Scientific Research Publishing

Open Journal of Social Sciences, 2019, 7, 362-374
https://www.scirp.org/journal/jss
ISSN Online: 2327-5960
ISSN Print: 2327-5952

Paranoid Schizophrenia from a Philosophical Perspective

Simona Trifu, Diana Istrate, Ana Vasile

University of Medicine and Pharmacy "Carol Davila", Bucharest, Romania
Email: simonatrifu@yahoo.com

How to cite this paper: Trifu, S., Istrate, D. and Vasile, A. (2019) Paranoid Schizophrenia from a Philosophical Perspective. *Open Journal of Social Sciences*, **7**, 362-374.
https://doi.org/10.4236/jss.2019.712028

Received: November 25, 2019
Accepted: December 23, 2019
Published: December 26, 2019

Abstract

Motivation: Paranoid schizophrenia, postulated in a macroscopic dimension, is conserved from consumption of the selves, perception, volition, cognition, affect, thought and behavior. The intense study of this condition, as well as the absence of a theory for the mechanism of occurrence, gives it its own aura that seems to absorb the normality known as a characteristic of the Self and transform it into a progressive disharmony, accentuated by acute psychotic episodes and "selective dehumanization". **Objective:** Presentation of a patient aged 35, with a psychiatric history and symptomatology started ten years ago. It was pharmacologically approached seven years ago with Escitalopram, Buspirone and Clonazepam, but the paranoid background culminated in his being admitted to a closed psychiatric regime (surveillance, "key room") three weeks after the apparent depressive episode. Material and method: Psychiatric evaluation, treatment initiation, psychological evaluation, excluding brain organics, evaluation of intrapsychic dynamics, observations. **Results:** The patient functions in the paranoid registry, being dominated by pseudo-hallucinations, ideas from the spectrum of xenopathy and control, joining formal and content disorders (circumstantial discourse, tangentiality). It associates the patina of the speech, illogical constructions, the impossibility of materializing the thoughts, the repeated jump between the abstract and concrete levels. He is so deeply immersed in his own ideas about honor, confabulation and self-control, which we "lose" him in what he claims to be: a "complex in continuous development". **Conclusions:** He describes himself as a warrior whose vein is supported by a willing Ego at all times to disintegrate. It is not compliant with the drug treatment, arguing that it "disturbs me and gives me changes of concentration", which destabilizes and disorganizes a possible ascent in the process of systematizing and engaging the thinking in a near normality.

Keywords

Paranoid Schizophrenia, Delirium, Pseudo-Hallucinations, Illogicality,

Xenopathy, Kandinski Clerambault Syndrome, False-Self

1. Introduction

The concept of schizophrenia is associated with a relatively recent origin. In the mid-19th century, European psychiatrists focused their attention on diseases of unknown cause, which mainly affected young people, causing a chronic, progressive deterioration. The one who managed to integrate these clinical manifestations into a nosological entity was Emil Kraepelin. The associated name was "praecox dementia", based on longitudinal determinations in a wide range of clinical cases that came together in a common pattern. By substantially altering Kraepelin's original concept, Eugen Bleuler [1] introduced the term schizophrenia, introducing a fundamental dissociation between the obligatory and additional symptoms of the disease.

Even though there are certain criteria that allow the identification and diagnosis of schizophrenia, it still remains a clinical syndrome defined by the reported subjective experiences (symptoms) and the loss of social functioning (behavioral changes).

Researchers have postulated numerous theories, including neurocognitive dysfunction, brain dysmorphology, neuromodulator abnormalities, but none of them possess the specificity and sensitivity of a diagnostic test.

It is known and unanimously accepted that schizophrenia consists of a series of changes lasting more than six months and involves an active phase, which may be preceded by prodromal symptoms. The symptoms are varied and affect the plane of thought, perception, behavior, liming, engraved on different subtypes, according to DSM V: paranoid, disorganized, catatonic, undifferentiated or residual [2].

Those concerned may experience a series of emotional, but also cognitive, dysfunctions, experiencing a progressive, insidious flattening, associated with social withdrawal, non-compliance with treatment, as well as poor affective resonance.

