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OBSESSIVE-COMPULSIVE PARTICULARITIES BEFORE AND AFTER REMISSION OF ACUTE PHASE EPISODES OF SCHIZOPHRENIA

Ana Miruna Dragoi (a)*, Angela Enache (b), Simona Trifu (c)
*Corresponding author

(a) Hospital for Psychiatry "Alex. Obregia", 10 Berceni Str., Bucharest, Romania.
E-mail: dragoimiruna1@gmail.com
(b) Hospital for Psychiatry Sapunari, Sapunari, jud. Calarasi, Romania. E-mail: angela.enache71@gmail.com
(c) University of Medicine and Pharmacy "Carol Davila", Bucharest. E-mail: Romania, simonatrifu@yahoo.com

Abstract

Background: Obsessive idea is related to act, the patient trying a resistance, so that, if in delirium the patient agrees and aspires to, in obsession, the disagreement is the main characteristic. Research Questions: In aggressive obsession, there is the fear of self of not being aggressive with others, while in paranoid delirium there is the fear of being persecuted by others. Aim: The concept of schizo-obsessive disorder, with onset in adolescence with OC phenomenology, with subsequently negative symptoms, productive perceptual and ideational area (auditory hallucinations and pseudo-hallucinations, next to Kandinsky Clerambault syndrome). OC phenomenology acquires connotations different from schizophrenia onset, the patient never acquiring again a disorder total insight. Results: When obsessions and compulsions were related to the content of delusional ideas and hallucinations, other typical rituals of obsessive-compulsive disorders appeared too, the patient considered sometimes irrational and excessive. The obsessive-compulsive symptoms were present a significant period of the prodrome, of active phases and residual period, being time-consuming, causing distress and interfering patient's routine, in addition to the schizophrenia deterioration. Conclusions: Social degradation is dictated mainly by the negative dimension of schizophrenia, secondly by energy consumption in fulfilling the rituals and compulsions and finally by the mood change in depressive sense. The family emotional climate in excess potentiates the negative inversion towards family, which amplifies the sensitiveness to rejection, sensitive relationship delirium, referentiality and finally social isolation.

Keywords: Schizo-obsessive disorder, pseudohallucinations, rituals.

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1. Introduction

The patient aged 32 years, at his fifth hospitalisation, which takes place at present in Sapunari psychiatry Hospital, previously presented four hospitalisations in "Alex Obregia" Psychiatry Hospital. The current hospitalisation is an extended one, reaching at around ninety days of hospitalisation, being given the affective inversion towards the parents, who made them reticent in bringing the patient home.

Other attitudinal changes that led to hospitalisation were the change of addressing register to the mother: "Are you a slut? Why don't you recognize it?!"

From heredo-collateral antecedents we remember the mother, diagnosed with schizophrenia, subsequently extended post-psychotic depression, the patient describing her as being passive and not making many things. (illogical construction)

2. Problem Statement

2.1. Childhood

He asserts at young ages the sobbing spasm and frequent moments of lipothymia. He was preoccupied of masturbation and he relates that he was pottering: "I was jumping in bed; I was bouncing around the house" to control the mood. He was accusing "memory erasure" from childhood, but he puts the question if many events were reinterpreted after having triggered the disorder or if psychotic perturbations existed since that (conceptual disorganisation, logical association weakening, non-selective retrospections delusionally integrated are).

2.2. School history

He attended Tonitza Arts High School, he sat for Baccalaureate exam that he felt as being a difficult exam. There followed the admission to the Institute of Plastic Arts, with the drawing test "a female model", exam he failed.

A period of three-five years he stayed home, and then he attended the Faculty of Theology, being prompted by his parents (the two twin brothers, twelve years older, were going in the same direction, brothers on whom the patient relates that he never coped with). After one year and a half, he interrupted his studies, the delirium influencing both his focusing capacity, and his memorisation at creativity level, losing his capacity to do something.

Being asked how he perceives the causality of his disorder, we identify a simplistic infantile thinking, in which all reduces to only one aspect: "My parents are divorced and everything is understood from here: There were discussions, scandals, and I did not want to be included". (the divorce of his parents took place when the patient was 5 years old, and his twin brothers 16 years old).

2.3. Professional history

For a very short time interval (approximately one week) he worked as call-center operator: "They were saying I did not meet the necessary conditions. They were mean to me. (nobody assumes decisions, everything is made under a locus of an external control)

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Professional life is vaguely represented in mind, he recalls that around the age of 29-30 years, he also tried to work at the painting workshop of a church, but he did not get along with those from that place. His accounts are made with sensitivity, even if his mood changes quickly in a superiority smile subsequently.

