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Adolescence and Psychotic Destructuration Risk

Trifu Simona, Dragoi Ana Miruna, Grecu Florentina, Trifu Antonia Ioana

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

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Abstract

Motivation: The ability to organize and make decisions in life ensures self-control and self-confidence. In assuming the tutor role (in the psychological dimension of meaning), the functions of maternalization and paternalization must be fulfilled, as well as ensuring the fulfillment of maternal, paternal roles after being incorporated by the child in order to be properly exercised. To determine the creative capacities or the systemic delirium as a solution for solving the failure to adapt to the socio-cultural environment, perceived as traumatic. Objectives: Psychological evaluation of the current profile and psychic personality structure for the understanding of the operational patterns. Testing mental capacity and the boundaries between real and imaginary that ensure success in the work of the therapeutic process, by having a departure prognosis. Hypothesis: In the case of patient T., the difficulties encountered may be caused by the onset of depression or possibly by adjustment disorder with anxiety on a dysfunctional attachment pattern. The essential element is the separation and division of the family for a period of one month from the onset of the stressor, involving both the vulnerability of the ego and the triggers, due to major life changes. The current difficulties and symptoms are internal and external disorganization, nervousness, amnesia, lack of interest and curiosity, affection disinvestment plus the excess-marked detraction model, and the major role of loneliness overlapping with family abandonment. Applied tools: anamnesis, clinical interview, building the life map, clinical scales to investigate the intensity of depression, anxiety, and the possible psychotic areal due to hereditary load of the patient-HAM D, HAM A, PANSS (to investigate prevalence phenomenology and differential diagnosis with the areal of an increase in the imaginative function, given the artistic formation of the adolescent girl). The combined application of the depression and negative scale of PANSS aims to lead to a better differential diagnosis between depressive coloration versus the onset of a major psychiatric disease at risk of association with psychotic phenomena. Also, the complex investigation of personal-

ity also involved the administration of a Lusher projective test along with the tree test, face test, and family test. Results: The case study highlighted the Ego scattering that is immature (unintegrated and inappropriate) and the existence of mental underdevelopment to which the familial, social and environmental factors contributed in a negative way. During this period of adolescence, the patient tries to rely on defense mechanisms, which however fail, because of having a poor psycho-affective structure since primitive childhood. Conclusions: This case study focuses on the links between hereditary data, psycho-affective developmental structuring during the primitive stages of the early childhood, mental health, or the etiology of a personality disharmony, where the princeps characteristics, as well as the Social and environmental factors play an important role. Panss was used because it was very difficult to realize if the patient only has only a psychotic functioning or is facing a delirious profile due to the loneliness she experiences and becomes aware of once the separation of her parents occurs.

Keywords

Environmental Factors, Incorporation, Maternalization, Paternalization, Ego Integration

1. Family and Personal History

This case study describes patient T., aged 18, unmarried, student, who just came out of parental control. She went to the Individual Psychology Cabinet sent by her father, as she was advised by her paternal aunt. The Application for Psychological Assessment and Counseling is made for the purpose of providing her support and help to become aware of the current life situation, the suffering and the difficulties faced. She also wants her to "organize herself and realize what she wants to do in life."

The patient is a student in the 12th grade at the Bucharest High School of Arts and prepares for the Faculty of Psychology/Philosophy, although she does not go to school very often and has many absences. She motivates her vocational choice by the desire to have a job that does not require to wake up in the morning and spend many hours at the office without enjoying more free time and the freedom to create the schedule for herself. Then she mentions that she wants to help people although she admits she does not really like people in general. She imagines that she will work with people who are deprived of their liberty and with children with family problems as she empathizes with them because of her similar problems: "I want to work with criminals because I have the same moods as them, sometimes I want to kill my mother, especially when she fights with me but I do not do it…with children, I want to work for them to feel a presence there, that there is someone with them." She has future plans and wants to live in the mountains, build a modest house out of natural materials, wood and stone and raise animals (she likes dogs and she recently got a dog) and after college she

wants to travel the world for a year with a truck and to work as a truck driver (to earn money and get to know the outside world).

The patient comes from a bi-parental family, but in this period her parents' divorce. It's been a month since they separated and she feels alone. The father is a truck driver and her mother a policeman (back office). Living conditions are normal, income levels are good in relation to their own requirements, and all expenses are paid by the father. The patient lived until the age of 8 with her paternal grandparents in the Province of Prahova County. The patient had a normal life until she moved to Bucharest in her parents' house to go to school. Then she began to be disorganized (often forgets, loses money, cannot care for herself), as she now recognizes herself as having problems adapting to the family and social environment. She lives with her boyfriend, but she expects him to leave in order not to suffer if that happens. The father lives in the same house with them, but she comes back every two months and is always away with work. Her mother moved with her boyfriend and rarely visits her. About childhood she remembers with nostalgia that she was organized and loved by paternal grandparents, especially by her grandmother. She wants to move to her grandmother or go somewhere in the province because she doesn't find herself in Bucharest and she does not know what to do with her life there. She does not understand the meaning of money and does not value them, saying that for her money is of no value. She still wants to paint icons and her room. She misses her grandparents and feels free without her mother. At present, the parents sign the divorce papers and she confess that she feels very good, considering that this has had a positive impact on her.