1.1. Theoretical Background

The diagnosis of schizophrenia can be based on several criteria. The Kraepelin criteria include attention disorders, hallucinations, thought disorders, affective disorders, behavioral disorders, obedience, echolalia, echopraxia, acting out, catatonia, speech disorders. If we consider Bleuler criteria we can find fundamental disorders: thought disorders, affective disorders, ambivalence, autism, disorders of the subjective experience of the Ego, disorders of volition and behavior and accessory symptoms: hallucinations, delusional ideas, memory disorders, change of personality, speech disorders, somatic symptoms, catatonic symptoms, affective symptoms.

According to Schneider's criteria we find two degree symptoms—first-degree symptoms: the sound of thinking—insertion, extraction, influence, transmission; voices that quarrel; commentary voices; experiences of somatic passivity; delusional perceptions; actions, feelings "done"—and second-degree symptoms: the intuition of delirium; other perception disorders; perplexity; changes of disposition; emotional impoverishment.

If we consider the comparison between DSM-V [2] and ICD 10 [3] we can highlight the following Table 1.

According to Crown criteria we see three types, described in the following Table 2.

1.2. Self and Schizophrenia

Plato and Aristotle were the first to discuss the need for the emergence of a theory that embodied the individualism of objects and entities. The concept of self, defined as a "private interior space" was reinforced by the desire for retrieval, retreat, introspection. The end of the Renaissance period brings the interpretation of the Cartesian self in the form of the idea "cogito ergo sum".

The incorporation of the Self into the psychiatry of the 19th century, as well as the dominance of the psychodynamic psychology towards the end of the century, led to the explanation of the pathology of the mental state in terms of dissociation and not of injury, as was customary before.

Schizophrenia emerges to the state of non-belonging, the experiences being difficult to quantify and capture. Thoughts are merely a development of another

Table 1. Schizophrenia DSM-5 versus ICD-10.

DSM V	ICD 10
1 Delusional ideas)	a) Echo, insertion, theft, spreading b) Control, influence, delusional perception d) Other delirious non-cultural ideas
2) Hallucinations	c) Auditory, commentary hallucinations e) Other hallucinations and delusional ideas
3) Disorganized speech	f) Disorganized speech
4) Disorganized/catatonic behavior	g) Disorganized behavior i) Catatonic behavior
5) negative symptoms	h) Negative symptoms

Table 2. Schizophrenia type Crown.

Type I	Type II	Type III
Positive symptoms	Negative symptoms	Speech + disorganized behavior
Premorbid good	Premorbid fool	Cognitive and attention defects
Acute debut	Insidious debut	Positive + negative symptoms
Normal CT	Abnormal CT	Many manifestations simulate
Good response to treatment	Resistance to treatment	negative symptoms, but they are
Good evolution over time	Bad evolution over time	the consequence of drugs

mind, dissociated by split, in the presence of feelings felt not to be self-generated [4].

From the perspective of the Self, in the premorbid phases, the indications that later make up the schizophrenia puzzle are mirrored. It is imperative that we listen and watch. In the presented case, the patient confesses an inability to function in the faculty where he studied, as well as an internal modification supported by the idea that the teachers do not understand it, that "it is not good enough", that "in the faculty he does not learn everything he should to learn", that "teachers exploit it". For this reason, he refuses to attend classes and is expelled. He never seems to have ever been truly present in daily life, experiencing an ineffable distance from himself and the surrounding world.

It has fluctuating tendencies of distinction from its own body, being shaped as a result. The absence of the recognition of one's identity and the lack of acceptance of the human self from the content of the present world and takes it into an external world itself, which does not belong to it and over which it has no control.

The presence of the Self within it is altered by unsystematic experiences, fragmented by the intentional aspect of the game of fugitive ideas that pierce his ad hoc thinking [5].

It is emphasized in a painful coherence the inner fracture and emptiness, described by anhedonia, reaching the absolute in the statement "I do not know what that soul is".

2. Description of the Patient Status

The patient, aged 35, is admitted for the first time in 2011, at the recommendation of the Ambulance, revealing the following on the psychic examination: poor care and hygiene; spontaneous hypoprosexia and fixation and evocation hypomnesia; delirious idea of persecution: "Everyone is against me!"; delusional hallucinatory behavior: "How do you come to me without money? You are cute!"; soliloquies; bizarreriesin behavior: "He puts a girl on the desktop and talks to her"; clastic accesses: "It sticks me to the fence, and I'm bound until people pass by"; social isolation; concealment; mixed insomnia; school dropout; decreased useful yield.