2.4. Medical history

He was diagnosed with paranoid schizophrenia in 2015, when he developed delusional jealousy ideation, in parallel with the feeling that something bad is happening to him, which my parents and my brothers are stronger than him. The first hospitalisation lasted one month.

The second hospitalisation was following a marking episode of negative symptoms and hallucinating phenomena: “I stayed dirty. Life and hope did not really count. I was staying backwards and they were coming towards me, they were hitting out at me, so humpback…I could even speak, because I had limits verbally…”

The third episode was two years ago, on which he relates that: “I could not go to bathroom, I was staying with poop and pee on me and I was eating from the kitchen floor.” The negative dimension of schizophrenia is conspicuously identified, the patient not leaving his domicile during the last year, not leaving even his bedroom, reaching to foul next to his bed: “I was staying dirty I the house”. He was asserting that he had reached to eat from the floor because of his overwhelming psychotic distress to the thought of exiting the room, distress that was paralysing his physical movement power, with incapacity of reaching to the toilet.

2.5. Perception disorders

Auditory hallucinations and pseudo-hallucinations, voices that are chatting one to the other, or who are commenting the actions of the patient, sometimes with favourable content, sometimes unfavourable. He prefers disorder, even if he lives in misery: “I am not perfectionist, but I want to be order…Aoleo! Are they speaking about us?” (quasi-present hallucinations during the interview). Illusions and visual hallucinations.

2.6. Delusional interpretations

His parents bought him a computer, where “strange things” happen, such as the pages moving in the browser, thing which is delusionally interpreted.

Ads that appear on the internet are perceived as being put by his father, the speech is disorganising and he loses his logical course.

2.7. Thinking disorders

Delusional ideation of persecution addressed to his family, built with high probability on the affective inversion towards them.

Suicidal preoccupations are identified; depressive intrusions, recurrent death thoughts that can determine suicidal conduct; projection mechanism; regressive behaviour, anguishes of Ego annihilation to

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abandonment, attachment pathology; overlap of obsessional phenomena in schizophrenia; hyper-analysis of other people's actions, interpretativity of phenomena of external world, assignment of significances, xenopathic control, delusional influence ideation.

Regressive behaviour of territory marking, of defiant opposition, characteristic of animal register; relationship sensitivity, existential loneliness; delusional influence ideation, transmission of thoughts, Kandinsky–Clérambault mental automatism syndrome, also incorporating pseudohallucinations.

Upon the extension of anamnesis, he recognizes inclusively the presence of verra auditory hallucinations, next to the delusional ideation of mystical colours.

Under psychiatric medication for months, the patient starts to confront the reality plane versus the plane of communication with God. His delusional system becomes elliptical, the person in question not confessing it, because he lacks the sense at times.

We can note the triple automatism (of thoughts, of feelings, and of actions) as nucleus of xenopathy and non-appurtenance to Ego; illogical explanations, by contiguity, infantile; delusional control ideation, persecution; delusional relationship ideas, belief in spells, delusional interpretativity of certain visceroceptive sensations; mind reading phenomena; xenopathic control; intrusive thoughts, control from a distance; personification of thinking; bizarre experiences, of body strangeness.

2.8. Association of obsessive-compulsive elements

"If I am late and I did not take the pills in time, I know I must be punished because I was to bathroom." (regressed, suggestible behaviour, with clinching to attachment persons towards whom he develops rituals as regards sitting and standing on/from the chair, greeting formulas, number and order in which they must happen) (Sterk, Lankreijer, Linszen, & de Haan, 2011).

He perceives physical imperfections related to the dimension and appearance of his nose, saying that at a given time he provokes vomiting by the contraction of the abdomen to preserve his weight and form. (dysmorphophobia elements)

We find collectionarism, the need to preserve some invaluable things.

Relating from his childhood, he recalls how his mother was buying him cloths she was bringing to him, which he reinterprets delusionally at present; intrusiveness and recurrence to an ideation the patient perceives as being embarrassing and parasite, reaching Chaslin hypermnesia mentism). He perceives aggressive thoughts as being "inserted in his head" by the parents who entered by force his thoughts. They are required to be quiet by certain compulsions, he uses to defend against obsessive ideas.

The content of OCD obsessions is abnormal and often absurd, thing the patient notices and toward which he reacts by criticism and effort to remove obsessions.