The memories about her parents are just conflicts between them. Mother accuses the father for alcoholism, although the patient does not agree. She thinks her quality of life was affected since she moved with her parents and she suffers after her grandmother and her lost paradise. She has a dysfunctional relationship with her mother who is always unhappy, always quarreling and "swears" and her father seems absent. She confesses that because her mother screamed at her every morning to wake up, she felt unmotivated to go to school, so she stayed home to sleep, but also because of her colleagues, whom she could not bear with because "they formed personalized groups in which they promote their femininity". She was lying her mother, considering she was punishing her that way. At the present moment, the patient reconciled with her mother, but wants to keep her away. She got closer to the male colleagues and made a group with them. She prefers boys as friends, but she does not have friends anymore because she has changed her phone number.

The relationship with the boyfriend is calming and without future perspective because she thinks they are too young. She expects to be left because she thinks her boyfriend will get bored of her. She likes to relax with her boyfriend by watching TV or by hiking and traveling with the train through the country.

The first visible trauma since childhood reappeared at the age of 8 when it suddenly broke up with grandmothers and the first feelings of discomfort oc-

curred seven years ago when she had the first panic attack at the age of 11, when her father threatened to commit suicide [1].

2. Clinical Examination of the Current Condition

Observations: At the first meeting, the patient is cooperative, with introversion tendencies, slightly sad and absent, the body movements express isolation and retreat, neglectful, teenage-style clothing, (promo t-shirt with black print, black jeans and dirty light color sneakers). From the attitude seems to express disinvestment and fragmentation, the way in which she presents her inner world seems to be empty, with a fragile sense of reality. She is self-confident and a dreamy, the attitude towards others is withdrawn.

Orientation: The patient is space-oriented and temporarily disoriented and her personally life history, possibly due to the depressive connotations of the present condition (she forgets the hours when she has meetings scheduled, she schedules several activities at the same time), to which can contribute her psychic immaturity, inattention, immediate memory impairment or affective-emotional overuse she's going through.

Perception: The presence of certain pareidolia born from visual illusions, accompanied by the interpretative justification of creative imagination. Synthetic phenomena = Creation of simultaneous sensations within the visual analyzer "I will paint my personal universe as I have seen it, everyone can do that…when we want to see it and stay alone with us…it will be on the ceiling in colors of purple and white. "We consider these phenomena do not touch the intense psychotics, but they are circumscribed to the area of interpretative artistic preoccupations and consistent with the increase of creativity. Adolescence creates a virtual world of loneliness, against which she criticizes (she knows that the universe projected on the wall is her own imaginary and imaginative universe) [2].

Attention: Insufficiency in the functioning of the distributive attention filter, concentration difficulties, stability, or selectivity of attention.

Memory: Hypomnesia in evoking certain facts, although it is a lifetime of repetitive situations, these being integrated in a particular manner, due to the multitude of stimuli and external disruptive factors. The phenomenon itself can lead us to a mechanism of dissociation, as the best existent at a certain moment in time.

Spontaneous hypermnesia with reference to certain data, facts, or events that play a role in maintaining the patient's emotional indispensable relationships.

Thinking and language: Ideational poverty (a paradoxical phenomenon, considering the increase of imagination and creativity). Logical and coherent discourse, and jerkily predominant with slow rhythm and low voice. Subjective confusion caused by inattentiveness and indifference. Ideational reference developed in an adolescent context, with phantasmal content and ruminative accentuation of normalization of her own perceptions "it is normal, we all do it."

Affectivity: The depressed, apathetic disposition that occurs when she is going to perform certain activities "l lie in bed in pajamas". Anger and nervousness

occur when her mother scolds her.

She is sensitive to rejection or in the state of competitiveness "I do not suffer colleagues who are extremely feminine," the protection mechanism being the avoidance of social contacts and the isolation in small groups on which they rely to be encouraged to criticize or ironize those who are difficult and reach and promote rebellion/retreat behaviors (smokes weed). It works on the primitive mechanisms of hate and love "I have my mother who always talks and does not listen to me…when we fight I want to kill her…everyone offers me something, including money." She has an anxious base, possibly induced by the lack of limits and discipline in the family, but the misunderstandings and conflicts between parents and emotional disengagement from the mother. She expresses a slight ambivalence for the authority, shifted by non-compliance towards society's rules. There is a tension in the social interactions, as a pressure that brings out the inner comfort "I do not know what I say, I have no ideas…I usually talk to myself only, I'm not talkative." Self-esteem at average level, reacting with frustration when her mother swears her or accuses her of being light-hearted, yet she is merciful to her mother and does not defend herself.