From the observation sheet we find out that the symptomatology had an insidious onset three years ago, but the one in question received a consultation at the Guard Chamber only three weeks before the first hospitalization, a consultation after which treatment was initiated with Escitalopram 10 mg (1-0-0), Clonazepam 0.5 mg (1/2-1/2-1), Buspirone 5 mg (1/2-1/2-1). They were given during hospitalization Haloperidol (If + If), Trihexyphenidyl (1tb + 1tb) and Diazepam (If + IIf), but the patient, under treatment, adopted an auto/hetero-aggressive behavior, associated with auditory hallucinations, which dictated the establishment of the non-voluntary hospitalization. During the hospitalization he associates cosmogonic delusion and persecution, reporting: "I am connected to the planet Earth, I am not me, I have transformed myself, I am a shadow. I'm always

on the lookout, even my mom and brother are caught up in it, not realizing it. Everything feels like a pulsation of the Earth, which transforms into the body, for example, into the heartbeat". The auditory hallucinations are also interwoven: "I hear the voices of my children in Japan, who tell me to stay home. In Japan I was through the space of fear."

Following the evolution of the patient, we see multiple admissions in psychiatry services so far. A CT scan was also performed which excluded brain organics. At the third hospitalization, the patient accuses depressive symptomatology that appeared on the reactive background, by the inability to find a service, idea of futility, psychomotor inhibition, anhedonia. From the analysis of all the observation sheets we appreciate the psycho-paranoid symptomatology of the one concerned, associated with tangentiality, suspicion and ideation with delusional content: "There are negative intentions around me, which change my state of accomplishment and balance. I also heard special senses, related to the frequencies and the limit they can reach. I don't like food at all, because I evolved, and I didn't need it anymore. I think we can progress and change our inner and outer form, as well as spirit, but not with the help of technology, but with our own capabilities."

As a life historian, he is part of a fraternity of three, he grew up and developed into a family of single parents (parents separated early, the patient staying in the care of the mother; the deceased father at the age of 14 years of the patient—acute myocardial infarction). As hereditary-collateral history, the sister on the paternal line is known with schizophrenia.

After graduating from high school, he attended a year and a half of the National University of Music, where he studied three instruments: trumpet, piano and violin, but refused to participate in the courses, thus being expelled, on the grounds that "the teachers used it".

2.1. Patient Speech

"I did not take my pills because I was not willing to go to the hospital, because if you go to the hospital, they are all kind of people and you are contaminated by their emotional states and I wanted to walk and return after." (*Circumstantial speech*).

"The ultimate goal of any being would be control over life, and I am only a consequence." (*Construction of illogicality*).

"The world has disappointed me too much."

"Medications disturb me and give me changes in concentration." (*Confusing the effect with the cause*).

"I am passionate about the Japanese or Asian religion, from the fifteenth, sixteenth century, it is a road, a determination, a dedication to a goal, an honor."

"There is a state of mind and then an intention."

"I suppose I knew once, I felt it, but I forgot them."

"There are representations as persons, in sleep and meditative state, in the zazen position."

"There are entities with masks in the sky, there is a fortress there."

"I like to play with the harmonies and the mood."

What music do you like the most? "Pre-classical jazz, pure simplicity."

Why didn't you play the trumpet again? "I was not satisfied as an artist, music without a soul cannot."

"I believe that God is possibility" What does possibility mean? "Possibility equals almost anything."

"The pain I think has always been, I believe in the senses, I have heard absolutely." (*pseudoreminescence*).

"Hearing can take you to many places, you can find things that bother you."

What bothered you? "I was frustrated by the frustration."

What is your frustration? "Vibration."

Did you associate vibration with color sounds? "I didn't associate the vibrations and sounds with colors until recently."

Did you write music? "I wrote music with an interpretive character."

"Emotions dictate music."

"When it comes to love, I don't see it in words."

"I don't think anyone would want to share anything with me."

"This is my destiny and my love. Death does not exist; we also go through it and change ourselves. I do not believe in death; I believe in change."