There are cases when there is critical self-assessment of absurdity of expressed thoughts. When they have the form and intensity of some aberrant beliefs, the criticism decreases progressively. Therefore, during hospitalization, as regards Kate, the patient tells that, however, what he thinks and feels for her make him well, they are exaggerate thoughts that consume his energy too much. Subsequently, following an event with stressing content, Kate reappears in the speech with the same strength.

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3. Research Questions

A psychiatric patient, for a relevant diagnosis, needs a longitudinal evaluation, so that in dynamics we can identify long periods of time in which the elements of an obsessive compulsive disorder predominate and, at a certain point, the severe impairment of its social functioning will be the one that raises the problem of a simple schizophrenia. In other cases, the onset is of schizophreniform coloration, and the overlap of the ritual elements is a factor of gravity (poor prognosis). The chronological sequence of the onset of symptoms is often clear.

However, in recent years, a number of specialized journals postulate the Obsessive Schizoid Disorder as an entity in itself, in which compulsions make the patient's life difficult, impede the social functioning and significantly reduce the potential for recoverability, by affecting the compensatory resources, because a huge amount of energy is spent in passing the act to perform the rituals.

The present case raises the problem of being included in this clinical entity, the particularity being relatively critical of the one concerned about the phenomena that belong to Kandinski Clerambault syndrome (xenopathy, influence, delirium of relation, sensitivity, as well as pseudo hallucinations). These tilt the balance towards the side of a schizophrenia, but the compulsions and rituals are not to be neglected, representing a core of relief that attracts the rest of psychotic phenomenology.

4. Purpose of the Study

The present study aims to highlight the presence in the clinic of such patients, who although ICD 10 diagnostic coding subscribes to a diagnosis of Schizophrenia (which currently meets DSM 5 criteria), they belong to an obsessive schizoid disorder. Usually, these patients meet the following criteria, which will be specified below and which represent the clinical conclusions of a series of cases from which we currently particularize one of those who have been admitted to our clinic for the last years.

The debut is in adolescence around the age of 16, although it does not take the form of a hebephrenia in the sense of DSM IV TR. In the foreground, the symptoms are the simple negative phenomena (loss of the existential drive, apathy, abolition, loss of motivation, purpose and meaning in life), the ritual phenomena appearing as a way to maintain control. In other words, through compulsions and rituals, the one in question is opposed to xenopathic phenomena, which make their place insidious in their own consciousness.

In about three four years, the psychiatric evaluation will reveal a Kandinski Clerambault type syndrome, in which we identify the loss of the borders of the E, the triple automatism (of thinking, of the behavioural acts and of the affections), the non-belonging to the I and the delirious idea of influence, the psychological transparency. . The negative phenomenology doubles the productive one, the disorganization of thought being prevented by the maintenance of rituals and compulsions, which continue to oppose the split of the personality.

The purpose of the present study is to highlight how the presence of obsessive aspects tries to anchor a patient with schizophrenia in everyday reality, even though the way of coupling to the world and life is a strange and non-productive one, yet it is a defence mechanism.

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5. Research Methods

The patient was at the fifth hospitalization in a psychiatric hospital, currently in the foreground being negative phenomenology, which emphasizes the importance of ergotherapy, as well as any activities with a social and professional stakes and involvement in actions and activities. Initially the hospitalization was done in a section of Acute patients, later in one of Chronicles, in total the last one of the fifth hospitalization, comprising about five months, when under high dose Risperidone (8 mg, next to SSRI as an antiobsessional election - Sertraline 200 mg) annihilated productive phenomenology. The compulsive ritual space seemed, in a psychodynamic perspective, a compensatory one for the patient, as a safety zone in which the person concerned kept his energy for himself.

There was a complex psychological evaluation, mainly of the projective type, which highlights the patient's impulsive structure, with an emphasis on the sadistic epileptoid component that envelops the paranoid nucleus, with the monitoring of the daily evolution under clinical scales of type BPRS, PANSS (separately from the evolution of positive and negative symptoms).).

Psychological interventions were highlighted by the regaining of the borders of the Ego, with an emphasis on self-recovery and the reintegration of each psychotic episode into the new extended personality, which was to become contingent on compulsions, rituals and residual delirium.