Activity: Risk of falling into depression with a strong anxiety in the absence of appropriate psychological treatment. She feels free because she turned 18, her parents divorced, and her mother left because she doesn't need to give anyone explanation. At this moment she lives her life at her own wills "she drove the car without a permit and she was caught by the police, she parachuted, stayed all night out in the city and smoked."

Voice and Motivation: It's a difficult time that leads to ambivalent feelings between the assumption of responsibility and the inability to mobilize. Generalized hipobulia, with increased states of dreaming.

Instinctual Life: There is a slight disinvestment and indifference expecting to be left and not listed to, psychically preparing herself and not suffer very much. Emotionally blocked towards objects to love, in relation to which she now feels above.

Consciousness: The lack of links between emotional difficulties and dysfunctional behavior (about doing things in real life) to build a successful future.

Criticism of the present state (dispositional modifications): It is aware that it is disorganized, "hoarseness", she knows when she has deep feelings of discomfort (lack of motivation/depression, panic attacks, anger, annoyance, isolation) and she has the ability to worry about the lack of decisions or about what she will do in life. She is afraid of insanity and wants to make sure she is not as crazy as she thinks her mother is, who talks for 3 hours without stopping, as she accuses her of madness "my grandmother says I look like my mother and I do not like it." The patient seems to be unaware of the boundaries between real and imaginary/fantastic, "a madman told me that she became like that because her father stole his mother and another one recited from the Bible, which he fully memorized and it seemed normal to me…I like madman people, I like to listen

to them." She relates to be suspicious of persons close to her in whom she cannot trust because they can turn against her and therefore prefer foreigners. She also insists on interrupting psychological counseling because she does not think she can engage in a long-term self-knowledge process that she does not think will be of help, but she wants to be psychologically evaluated.

3. Applied Tests

3.1. Drawing Tests

The global impression of the tree indicates at the psychological level indexes with tendencies towards apathy, detachment, fragility. Refugees in the world of desires, idealism, exaltation of imagination, unrealistic goals, the need for valorization and self-motivation. Truncation, helplessness, lack of action, jamming, bumping. Lack of roots, lack of connection with the unconscious, self-doubt and the construction of false ones (false, inauthentic spirit). The self-image of the person's test appears in a caricature-it is because of our relationship that at this point of psychological testing is not defined by a strong bond, or because it is a constant experience of her life in which she finds and She imposes how she can. Anxiety, hesitation and avoidance in decision making, transposition of the emotional void (absent look). The power of the self appears as a (victory over itself) given by the interpretativeness and insubstantiality of the extreme that overwhelms it as a form of defensive breaking away from the world. Unsuccessful attempts to use humorous and dissociation defense mechanisms that lamentably fail in a depression of greater intensity than can be clinically expressed. Difficulties in abstraction and use of abstract notions, despite the fascination for the area in question. Compensatory responses, the need for dependence in interpersonal relationships (rigid in obedience). There are still the following signs that mean: Verbal abuse (ears), a kind of nervous excitability and anxiety, indifference, feelings of insecurity and inadequacy, isolation.

3.2. Hamilton Test-Depression

Total points score = 14. Poor depression.

3.3. Hamilton-Anxiety

The patient falls to the grade 2 level indicating moderate anxiety.

3.4. Luscher Test-Projective Exam

Desirable goals/behavior dictated by the desired goals: Because of the sensitivity (understanding a patient's personality dimension), as a threshold of low resistance to frustration, we highlight rejection that arises as a consequence of interpretativity and which is closely related to this emotional dimension. Her feelings of insecurity arise instead of anxiety by longing for a content understanding with the tendency to protect herself to exhaustion. It is necessary to manage the unsatisfactory situations and to get rid of existing thoughts that are equally deplora-

ble and intolerable. Being no way out with the impossibility of finding solutions, it is necessary to develop constructive defense mechanisms to lean on a powerful Ego. It tends to enter into abstract discussions up to self ruminations that can trigger major internal conflicts or even aggression in relationships with others.

Existing Situation/Behavior Dictated by the Existing Situation: It automates its primary needs by repressing much of its satisfaction. They remain unexpressed and receive a maximum pulse load, becoming reactive under the imminence of imminent behaviors and driven to the extreme, being difficult to achieve without any concession. He always has the need to surround herself with an aesthetic framework and/or with a partner (equally sensitive) and understanding with whom she needs to share a warm intimacy.

Characteristics suppressed or burdened by anxiety/behavior inappropriate to the existing situation: The patient is frustrated and unhappy because of the difficulties she has and fails to achieve the degree of co-operation and harmony she is aiming for. Because of her resistance she faces every time she tries to assert herself, she revolts and remains indignant at her impotence. It is often lost in these failures, increasing your inner agitation, predominantly the apathetic disposition it manifests externally.

Physiological Interpretation: There is a marked state of anxiety due to the stress that arose from the effort to defend itself, from uninhibited limitations and unwanted restrictions that kept it in a state of mismatch to the outer reality.