"Not that he doesn't want to say, but he still isn't."

"Many things were highlighted: physically, spiritually, for example reincarnation."

"I do not know what that soul is, but I believe in immortality." (*Curls the Cotard syndrome through the delirious idea of negation, through immortality and enormity*).

"I believe that even when I sleep, I am awake" (*lack of need for sleep*).

"I am a constantly developing complex."

What did your grandfather mean to you? "I think he saw me the way I am."

"One thing you remembered never happened." (*Construction of illogicality*).

"The evolutionary process led me to not eat, and my piano teacher told me that the extremes are attracted and the weaker they become, the stronger they become." (*Construction of illogicality*).

"I think anyone can change and I don't believe in the lawsuit."

"At one point I made a notch on the left side with a hot knife, here on the left side of the eye, but I didn't cut my eye, I'm just not crazy."

What did you do that for? "To have a perception of vibrations or emotions; the wolves have a notch that means a sense and I wanted to open that sense."

And did you feel anything? "I felt some vibration."

"It could be the aura of the person walking in the room"

2.2. Psychic Examination of the Present Condition

Remarks: Patient in hospital care, unmanaged, poor hygiene, mimic and hypomobile gesture, partially oriented in time and space, auto and allo-psychic, with

cooperative attitude, psycho-visual contact difficult to initiate and maintain.

Perceptions: It presents quantitative disorders of the type of hyperesthesia, which results in qualitative disturbances of perception, both in the present and in the past. The plane of reveries is correlated with the hypnopompic and hypnagogic pseudo-hallucinations, associating in the mental plane "the image of the clouds in the sky, to let your mind clear", distinguishing with the eyes of the mind "entities with masks, like a city in the sky". The speech plan notes the tangentiality and circumstantiality of the phrases, outlined by the inability to reach the quintessence of the questions asked:

"I came to the hospital because I didn't take my pills.

- Why didn't you take your pills?
- Because I didn't have the disposition to go to the hospital, because if you go into the hospital there are all kinds of people and you become contaminated by their emotional states and I wanted to walk and return after ..."

The broad answer that bypasses the punctuality of the question weaves around the personality of the patient, both the fragility of the pre-psychotic Self that risks fragmentation and disintegration, as well as the false perception about hallucinations and pseudo-hallucinations, stored in the self in the form of the words "as far as I can remember", and thus the impression that the speech loses itself before asking the question itself. The auditory perception is conceived in a separate, vibrational and color plane, brought from the hallucinatory sphere into the realm of reality through a register of simple, perceptual experiences, consistent with his professional training [6]. "Pure simplicity, the game with harmonies, with the mood" determines the decrease of sensory thresholds, disrupting us both from the quantitative spectrum and from the qualitative spectrum, perceptual tubing in full accordance with its affect, qualities and experiences through the perception of colors and vibrations, other than the rest of the people.

Attention: Spontaneous hypoprosexia, associated with the decrease of the concentration capacity in the context of maintaining the discourse on the logical vein, as well as the inability to keep it in the real, current plane of the conversation. The sympathetic of hypoprosexia is felt from the first ideas of the patient, mentioning that "the pills disturb me and give me changes of concentration", thus suggesting an inner turmoil that tries to assemble in the concept of medication and not the lack of ability to concentrate.

Memory: The use of the phrase "memory can be altered" springs into the world of his psychic self the answers of possible mental deficiencies in relation to the disorganized disorganization of his memories. The memorial circumstance as well as the assertion that "one thing you never remembered happened to you" embroider around his personality an impenetrable, inaccessible pseudomnesia.

Thinking: The formal thought disorder, postulated with the help of delusional xenopathic, influential ideas, associates a color of both mystical provenance "I believe that God is a possibility", as well as cultural "I am passionate about Japanese and Asian culture", deduced by illogicality that converge the two plans, concretely and metaphorically, "the evolutionary process led me to not eat, and

my piano teacher told me that the extremes are attracted and the weaker they become, the stronger they become." The obstructed, sharp jump of his mind suggests a precarious organization at the level of analyzability, croaking the paradox and relaxation of associations of a "complex, constantly developing self." The ambiguity of one's beliefs "I believe in senses, I do not believe in death, I believe in change", metaphorical thinking, surmounted by the awareness of one's own existence and immortality, abstract the fragility and the perception of vibration. Its relation to the world around it, commemorating itself by acquiring it every time, following evaluative judgments, the philosophy that guides the self "the ultimate purpose of any beings is control". The disappointment felt on a vibrational and coloristic level, "has disappointed me the world too much", transposed from the spectrum of illogicality, into the spectrum of authentic self-syllogism "I am a consequence", quantifies in the register of prevalent interpretations the way to which only he has access.