5.1. Treatment:

Even if he asserts that if he does not take his medication, he feels an inner void feeling, he reports to it in a paranoid manner, refusing help and considering in his narcissist fragility inacceptable to depend of something. (Hodges, Myers, & Michael, 2007) Symbolically, as in the case of any authentic paranoid, he has the feeling the medication changes his personality, not managing to preserve in his mind a continuum between him the symptomatic one and him under treatment (Trifu, Udangiu, & Tilea, 2013; Trifu, 2016).

5.2. Psychological examination:

We can identify hypomobile mimics, reduced gestures, voice with low tonality, the presence of pseudohallucinations, lexico-informational volume limited to usual, simple words. The decrease of capacity of emotion contention, restraint of interest sphere and activities around psychic suffering, low frustration tolerance, increased suspiciousness (Thomas & Tharyan, 2011).

Calgary scale highlights severe depression, patient dominated by negative thoughts of incapacity and lack of existential sense.

Luscher: emotive subject with perturbation of affective emotions, impressionable, with high sensitivity and soul receptiveness. He cries easily, of sadness, of pity and of tenderness. Any external hit can be felt with pathological intensity, depressing the one in question.

Schmiescheck questionnaire of accentuated tendencies: hyper-perseverance, extreme ambition, sensitivity, instability of emotions.

Tree test: splitting in three, corresponding to the metaphor of non-separation regarding the parents, self-limitation, infantilism, “to identify himself from nothing”.

Experimental psychodiagnostics of drives (Szondi test):

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In the foreground:

Vector S = h+s0: dominant of infantile type love, with satisfaction acquisition from aggressiveness.

Vector P = e-hy0: accumulation of anger, revenge, envy and jealousy, suggesting Cain constellation (e-) without moral brake (hy0).

Vector Sch = k-p±: the use of mechanisms of negation and projection, which leads to estrangement and finally to alienation; abandonment, incapacity to define his own genre, depersonalization feelings.

Vector C = d+!m±: obsessional ambivalence in attachments, which leaves space for some paroxysmal depression outbreaks, Ego being introjected.

Perspective profile:

Vector S = h-s±!: sadomasochism (s±) with Eros suppression (h-), namely aversion towards people in general; aggressive tendencies inhibit the need of culture and civilisation, the self-love lacks, Ego being in overpressure, with risk of extreme sadism.

Vector P = e+hy±: for the future, the Abel nature will defeat the Cain one of the present, the patient exteriorising his kindness, even if he will do it in demonstrative manner; he will reduce his dilemmas and moral doubts by assumption of guilt; the flow of emotions (e+hy+) will tend to concealment (hy-), leaving space for phobic pathology (e+hy0).

Vector Sch = k+p0: total introjection in a schizo-obsessive type profile.

Vector C = d-m0: clinching, perseverance, conservatism, anal character expressed psycho-pathologically in a delirium with hysteriform roots.

Conclusions:

The patient feels depressed, being conscious of his inner conflict towards objects from environment, he perceives as necessary and very appreciated (d+), but of which he cannot enjoy (m±).

6. Findings

6.1. Psychodynamic interpretations

The patient is regressed, blocked in a point situated most probably in the period of anal development, coprophilia and “fixation” for faecal matters representing a modality of control, the only power he has over his body. An animal instinct to revenge and territory marking can be identified, a pathology of containment. Given the incapacity of adults to offer him attachment, the person in question reaches to discharge his discontent in a physical manner.

The evolution of schizophrenia is an old one, in which we identify the symbolic significance of happiness theft when he lost his antivirus, namely protection.

His thinking is a paranoid one, with delusional persecution ideation, influence and insertion fo thoughts, occasionally associating suicidal preoccupations. Obsessive ruminations represent a seriousness prognostic. We identify hyperesthesia and a slowed time perception, a crucifixion beyond its passage (feeling of atemporality of the schizophrenic person). During acute moments of disorder, the patient’s pathology runs in the sensorial-kinesics register, with slowness reaching up to the incapacity to perform movements, when there is the risk of catatonia.

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We can notice Chaslin hypermnesia mentism, when the person in question cannot stop his representations, thoughts and memories that are coming in an embarrassing and parasite manner, subsequently being overlapped with Kandinsky Clerambault syndrome (pseudohallucinations, delusional relationship ideas, insertion of thoughts and xenopathic control). The adjacent anguish feeling determines the patient not to want any contact, at limit, nothing to enter, nothing to exit from his inner being.