Psychological Interpretation: The existing situation is disagreeable. Due to self-loneliness and self-confidence, the patient needs to achieve personal satisfaction and validation of others at the same level as her high aspirations, aiming to get out of the "ordinary" category. Feelings of isolation and loneliness that he insistently imposes on something natural increases her needs and amplifies them, transforming her personality. Because she wants to demonstrate the unique quality of her character, she refutes the need for social contacts by adopting a false self-confidence, unrepentant attitude to hide her fear of inadequacy. At the same time she scorns those who criticize her behavior. Still behind this arrogance and indifference, the patient longs for the approval and appreciation of others.

(The Luscher test shows the patient's feelings at the deepest level as the feeling of disillusionment that manages to exterminate by so much so obvious indifference. It also shows a clearer perspective on her need for independence that she tries to Claim it through the tendency towards perfection).

The current issue: The deviant behavior it manifests from stress. Her marked anxiety shows the desperate attempt to resist any form of pressure from others as well as her insistence on autonomy/independence. Thus the origin of the vehemence of self-delimitation can be determined in order to be able to self-manage itself. Her rebellion behaviors show a need to decide alone and make her own decisions without being influenced by anyone. In an attempt to remain objective, it reacts against its will to get out of a pattern of society that makes it intolerant of others, thus remaining self-confrontational. This keeps them in a state of in-

consistency with her experiences and self-image. Being very impressed by the novelty and original, she lives fantastically trying to equate the qualities she admires with people who have remarkable qualities to fake their own originality. The unfulfilled desire to be respected and to make one's own personality is the cause of the anxiety that causes her to stay away from her companions. Because of the reflexes and the inhibition of expressing the self, the patient refuses to involve or participate with others even in some ordinary activities, stifling her most normal sense of sociability [3].

Conclusions on the Luscher Test: Due to this loneliness, the patient at the level of functionality remains in a continuous effort to defend herself, feelings of isolation and insubstantiation that she insistently insists on as something natural.

The sense of disillusionment is masked by indifference and by the false ones with which they interact with others. Depression appears with an apathetic color that is revealed by its sensitivity that appears before interpretation. Other predominant diagnostic features are: apathetic predisposition, frustration and unhappiness, revolt and indignation of her impotence, living in a fantasy world, conflicts with herself, inconsistency with her feelings and self-image, aggression, self-confidence Fake, remarkable anxiety, abstract discussion to self-rumination, and the process of transformation that changes her personality, the feeling of disillusionment that she manages to conquer outside by such a so obvious indifference. What could not be observed clinically is the tendency towards perfection that the Luscher Test highlights.

3.5. SCI-PANSS. Scale for Schizophrenia + Associated Symptoms

P1: Delusive ideas

There is the presence of delusional ideas that do not keep it isolated from social life and how it thinks of life. Unrealistic deliberations, unaltered conceptual and abstract thinking, good ability of social and behavioral activity. 3

P2: Conceptual disorganization

Difficulties in organizing time orientation. Sometimes she or she is missing and cannot plan a real time assignment to perform her/her activities (at the same time schedules at the Counseling and the Driving School). It is heading in space. 2

P3: Hallucinatory activity

The patient is convinced that she has the ability to see the interior that she projects in her artistic works. Thought can be affected to a small extent by frequent hallucinations. Severe sporadic hyperexcitation with episodic outbursts. 4

P4: Excitability

During the interview, one can see how the patient breaks her nails and has a slow rate of response to the response. 4

P5: Delusive ideas of grandeur

Reference ideas-not found in relationships with women. She designs the false

self to her colleagues whom she sees as true, but full of superficiality. It is best understood with men, but it does not feel that they dominate them, but they are fleeing in search of comfort. Boasting but without delusions of grandeur. 3

P6: Suspicion/persecution

Ideas of humiliation and exclusion from the school group, hostile and deliberate behaviors from others but do not feel persecuted. Distrust in itself is obvious, but does not feel persecuted in interpersonal relationships. 4

P7: Hostility

Involuntary hostile communication from the others and transference from the patient through acts of disrespect, curse and evocation of traumatic situations caused by others, especially from the mother, nervousness. A hostile, irritable attitude, direct expressions of anger or resentment. 4

N1: Emotional shooters

Affective flattening and slow reactions in speech. The presence of disappointment. Monotone without facial expressions or behavioral gestures. 4

N2: Emotional withdrawal

The patient reports the lack of interest and demotivation. It is detached from the assumption of responsibilities and respect for its involvement in everyday activities (absenteeism, it is difficult to mobilize to get out of the house, miting). The marked deficiency of interest, emotional investment is limited in conversations and limitation of personal functions (requires assistance). 6

N3: Early reporting

She is cold, keeps an interpersonal distance, answers mechanically to questions, gives signs of boredom, manifests indifference, but maintains an empathic involvement with her mother. 4

N4: Social repatriation of apathetic/passive type

It tends to retreat with the disinvestment of others, and there is no interest or initiative in activity. 5

N5: Difficulties in the abstract thinking

Uses the ideal and fantastic way, but the phrases are spoken with distrust. It manifests a certain rigidity of attitudes and beliefs, has difficulty accepting another perspective from outside, cannot move from one idea to another. 2

