this being the reason for which he accepted for a while to carry out an activity below his academic training.

Behaviour: He is psychotically changed (the patient keeps an icon in his hands as “anchor” and he asserts he prays 6-7 times a day). He is unpredictable, instable, with dromomania tendencies.

Instinctual life: he presents food appetite disorder and low preoccupations for erotic life: *“I had sexual relationships at the beginning, but it did not seem normal how they were running, so that I renounced three year ago. It seems normally to me this way, not to have intimate relationships until marriage.”*

Circadian rhythm: He complains of mixed insomnias, sleeping interrupted by nightmares.

Personality: A bizarre aspect of personality can be noticed, suggesting that the patient faced a psychotic process [5].

Insight: Partially preserved.

Feelings induced in counter transfer: He suggests grandiosity

(involving both grandeur and narcissism, narcissist – paranoid area in which patient functioning carries out at present) [6].

Syndromological diagnostic

Starting from the psychiatric description above, we can systematise the symptoms present in the following syndromes:

Paranoid syndrome:

- Partially systemised delirium with persecutor content and presence of suspicion: *“In Denmark one shall find out of the failure of Romania.”, “I feel I am followed-up.”;*
- Auditory hallucinations: *“It told me I must go to church. I was told: Go there. Throw the key and go to church! I believe it was God, who was sending me to Church for my sins.”;*
- Psychotic anxiety that determined bizarre changes of attitude and behaviour: *“As the summer was coming, I was feeling the heat more and more. I was afraid to leave the house because my skin was burning badly”*, *“For a few days I was so scared they would find out in Denmark of the fact I did not have an ethical behaviour at a Romanian company”;*

Ideo-verbal disorganisation syndrome:

- Tangential answers;
- Circumstantial speech;
- Mimic – gesture expressions inadequate and in disagreement with the discussion: During anamnesis, the patient keeps an icon tightly in his hands and expresses a continuous emphatic smile, unjustified, suggesting a superiority attitude, as well as the fact that other are not sufficiently dignified so that he reveals to them [7].

Psychotic anxiety syndrome:

- Continuous feeling of a danger: *“As the summer was coming, I was feeling the heat more and more. I was afraid to leave the house because my skin was burning badly”;*
- Excessive worries related to what might happen in the near future: *“For a few days I was so scared they would find out in Denmark of the fact I did not have an ethical behaviour at a Romanian company”;*
- Insomnia;
- Suspicious posture [8].

Inhibited depression syndrome:

- Towards himself, the patient manifests lack of trust, self-depreciation and has a low self-esteem [9] (*“At church, during the last years, I was praying only for others, because I did not consider myself important. I was saying the names of the persons I know and after that I was praying for all beings on Earth.”*), he considers guilty for minor reasons or for no reason (*“I have two children with whom I am not in a relationship because my girlfriend underwent abortion when I was 18-19 years old. I feel guilty because I didn't even care.”*);
- Hypochondriac delusional preoccupations focused on cenesthopathies: *“My physical pain started because of the ultraviolet bulb... I felt my teeth are drying. I slept with it and when I woke up I had the eyes swollen, I was red on my throat and on my face, I was a little tanned.”*. Prior to the presentation to psychiatry, the patient carried out multiple visits at ophthalmologist and

dermatologist;
 • Reduction of sleep by insomnia.

Vth axis –GAFS score=30

Multiaxial diagnostic

Taking into consideration the previously described symptoms, we assert the diagnostic of **Ist Axis as being:** Transitory acute psychotic disorder.

Diagnostic criteria for transitory acute psychotic disorder according to DSM IV:

- A. Sudden onset and at least one of the following psychotic symptoms: delusional ideas, hallucinations, disorganised language, disorganised or catatonic behaviour;
- B. The episode lasts at least one day and at the most one month, and subsequently the individual comes back at the previous functioning level;
- C. The episode is not better explained by another psychic disorder or another medical condition.

IInd axis – Schizotypal personality disorder

Diagnostic criteria for schizotypal personality according to DSM IV:

- A. A pervasive pattern of social and interpersonal deficits, manifested by acute discomfort within relation-making with others, reduction of capacity to establish intimate relationships, cognitive and perception distortions, behavioral eccentricities, starting precociously in the adult period and present in a variety of contexts, as it is indicated by 5 (or more) of the following:
 - (1) reference ideas (excluding reference delusional ideas)
 - (2) magical thinking or foreign beliefs influencing the behaviour and they are compatible with subcultural norms (for ex. superstitions, clairvoyance belief, telepathy or “the sixth sense”; in children and adolescents – fantasies and bizarre preoccupations)
 - (3) unusual perceptive experiences, including body illusions
 - (4) bizarre thinking and language (for ex. vague language, circumstantial, metaphorical, over-elaborated or stereotypical)
 - (5) suspicion or paranoid ideation
 - (6) inadequate or limited emotions
 - (7) bizarre behaviour or appearance, eccentric or particular
 - (8) the lack of friends and close confidants, other than Ist degree relatives
 - (9) Excessive social anxiety, which does not diminishes with familiarization and tends to be associated rather with paranoid fears than with negative judgements on the self.
- B. It does not occur exclusively during schizophrenia, during an affective disorder with psychotic elements, or another psychotic disorder or of a pervasive development disorder.