Affectivity: Taking into account Bleuler's eponym, we can relate the affection with the patient's proximity and personality: "to stay internalized on his own." From an analytical perspective, the foundation based on the "dictating emotions", complements the altered affect, as well as the non-belonging to me. Also, from his speech, we can process under the pseudonym "I am a consequence", a coherent subjectivity that explains both the meaning of existence in the abstract and the sense of nonexistence in reality. The dissociation of affectivity in the intuitive process is sporadically terminated by pseudoreminescence from the sphere of the countertransference: "the pain I think has always been", but recovers its substantiality a few sentences later through factual attempts: "I made a notch on the left side because I open my senses. "Ambivalence based on contradictory tendencies gives it" a state of mind and then an intention", a state of mind and intention embroidered on a low tolerance for frustration ("I was frustrated by frustration"), culminating in a degree of anxiety meant to solve internal and external conflicts. He manages, by paraphrasing the ideas about humanoid feelings ("when it comes to love, I do not see it in words") to give to his own affection the devotion to the artistic area in which he was formed, as well as the alloy necessary to contain the synergism of the prevailing interpretations.

Activity: Useful efficiency reaches nullity. Psychotically motivated addiction ("I walked 2 days on the streets") is correlated with psychomotor agitation clinically related by rhythmic movements of the hands, which betray anxiety. It performs with difficulty the activity of verbalizing thoughts, offering circumstantial answers, in a disguised context.

Nictemeral rhythm: Insomnia of numbness potentiated by the circumstantiality of one's philosophical discourse: "I believe that even when I sleep, I am awake."

Instinctual life: Food appetite diminished in the context of one's beliefs, sustained by the evolutionary process and the ascetic path to which it accedes under the sign of a spiritual development "the evolutionary process led me not to eat", juggled by the characteristic intuition that establishes constructions in multiple

planes: metaphorically—concrete-illogical. The paradox obtained by milestone, thus outlines the specific leap to his own paradigm: "and my piano teacher told me that the extremes are attracted and the weaker they become, the stronger they become." It is noticeable from the speech and a decadence towards the rudimentary, animalistic instinct "the wolves have a notch on the left side and I have made a notch", distinguishing the febrile access and the need to return to the ground, in primitives "I like Japan beforehand of technology, from the 15th, 16th century".

Motivational system: The censorship of the personality in the social context associated with an increased impulsive fragility marches to the inability to meet their expectations and needs "I was not satisfied with myself as an artist", and to the inability to support actions in concrete "I could not keep up".

We can conclude that the patient personality is of paranoid type.

3. Diagnosis and Discussion

3.1. Main Diagnosis

We consider that the main diagnosis is paranoid schizophrenia.

Arguments: Constellations of signs and symptoms that support the diagnosis of paranoid schizophrenia in the patient presented, can be conceptualized, according to DSM V, in the form of several criteria:

Criterion A, with two subtypes of symptoms, positive and negative:

- From the area of positive symptoms, we notice distortions at the cognitive level of the type of delusional ideas of xenopathic type, of control, of influence.
- Framing in the philosophical color of the discourse, culturally imprinted discourse and supplemented by hypnopompic and hypnagogic pseudo-hallucinations.
- The disorganization of thought emerges at the point where the quintessence of the speech is lost, the systematization reaching the climax by the absence of a logical argument.
- The sliding of the speech is all the more visible, as the questions asked try to look at the answer, creating a dissociation of the question vs. question diagram answer.
- Psychic lability accompanied by the primary schizoid-paranoid delirium that captures a rich fascination combined in the area of xenopathic influence and a brutal jump between the plane of perception and plane of thought. [7]
- The sonorisation of thinking described by Schneider as a rank I symptom is molded on the patient's personality in the form of perceptual musicality from a synesthetic perspective, being transported into the thinking area in the form of the control pathology.
- The ideational access born from the phenomenon of control and influence that overlaps with the feeling of sharing and diffusing the thought generated by his grandfather ("I believe he saw me"), as well as with the defining passivity towards others.