N6: Absence of spontaneity and conventional flow

She sums up just to answer the other's questions during the conversation that seem to take her out of the comfort zone. Conversations do not flow freely spontaneously, jerk, cheery, and in order to get answers, clear, concise questions need to be addressed. 4

N7: Stereotypical thinking

The conversation is confined to the clear and concrete thoughts (it speaks of the mother) that it presents without linking it to its emotional side or to its experiences in relation to behaviors in various situations consistent with reality. 3

G1: Somatic concerns

Head and back pain. Sometimes the muscles in the left hand (in situations of

interaction with the other) are blocked. It presents somatic dysfunctions and clear delirium that involves bothersome themes but is not concerned with delirium. 5

G2: Anxiety

Dismissed with obvious anxiety. There is a subjective state of fear, almost constant associated with phobias, restlessness or somatic manifestations. 6

G3: Feelings of guilt

The patient assumes her gestures and behaviors of being irresponsible and she is guilty of what she did (she does nonsense, is not serious, cannot keep up with the given word, feels disappointed). Preoccupation with guilt with self-appraisal. 5

G4: Tension

She feels a continuous internal tension that amplifies when she is argued by her mother. Voltage that disturbs her in interpersonal relationships (hyperventilation). The tendency towards inactivity, passivity and non-involvement (it would only lie in bed). 6

G5: Manners and positions

The posture seems to be cautious, seems to want to avoid something, it is difficult with silence; it feels like it wants to leave or retreat itself. She prefers to emphasize inner feelings in the form of defense (as if she masks something). 4

G6: Depression

Episodes that occur in the evening before sleeping or in loneliness with an impact on their behavior and social functioning (feel sad though they are aware of the need of the other to withdraw socially). Apparently it is positive and comfortable in interaction. 5

G7: Retard engine

Diminishing voice and slowing the speech rhythm. It amplifies when it is in dialogue or when it is in direct relationship with the other, as if it is prudent or feels interrogated. It is slow in movements. 4

G8: Lack of cooperation

She responds, answers the questions but expects to be questioned, seems to have a hidden, harmless but defensive lack of ideas. It manifests itself openly but organizationally conforms. 4

G9: Unusual content of thought

The patient lists numerous ideological ideas that can be interpreted as rebellion (she wants to move from Bucharest to the mountains and build a house, but first to travel through the world by shooting and earning money—to be a driver on the train). Ideosincratic thinking, ideas emerging from common contexts. 3

G10: Disorientation

She may have control over herself and her inner pulses. 2

G11: Worry attention

The conversation is affected by the slowness with which it responds and the moderate lack of attention. It is a dreamer, being absorbed by the inner feelings that disturb communication. 4

G12: Lack of judgment and criticism over their own condition

Sometimes they are aware of the need for organization and support from specialists. Criticism and awareness are occasional deficits such as delirium, disorganized thinking, suspicion, and social withdrawal. 3

G13: The distress of the will

It interferes with thinking and behavior. The patient is confused and vulnerable in making life decisions. It is left slightly distracted in the conversational thread, avoids a concise response, or the attention moves to another idea. Undetected, with minimal impact on speech and thought. 6

G14: Deficient pulse control

Episodes of impulsivity with verbal abuse and anxiety/anger for which it requires isolation. 5

G15: Concern (autism)

Dreaming with open eyes regresses profoundly and loses herself. 4

G16: Active social avoidance

Do not engage in interactive social activities and relationships with women due to feminine jealousy. Retiring socially spends time with oneself but on a disorganized level.

Positive Symptomatic (SP) = 21

Symptomatic negative (CN) = 54

Symptomatic general psychopathological (SG). Total score = 123

Symptomatic composite (SP-SN) = 33

Resulting reactions: retreat and isolation from the social environment but also from the mother. Lack of full support on the part of close people.

As a progression, the patient can be maintained supportive by psychotherapy with possibilities of affective disinvestment and long periods of absenteeism.

Conclusions on the Panss test:

The heteroevaluation scales have revealed that we cannot validate a diagnosis of psychoticism, although the Panss test has elevated values. The applied tests did not reveal anything psychotic in the psychiatric sense in the patient's structure in the negative symptomatology scales + general symptoms. We chose items with values over 5 that we grouped into columns on two value dimensions, some that support depression and some who support anxiety.

Depressive symptomatology size:	General Symptomatology Scale
-depression (6)	of the anxiety size:
-emotional withdrawal (6)	-anxiety (6)
-social re-adaptation(6)	-tension (6)
-culpability(5)	-poor control (5)
-will disorder (6)	-Symptomatic concerns (5)

I chose to apply the Panss test due to clinical observation and psychiatric symptoms revealed in the patient's accounts (reality, soliloquy, mother's inability to relate to her nipples and her expectations).

I think that in the next interviews with the patient I would expect to investigate this sphere of somatic concerns that the Panss Test revealed.