IIIrd axis – Absence of somatic diseases.

IVth axis:

- precarious social support (lives alone in Denmark, having few friends)
- professional instability (change of workplace repeatedly, the absence of a job at present)

Differential diagnostic

In evolution, the psychotic episode described above can contour in a form of paranoid schizophrenia, or in a bipolar affective disorder, or a schizo-affective disorder.

Paranoid schizophrenia	Bipolar affective disorder	Schizo-affective disorder
Polymorphous delusional ideas (psychotic rank religiousness, xenopathy, persecution and damage delusional ideation, paranoid grandeur)	The presence of an affective episode in antecedents	
(depressive or expansive)		
The chronology of events is important:		
The mood changes firstly, subsequently psychotic phenomena overlap	We find in antecedents both mood episodes in the absence of psychotic phenomena, and mainly psychotic episodes, without changes of thymic function, but also periods overlapping both types of manifestations (affective and psychotic)	
Auditory hallucinations	At present, he has a pathological sad mood, with loss of interest for social activities, mixed insomnias, low food appetite – suggestive for a new depressive episode	Psychotic phenomenology existed in the absence of affective symptoms
Distortion at the thinking level with weakening of logical associations, tangential, circumstantial answers	Change of workplace + professional reorientation can be suggestive for a maniacal episode, as well as the period during which he had financial success and the relation-making track disappeared	
Affective flattening in relation to the social relationships and events in his life. Depression seems to occur because of psychotic exhaustion.	Professional success and sexual behaviour accentuated in 2009 can be explained by a hypomania	
Lack of criticism on the disease	Remission of very good quality after the previous episode (dated 2009) after a treatment of only six months, with good social-functional reintegration.	
Schizotypal premorbid personality	Avoiding premorbid personality, traits removed by the occurrence of hypomania	
Insidious onset		

Remarks! Clinical experience shows that there are also forms of paranoid schizophrenia that affect in time.

The differential diagnostic of schizotypal personality disorder in the present case can be made with:

Avoiding personality disorder

Pro	Against
He has at least or has no interest in having sexual experiences with another person	He wants and enjoys close relationships, but he is afraid he cannot have or preserve them. He is solitary, but willing for social involvement.
Presents affective flattening	Has close confidants, but also has inferiority complexes, he does not trust himself, structurally he is modest, and he erroneously interprets the comments of other people, as being despiseful or negative, he considers himself unattractive.
	He is not indifferent to criticisms and praises of other people. He avoids interpersonal contact activities being feared of criticism, disapproval, rejection. He does not want to involve with others, if he is not sure it is pleasant. Restraint in the intimate relationships comes from the fear of not being embarrassed, of not being ridiculous. He is preoccupied of not being rejected in social situations and inhibited in new interpersonal relationships out of inadequacy feeling. He thinks he is inadequate, unattractive, inferior. Retained in assuming risks in any new activity (because it could be an embarrassing situation), which makes him undecided if he must stay in Denmark or t return to the country.

Evolution and Prognostic

Positive prognostic factors

- the presence of affective and confusion elements;
- the absence of genetic load;
- sudden onset;
- good global premorbid functioning (high);
- Capacity to establish a good therapeutic alliance.

Negative prognostic factors

- male sex;
- psychological incapacity to connect the symptoms to possible psycho-traumas;
- the typical use of negation in relation to the life perturbing events (Kohut, 2009);
- magical thinking, potentiated sub-culturally by the provenance physician;
- mentalization deficit;
- ascetic dimension of his personality, which is egosyntonic at present;
- Development of adverse reactions to Aripiprazole of the area of dyskinesias, grafted on previous cenestopathies and hypersensitivity in proprioceptive register.

Evolutive risks are

- medico-legal complications under xenopathic control;
- risk of continuous disorganisation in thinking and behaviour, with affectation of social functioning;
- risk of non-compliance to treatment;
- Suicidal risk in the context of a major depressive episode or under xenopathic control [10].

Treatment

At present, the patient had indication for hospitalisation, taking into account the severe symptoms with psychotic anxiety and bizarre

behavioural changes, dictated xenopathically. At present, he was administered injectable antipsychotic (Abilijy 7.5 mg 3 vials/day, with subsequent passage to 30 mg Aripiprazole orally), anxiolytic and sedative, next to Trihexyphenidyl, given the dyskinesia reactions occurred to Aripiprazole. The patient responds well to treatment, psychotic phenomenology is inhibited by medicines.

Upon discharge, he was recommended to continue psychotropic treatment with psychotherapy for Ego strengthening, integration of the episode passed in his personality and increase of compliance to pharmacological treatment [11].

Once arrived in Denmark, the patient starts to develop adverse reactions to treatment, suggestive for the intensity of paranoid psychosis, reasoning thus his non-compliance [12]. He seems to evolve well in the absence of anti-psychotic too, as it also did during the previous episode (counter argument for a paranoid schizophrenia), laying thus the foundations of a new episode, with slow evolution.

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