- Behavioral jokes laced with ideas of return to primitive, primordial, universal function.
- Fragilization of the self through permeabilization and depersonalization known at the level of discourse through non-belonging, crossed by the desire to take over the self in the drug context.
- Destruction of the ego and juggling between different planes, as well as the lack of awareness emerges in the core of the KandinskiClerambault mental automatism syndrome, sketching it in the form of delusional ideation, xenopathy and pseudo-hallucinations.
- Interior Inner consumerism masked by the onset of dromomania, insomnia, but also later meditative states, conceptualized at psychological level in a return to space and past time, in what has always existed.
- The spectrum of negative symptoms is in a continuum with normality, with reminiscences of allergy and avulsion. An affective flattening is sustained against the background of decreased emotional expressiveness in the context of topics that do not reach its core of interest, its mind being circumstantial around the discourse about influence and honor.

Criterion B, characterized by malfunctions in different operating systems:

- Inability to function socially supported by statements of the type "I was not satisfied with myself as an artist".
- The renunciation of the artist's career and the abandonment of the National University of Music, related to the fact that he finished the National College of Music "George Enescu", places him in the area of anti-social personality.
- Although he knows three instruments, he is unable to juggle the artistic area in which he was trained.
- Dominant—the dominant pattern of perception does not allow it to disassociate from the illusory reality in which it is currently active, but it amplifies its state of disorganization by engaging in destructive thoughts "I could not keep up" [8].

Criterion C

- Symptoms last longer than 6 months.
- Absence of criticism of the disease, as well as absence of "normal" periods.

Criteria D and E

- According to the observation sheets and the historian, in the present case, the disturbance is not due to a consumption of substances, an associated medical condition or other direct physiological effects.
- According to the differential diagnosis, the symptomatology does not lead to a schizoaffective disorder or an affective disorder with psychotic elements.

Criterion F

- A pervasive developmental disorder is excluded.

3.2. Other Possible Differential Diagnosis

1) Schizoaffective disorder

- Arguments:

- The expansive coloratura of the discourse in the context of the description of the senses;
- Beginning with manic episode and insomnia;
- Running ideas;
- Delusional ideas and pseudo-hallucinations lasting more than two weeks;
- Disorganized speech.

• Counterarguments:

- The speech mainly concerns the thought and not the affect;
- The absence of an affective episode concurrent with the delusional ideation, the pseudo-hallucinations, the antisocial behavior;
- Pseudo-hallucinations present outside an obvious dispositional sphere;
- The absence of contamination of the interlocutor through the counter-transfer.

2) Bipolar affective disorder

• Arguments:

- The debut occurred in the context of a manic episode with addiction and insomnia;
- Affirms the lack of need for sleep "I without sleep I felt good";
- Fascination for the affective world;
- Symbolic argumentation.

• Counterarguments:

- Continuous, progressive deterioration;
- Lack of critical intervals on the disease, social functioning, flattening of the psychotic episodes;
- Late onset of the disease.

3.3. Psychodynamic Perspective

From a psychodynamic perspective, a fragile, narcissistic man is trained, with a very weak self, incapable, of an avoidant type, antisocial, who tries through Adlerian overcompensation a kind of struggle with the disintegrated self [9]. He acquires the warrior model of traditional Japanese culture, refusing his own food by engaging in a bizarre, illogical idea "the weaker I am, the stronger I am", thus strengthening itself only by existence.

In this case, delusional ideas of jealousy are between truth and falsehood, between reality and the imaginary. At first glance, the patient's suspicion seems unjustified, with the history of bipolar affective disorder making it more likely the first differential diagnosis of delirious disorder with the theme of jealousy (the psychotic elements are, in fact, in the manic episode). However, the "evidence" presented is plausible and shows that the patient's suspicion is indeed justified. Non-bizarre delirium is defined as delirium with themes that can represent real life situations. This case shows that sometimes, under seemingly delusional behavior, fragments of truth can be hidden, which feeds, creates a matrix on which the patient weaves his delirium in a systematic, organized, plausible way.