3.6. CAQ Personality Inventory

Affective heat (A = 5): The small individual score indicates affective flattening and inability to use empathy.

Intelligence (B = 5): score below average. The patient may not have responded correctly to the test, being inadequately careful and unable to concentrate due to the depression state they are in.

Emotional Stability (C = 8): High Shortage is a means of overcoming tense situations and relative emotional stability.

Dominance (E = 6): Lower score cannot be dominant, "closing itself". However, the clues that appear at the limit may mean that it can oscillate between the states of dominance/obedience and the hostile feelings can burst unexpectedly and violently, as is typical of the passive-aggressive pattern.

Impulsivity (F = 4): low values of this scale contribute to the pattern of depression.

Conformism (G = 8): the high score shows the possibility of disgust towards the weak and cannot bear the full chambers. The patient prefers to anticipate problems before confronting them, generally follows very strict rules.

Eccentricity (H = 7): high scores indicate the tendency to be the focus of attention within a group. The patient may be faced with the inability to make the right decisions, but may consider that fun is more important than victory.

Sensitivity (I = 9): Descriptions of this feature associated with high scores include tenderness, addiction, super protection, insecurity. She may prefer sentimental music, the use of reason rather than force to achieve certain things. May have preference for literature as compared to mathematics.

Suspicion (L = 5): Indicates M's ability to live jealousy and criticism and irritability. The lowest scores show the patient's health.

Imagination (M = 4): low score, the patient states that parents were concerned about existential problems. It is not a clinically significant factor.

Perspicacity (N = 3): low score indicates that the patient tends to be restricted by rules and standards.

Insecurity (O = 5): correlates with L indicating the fear of criticism and punishment from the authority, a situation in which it is often found and provoked, and the patient also finds herself frustrated with low confidence and group interactions. The average score shows the trend towards depression.

Radicalism (conservatism versus non-respect for conventions) (Q1 = 4): corresponds to autonomy and aggression. The low score shows the lack of spontaneity, freedom and analysis ability. The patient believes that society should return to nature to primitive living habits. It tends to be guided by feelings not by logic.

Self-sufficiency (Q2 = 7): the need for independence to which it accedes, the preference for loudness caused by fear of loneliness, abandonment. T. needs to be assisted for someone else to take responsibility for her behaviors as she oscillates from confidence to disinvestment from the inability to self-support herself.

Self-discipline (strong self-feeling versus weak self-feeling) (Q3=): low score

contributes to building the pattern of anxiety in CAQ. Along with high scores at the O and Q4 scales, this indicates a trend towards an excess of compulsiveness, resulting in obsessional behavior.

The tension (Q4 = 8): inherent correlation with Q2. Higher scores of Q4 signal a cry for help from the person concerned. Such people need a longer time to calm themselves, when they are irritated by minor things, easily upset and sleep hard.

Hypochondria (D1 = 4): low value of hipocondria inclines to maintain depression at an average intensity. At the same time this score makes us consider the patient as belonging to the real neurotic.

Suicidal depression (D2 = 3): this score tells us that the patient has viable energy resources and that she has not yet reached an out-of-date situation (although the Lucher test is limiting). In other words, it is far from the end of the bridge). A low score on the scale of suicidal depression may indicate rather aggressive passive tendencies in personality structuring.

Agitation (D3 = 6): patient has a special way to mask the increased agitation at the middle level within it but which is betrayed outwardly by splitting and breaking the verbal rhythm or aggressiveness.

Anxiety depression (D4 = 8): paranoid-type anxiety score by the imminence of her or her expectation of danger or of a disaster. She lacks confidence in her own forces, puts herself in dangerous/extreme situations. She is unable to assume the responsibility of her requests.

Low energy depression (D5 = 9): sadness, fatigue, anhedonia, lack of motivation and motivation.

Binge and resentment (D6 = 4): patience tends to show empathy to her mother but ends up manifesting ambivalence because she feels a lot of hatred at the same time.

Boredom and withdrawal (D7 = 9): the feeling that life is meaningless, is lived at a level of uniformity and social mediocrity without the freedom to create its own rules, laws.

Paranoia (Pa = 9): high score indicates paranoid schizophrenia (associated with suspicion and a sense of injustice and persecution).

The psychopathic deviation (Pp = 6): being increased modifies the diagnosis of schizophrenia and indicates a personality disharmony.

Schizophrenia (Sc = 8): corrected with D7 indicates the trend of social withdrawal. Together with A = 5 it suggests a low level of affectivity. The above-average score at this scale indicates that the patient feels rejected by the people, presents feelings of derealization and hallucinatory experiences.

Psychiatry (As = 8): signifies and supports the tendency of obsessional behavior and expresses T.'s efforts to resist xenopathic control.

Psychological inadequacy (Ps = 8): the result obtained indicates the existence of feelings of futility, self-devaluation, the area of self-assessment of the reality being distorted; Correlated with D2.