We can identify the Ist rank symptoms of schizophrenia (according to Kurt Schneider), and in Gruhle's vision, we can speak of a paralysis of Ego, which represents an interruption in psychic life, determined by the cessation of consciousness flow, with the loss of feeling of his own activity and autonomy feeling, next to "thinking or acts that happen spontaneously, independently of his will and which sometimes can escape the conscious record" (Öhman, 2008, p.720).

From the positive dimension of schizophrenia, we note external influence syndrome, the patient feeling prevented/influenced by his parents in all he does.

Complementarily, we can identify the transparency syndrome, in which the subject feels the occurrence in his consciousness, without his will, of some thoughts he perceives as alien from himself, imposed from exterior, by others.

6.2. Case particularity

We can remark the association of obsessive symptoms over Kandinsky Clerambault syndrome, namely the person in question can make the difference when obsessive and intrusive compulsions are from his inner being and when they come/are imposed from outside, from persecutors, both types of pathologies existing.

The obsession is that idea that outbursts, erupts, besieges thinking and imposes to consciousness even if it is in disagreement with it. It is alien and contradictory to the situation and personality of the individual, the person in question recognizing its parasite or pathological character and fighting to remove it (Prins, 2001). The obsessions invade patient's mind, appearing as unwanted thoughts he tries to ignore and being dominated by anxiety that the person in question tries to solve by means of compulsions. The closure of vicious circle is tried, with occurrence of the repetition need, which will increase intrusion and, at the same time, will increase anguish.

Obsession can appear following a psychic process of controlling something, attacking usually the most appreciated values by the individual. There are endogenous obsessions or autonomous obsessions, represented by thoughts, image, inacceptable drives, which appear spontaneously following some triggers and reactive obsessions, which appear under the form of some concerns, doubts activated by certain triggers.

6.3. Differential OCD diagnostic:

In DSM V, one renounces to criterion B, which mentions that along OCD evolution, it is required that the individual permanently recognises the thoughts as being excessive or irrational, adopting the idea that the insight can oscillate. Therefore, when the individual is far from the anxious stimulus, he manages to be more critical.

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Disorder criticism refers to the awareness of the negative consequences of the disorder, the individual being capable of insight on the negative impact the compulsions have on his own life and intimates. At the same time, the individual considers his preoccupations as being exaggerated and time-consuming.

In case of intrusive thoughts, the individuals are scared that they had such ideas, there being a negative assessment related to his own person: "What kind of person am I if I had such thoughts?". In most cases, these ideas have aggressive connotations, blasphemies and perverse thoughts, which leads both to behavioural compulsions, and to mental compulsions.

These processes are energy-consuming, the person in question trying to calm down as regards the said thought or trying to understand if he really wants or not that thing, which leads to ruminations in the process of simulation in mind, to check if the said situation leads him or not to satisfaction. Being obsessive, only one simulation will not be sufficient for him, so that he will try many times, which will lead to the increase of intrusiveness in intensity and frequency, by adding details.

Compulsions are noticeable behaviours or mental acts to prevent or neutralize the threat, being different from those of control of drives that leads to pleasure.

In the case of impulsive obsessions, the patient resorts to particular acts, deprived of reasoning, inacceptable or ridiculous (Hettema, Prescott, Myers, Neale, & Kendler, 2005) because the free manifestation of these drives would have negative consequences, by opposition, the individual charges emotionally, being awestruck and panic of not responding to impulsive tendency, of not committing the act under the form of a compulsion (Balint, Ornstein, & Balint, 1972). To defend against committing impulsive acts, the patient usually resorts to certain actions meant to free, to discharge the tension and to temporise the obsessive drive.

By these rituals, the obsessive act is carried out in a form, being exercised against the will of the individual, dominating the conscience until they are completed, and if the patient tries to remove them, there appears a state of excruciating anxiety (Banissy, Kanai, Walsh, & Rees, 2012). The rituals consisted of actions succeeding in a certain order, always on the background of a marking anxiety, which attenuates only if the patient fulfils that process of actions, and failure to fulfil these rituals creates him a state of anxiety that makes him incapable of fulfilling the action undertaken (Dichter, 1972).

Another characteristic of compulsions refer to their persistency and repetitiveness, often being ritualised – if the person in question makes a wrong step, the entire process is resumed from the beginning. The acts are reasoned and intentional, being different from automatic behaviours, mechanical, which are of neurological nature (Alkozei, Cooper, & Creswell, 2014).

In certain conditions, the individual can defer or can renounce to the ritual performance – for example, if the patient feels embarrassed to implement them in a certain context. In addition to compulsive acts, he also resorts to avoidances, distractions, insurance requests, suppression of thoughts.