3.4. Treatment

Currently, the patient had the indication of hospitalization, given the circumstances of stopping treatment, hallucinatory delusional behavior, as well as drug addiction.

It is currently being treated with Aripiprazole 15 mg 1 + 1, 2nd generation antipsychotic, Depakine 500 mg 0 + 1, Solian 400 mg 1 + 0, atypical antipsychotic and Diazepam 0 + 2.

Given the noncompliance with treatment, it is difficult to achieve a balance of drug efficacy, it is hoped in the future to create a therapeutic alliance that is aimed at improving the symptomatology.

4. Conclusions

The patient has a pattern of withdrawal, irritability, aversion, has problems of personal care and related to establishing friendships, reaching performance, feels perplexity, alienation and lack of concentration. Feelings and perceptions appear dissociated from each other, which requires validity checks and confirmations.

His bodily sensations can be felt as unfamiliar—the body, the boundaries of the body, his position appear as distorted, unstable, the one in question experiencing depersonalization and desomatization.

The patient responds to these destabilizing experiences through innate patterns of adaptation: denial, symbolic explanation, rational explanations, which eventually become implausible or frankly bizarre. She experiences fear, shyness, introversion, poor relationship, motor awkwardness, cognitive precocity in some areas and unexplained deficiencies in others and increased vulnerability to stress. He is a good, obedient and non-confrontational former child.

The qualities that make a person unitary are badly integrated. PATIENT LIVES Perplexity, opposition hostility, confused naivety, feeling "empty", forgetting to thank, to smile, to answer questions; he does not seem interested in discussing his situation. He does not have a clear idea where his body, mind, influence ends, LIVES the feeling of being merged with external objects or being completely disintegrated, self-delusion, depersonalization—derealization, delirium of external influence.

Its affect is inadequate, inconsistent with the content of the speech, it is disrupted the cadence, the modulation of the communication (aprozodia), the one in question experiencing bizarre emotions of exaltation, omnipotence, loneliness in the universe, ecstatic religious states, the appalling apprehension of being disintegrated bodily, anxiety imminent destruction of the universe, emotional sensitivity (feeling slightly hurt by the rejecting behavior of others).

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

[1] Bleurer, E. (1866) Dementia praecox oder die Gruppe der Schizofrenien. Deuticke, Leipzig.

[2] American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders. 5th Edition, American Psychiatric Association, Arlington. https://doi.org/10.1176/appi.books.9780890425596

[3] World Health Organization (2018) International Classification of Diseases for Mortality and Morbidity Statistics (10th Revision).

[4] Jablensky, A. (2010) The Diagnostic Concept of Schizophrenia: Its History, Evolution, and Future Prospects. *Dialogues in Clinical Neuroscience*, **12**, 271-287.

[5] Kircher, T. and David, A. (Eds.) (2003) The Self in Neuroscience and Psychiatry. Cambridge University Press, Cambridge. https://doi.org/10.1017/CBO9780511543708

[6] Yamada, A.M., Lee, K.K., Dinh, T.Q., Barrio, C. and Brekke, J.S. (2010) Intrinsic Motivation as a Mediator of Relationships between Symptoms and Functioning among Individuals with Schizophrenia Spectrum Disorders in a Diverse Urban Community. *The Journal of Nervous and Mental Disease*. **198**, 28-34. https://doi.org/10.1097/NMD.0b013e3181c8aa71

[7] Najas-Garcia, A., Carmona, V.R. and Gómez-Benito, J. (2018) Trends in the Study of Motivation in Schizophrenia: A Bibliometric Analysis of Six Decades of Research (1956-2017). *Frontiers in Psychology*, 20 February 2018, 63. https://doi.org/10.3389/fpsyg.2018.00063

[8] Lazarescu, M. (2014) Schneider's First Rank Symptoms. *Approach of Clinical Psychopathology*, **32**, 8-13.

[9] Trifu, S., Braileanu, D., Carp, E.G., Chirilescu, A. and Mihai, I. (2015) Psychodynamic Particularities in Expressing Systematized Delirium in Paranoid Schizophrenia. *Procedia Social and Behavioral Sciences*, **203**, 412-418. https://doi.org/10.1016/j.sbspro.2015.08.315