Clinical factors with psychedelic representative values are:

Factor D2 (Suicidal Depression) = 3

Factor D4 (Anxiety Depression) = 8

Factor D7 (Boredom and retreat) = 9

Factor Pa (Paranoia) = 9

Pp factor (psychopathic deviation) = 6

Sc Factor (Schizophrenia) = 8

As Factor (Psychostain) = 8

Consequently, the diagnosis of anxiety depression is supported by the high scores of factors D4 (8), Pa (9) and D7 (9). The patient is in danger of self-management, loss/abandonment, due to the difficult situation of separating parents at the time of adolescence. Thus, the impact felt is maturing in a forced manner is phantastically solved by a content and supportive world.

The Pp factor (6) appears to be increased to the limit, indicating that a change in the personality structure with a risk of onset of mental decompensation is possible.

Factor As (8) and Sc (8) show the self-perception of symptoms and an awareness of the difficulties that may have been good compliance in the psychotherapeutic approach.

Factor D2 (3) shows a low depression and D4 (8) expresses an indicator of the presence of anxiety.

CAQ is a self-assessment questionnaire, which can influence the responses because the abstraction ability of some items is missing. The resulting profile of this test confirms the diagnosis Depressive Disposition with anxious debut as well as the rest of the data obtained through the interview and clinical observation [4].

The patient in difficulty to manage the emotional feelings that affect her quality of life and self-evolution, presenting an emotional inversion in the sense of inappropriate feelings unrelated to the mother.

Considering the patient's ability to complete a complex questionnaire and numerous questions is doubtful about the sincerity of the responses although she has obtained an average score on factor B (5), intelligence and relatively good cognitive functioning.

4. Diagnostic

Axis I: The profile of an Acute Response to a stress factor, predominantly depressed mood of moderate intensity. We note that immune dissociated defense mechanisms attenuate the intensity of clinical expression of depression and have raised the suspicion of psychotic functioning in preliminary interviews.

Axis II: The personality structure has obvious borderline features, where the acute inner void feelings and the image hitting predominate. Risk of short and variable short-term psychotic decompensation of the order of hours, insulated and diurnal dreams.

Axis III: Paresthesia, headache and somatization, migratory localization, but affecting academic performance and altering quality of life. Subjective feeling of floating and the experience of not being in enough contact with reality.

Axis IV: The present profile contributes psychotrauma to the divorce of parents, together with the growing teenage imagination and creativity, thanks to the investment and activation in the artistic area. Alcoholic father. A mother with obvious inatteness and logos, emotionally absent. Reduced social support network (limiting circle of friends).

Axis V: GAFS = 60 (low value through repeated absences from school, self-isolation, and inability to learn). It is worth mentioning the decrease in academic performance compared to previous years, with the behavior of not having enough contact with personal needs and not taking care of them [5].

5. Prognostic Factors

Positive: The patient can maintain good internal and external functionality at the level of relationship thinking and behavior. It promotes the need for self-esteem and appreciation. It oscillates between agitation and passivity within limits of normality. Aware of the need for self-knowledge. It can make a positive transfer and accept psychological assessment to get out of confusion or to secure self-help and the opposite of what the mother systematically promotes "being crazy". She has the belief that she can have an independent life and a job. It can have a proper attitude and self-control [6].

Negative: The results suggest that the negative symptoms of schizophrenia could be grouped into three main dimensions, affective flattening, poor social interaction and allogony (marginal speech impoverishment or impoverishment of thought content). Moments of rebellion, lack of organization and concentration (cannot focus on just one thing, do more at a time), hallucinatory behavior of mild intensity can reveal the quality of detriment of perception and can contribute to the maintenance of the delusional idea [7].

Resulting reactions: retreat and isolation from the social environment but also from the mother. Lack of full support on the part of close people.

As a progression, the patient can be maintained supportive by psychotherapy with possibilities of affective disinvestment and long periods of absenteeism.

6. Psychodynamic Explanation of the Case

At the time of the psychological counseling request, the patient displays massive defenses and retreat herself. It presents itself in a deplorable image but with attention directed at emotional speculation. Her visual perceptions may be related to the loneliness they are in.

Analyzing the stress-diathesis model for T. patient, difficulties have been identified that have emotionally loaded and amplified its vulnerability: separation from the paternal grandmother that has grown; The poor relationship with the mother for which she had to be supportive; Emotional vulnerability of both

parents; Divorce and separation of parents; Lack of social support; Diminishing interest, motivation, and lack of mood.

Defense mechanisms developed by environmental influences on its personality structure and its loaded diathesis that threatens its mental integrity are:

Isolation of affections-dissociates the experiences of traumatic events from the reality of events that they factually evoke as a natural way.

Projection—The patient thinks that the behavioral reactions of colleagues are intended to harm them. She wants to get rid of the mother who wants to make her be just like her "crazy".

Rationalizing constructive affections by which the patient avoids working hard to shower and justifies her actions (loss of memory, loss of things and money, nerve, ignorance, and arrogance).

Absenteeism—does not attend scheduled appointments on the grounds that it has other urgent needs "courses at school and driver school [8].