The delusional idea is distinguished from the obsessive idea by the mode of occurrence in thinking. The delusional idea expresses clearly, there being the belief that cannot be influenced by external reality that leads to delusional behaviour, coming this from the inner side of the individual.

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The obsessive idea besieges thinking, erupts and imposes from outside of consciousness, even if it is in disagreement with it. There is the capacity of recognition of its parasite character and a fight or an opposition is attempted or wanted (Goldin & Gross, 2010).

Both types of ideas are accompanied by anxiety. In the present case, it is a challenge in itself to differentiate in the patient's speech his psychotic bizarre behaviour, occurred following delusional ideas and compulsions occurred following obsessive ideation.

In compulsion there is a tension state, when the fight is between impulsive tendencies, under the pressure of which the individual cedes and he relaxes committing the act, he relaxes feeling satisfaction (Samuels et al., 2000), In obsessionality, the force of repetition of the same need of satisfaction leads to a higher and higher tension, generated by the consequences that cold exist following the refusal of executing the compulsion (Mar, Oatley, Hirsh, de la Paz, & Peterson, 2006).

7. Conclusion

In patients with schizophrenia, the obsessions and compulsions can pre-exist, can occur spontaneously during psychosis or they can be precipitated or exacerbated by the anti-psychotic medication. In some cases, the obsessive-compulsive symptoms remain distinct (Calvert, Strouse, & Murray, 2006). The insight on their rationality is present, they are being felt as excessive and ungrounded (Swets et al., 2014).

In other cases, obsessions and compulsions become subject to a delusional elaboration during active phases of psychosis or obsessional symptoms are inseparable of psychotic symptoms (Kaplan & Sadock, 2001).

Unlike phobias, in which the subject fears of something outside him, in obsession, the fear targets even the acts of the subject, there being the question of inner tension reported to what the patient himself does (Schirmbeck, 2013). The anxiety is considered secondary to the reception of content of obsessive intentions to perform an aggressive act.

In the classical concept of Pierre Janet on neuroses, within the psychasthenia concept, the author also approached the obsessive-compulsive disorder, as being a perturbation in perception and synthesis of the time lived (Davison & Neale, 1998). We are discussing on an elaboration of the subjective "present", an authentic insertion of the person in question in the given reality: the synthesis of the present is based on the act, behaviour in which the subject is engaged (Calvert, Strouse, & Murray, 2006).

The central aspect of the psychasthenia, which leads to obsessions, is considered to be the feeling of "incompletion and imperfection". The following phase of the disorder is that of obsessions and compulsions. The ideas and involuntary drives appear very easily and frequently, dominating patient's life (Seedat, 2007).

As a conclusion in the present case, the obsessive-compulsive symptoms of the patient represent a clue of disorder seriousness and as "filiation" they are closely related to paranoid delirium (Frick, et al., 2013). Specialty literature of the last years shapes the existence of a schizo-obsessive nature disorder, in the present case the mechanism being the following:

The patient onsets as authentic schizophrenic, where delirium is of persecution, preponderantly focused on the parents, in relation to whom he presents affective inversion (Zhou, Baytunca, Yu, & Öngür,

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2016). The parents want to hurt him, when there appear certain auditory triggers, such as strong noises, screams, bangs, or motor triggers (rushed walking, haste in the execution of activities), moments that are possible on the background of a sensorial perceptive mood (a generalised decrease of sensorial thresholds, this pathology being renown in schizophrenia) (Tandon, Keshavan, & Nasrallah, 2008). To defend against these images that come accompanied by strong anxiety and fear, the patient manifests specific compulsions: touches the doorknob six times precisely, repetitively checks his money he keeps in the house in the drawer in a certain position, repeats verbal or attitudinal rituals within dialogue, etc. (Üçok et al., 2011).

He feels that both triggers, as the images that come in his mind are imposed to him and he must face them by these behaviours, the fact occupying most of his time and making him incapable of carrying out any other useful social activity. In the category of "fixations" there is also included the preoccupation for the actress Kate, presence he feels as "unwanted" in his mind and "imposed": "She is the one and only chosen unwillingly. I did not choose her, it is not as if I can chose between her and Pamela Anderson, so to say. But I watch her, and her face is perfect. And this matter!"

He frequently draws pentagrams of perfection, where perfection is interpreted as happiness, it having as antonym suffering. These are called IMA's collections (his initial letters), where he is to collect toys.

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