It is difficult to interpret the impact of the type of relationship in the family environment that influences the patient in the social environment because her behaviors can be perceived as a way of solving the current traumatic situation through which she passes. As a kind of rebellion on their own parents because once with their separation of their couple they can no longer exercise and assume the process of parenting in relation to it. Thus they have limited the hope of being in the parental care that has brought her out of the comfort zone by forcing her to self-sustain as she has been since she is at the age of majority. From the point of view of current anxiety, lack of maternal presence and affective support are perceived as traumatic experiences that force it at the level of thinking and organization, of psychic economy but also of assuming its real life.

7. Conclusions

During the first five preliminary meetings, I followed my mother's relationship with my dad to observe the relationship, but also the interactions with the loved one and the social environment. As an objective in itself, we pursued the psychic structure of the patient itself because her disinvestment and emotional impoverishment indicates psychotic suppositions. I've been watching some aspects of small childhood to determine what the painting and the vocational choice she proposes in life means for her. Also to observe the power of the self and its creative ability in testing reality. Looking at the heredocolateral history, the father is accused of being an alcoholic, and the mother with emotional-emotional difficulties, psychotic features that she speaks alone in the house. The fact that the patient was minding the mother and all the others was necessary to investigate at a real level with personality scales to be able to investigate the dimensions of the fantasy/confessions, to capture the somatization and symptoms of the nasty suffering she passes through, as well as her behaviors Defensive/rebellious due to the depressed state (lack of pride, impatience). The patient's sophistication and somatic concerns are two aspects that following the application of the tests or

highlighted that the patient did not support in the direct communication from the clinical interview. Also the tests revealed the awareness of the anxiety and the depression faced by the patient's states of defense and trying to mask them out of fear of identifying with their own mother, "I'm not crazy as the mother says the grandmother." These feelings do not reveal them, and they do not want them to be discovered by others, keeping them in counterbalance with her need to be evaluated/know about her true identity and mental capacity.

After the psychological examination I noticed the following:

At the subjective/emotional level, the patient idealizes and wants to achieve a certain quality of life both professionally and personally. She invests superficially without having to do enough of her career by falsely motivating her dedication to study and developing her personal skills (she wants to get the driving license) with no correspondence in reality. There appears to be a reduced capacity to persevere in actions with a particular purpose when they involve a sustained time with a constant frequency that implies the delay of satisfaction. It manifests altered emotional behaviors characterized by emotional lability, good surface disposition, inadequate oscillation, instability, aggression and apathy. They often recapture in an apathetic immobility, denying the states of discomfort in which they compose, which they recognize as natural/normal through a superior detached attitude. She lacks empathy in her relationship with her mother, but she feels supported by her father, who cares for her through material satisfaction (financial support) and her relationship with others [9].

Unspoiled sexual behavior.

Disinhibiting the expression of the needs of the pulses without taking into account the social consequences or conventions "are not a church door, they do nonsense, they are arrogant, I like to go round." It is generally withdrawn though it is considered communicative is very selective in establishing new relationships.

Cognitive disorders in the form of the paranoid idea "I do not want to be crazy as a mother, she falsely accuses my father that she is not alcoholic…colleagues call me specially through their false femininity"; Obsessive preoccupation to help those with psychological difficulties, "I met some crazy people that I understood and believed." She is disturbed by the dysfunctional attitude of the mother and her health condition, a state she feels like madness. Alteration of flow of speech fluidity through intermittent, slow, confusing communication without being able to follow the coherence or purpose of speech. The content of her references is rudimentary in the absence of mature defense mechanisms, promoting ideal/fantasy thinking.

It affects the image and self-esteem that seems to be inconsistent with its external behaviors. At the psycho physiological level, the patient is somatized by her inner, unthinkable traits (back, muscles, tics).

At the personality level the patient manages a type of dependent personality:

Favors/Predisposing Factors: a dysfunctional attachment pattern that generates ambivalent cohabitation with the lover and with others;

Supportive factors: the presence of the lover;
Triggering facts: Lack of parental support, anxiety.

In the face of the anxiety that permanently threatens the integrity of the Ego; the patient clears and projects only in the well-being area, trying to avoid the evil that seems imminent and threatening. Fragmentation seems to be a solution to defend themselves from others, but the danger arises through the disappearance of the boundaries between themselves and others, retreating into the projection. Thinking remains grandiose trying unconsciously to satisfy its own narcissism. The patient has a predisposition to an aggravating mental state, a social retreat that is increasingly present, environmental stressors become more and more uncontrolled. The whole energy of the patient is directed towards defense, avoiding the reality of being difficult to adapt. Its actions are driven by internal pulses oscillating between aggression and isolation.

It has been found with this patient that self-evaluation removes clinical scores/ scores higher than heterosexuality. What we conclude that the patient does not want to outsource the world rich in fears of not being perceived as "crazy" with psychic difficulties, so chooses to appear indoors as empty and affectionately disinterested in awakening other feelings (empathy and support Affective) than a need for deeper investigation.

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