ON THE APPARENCE OF DEPRESSIVE ANXIETIES AS A CONSEQUENCE OF DELUSIONAL SOLVING. CLINICAL CONSIDERATIONS

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Estratto da:

THE MODES OF DEPRESSION:
psychobiology and psychodynamics

II International Meeting
of Psychopharmacology
Turin 11-14 May 1988

Editors:
L. RAVIZZA E. GENAZZANI
R. TORTA C. EVA

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The schizophrenic condition is linked, according to M. Klein, with the regression to the paranoid-schizoid position where the archaic Ego is not able to bear frustrations or to make a distinction between the self and the outside world. This archaic Ego relates itself to the outside world by means of experience of grandeur and omnipotence through the so-called "reintegrative symptoms" (allucinatios and delusions). These symptoms are supported by archaic defensive mechanisms such as splitting, projection and denial which represent the only possibility that the Ego has of restoring its connections with the outside reality.

In individuals with S.F. the seriousness of the original narcisistic trauma prometes splitting and hinders the integration of the split parts. Therefore ambivalence cannot be borne and the modes of regressive functioning become more evident, thus sorrow and nostalgia tend to appear.

Arvanitakis compares delusion to Perseus' "reflecting-shield" with which he manages to destroy Medusa and without which he would be destroyed by her. Similarly the individual with S.F. is destroyed by his feelings of guilt and has no possibility but to protect himself behind the "shield of delusion" and go somehow back to a more archaic world.

If we regard delusion as a shield and therefore as a defense it becomes clear that its fall gives rise to the appearance of underlying depressive anxiety.

This anxiety is so unbearable that it can be managed only through its projection onto the therapist who acts as a container, causing feelings of guilt and pressures of atonement in him.

This is a moment of deep sorrow, perplexity and confusion during which the therapeutic relationship can, even it considerable difficulty, prevent the patient from going back to the delusional phase since it enables him, as reported by Rosenfeld, not to use "the projective identification as a denial of

psychic reality any longer but, rather, as a means of communication", using his feelings of destruction and guilt in a dimension of atonement.

In this situation, it becomes of basic importance to use an emphathic dimension which makes receptiveness possible without any disturbing involvment and without omnipotent hypotheses of rapid and/or total resolutions.

Both the use of neuroleptics and psychotherapeutics treatment can lead to the fall of delusion and the beginning of the phase of depression.

In this respect some authors maintain, on the contrary, that a considerable part of depression in individual with schizophrenia cannot be abscribed to neuroleptics. Yet, since depression is common in those patients who take heavy dosage of neuroleptic depot or exhibit extrapyramidal symptoms, we are inclined to think that these drugs play a role in depression. The slightest incidence of depression is detected among patients who have been treated with moderate doses of depot.

According to Arvanitakis, one of the main aspects of the psychotherapy is, in these cases, what he defines as "frame" which consists of all elements that gravitate around the setting: among these psychopharmaceutical intervention. Psychopharmaceutical treatment combined with the psychotherapeutical one proves to be of incontrovertible therapeutical value in the treatment of schizophrenic troubles.

Careful examination both of history and of the clinical evolution of the following case allows us to conferme the above theories.

A.M. is 25 year old woman. As a child, her parents describe her as kind and open, with no problem of socializing with other children. After the secondary school-leaving certificate, she became a teacher of Gymnastics and carried out this activity for a short time. Her behaviour (and her ideational contents) seem to have changed as a conseguence of a sentimental disillusion when she was 17: A.M. becames more and more introspective, bashful and parts company with her old friends, displaying aggressiveness mainly in the relationship with her mother.

Her life becomes chaotic with a short period of drug addiction which comes to an end by means of a therapy with gradually decreasing doses of eptadone and 30 days in a recovery center for drug addicts.

At the age of 21 she starts a love affair, still going on, with a separed man who has a daughter and lives with another woman. During this period A.M. has three abortion; two of which were voluntary abortions whereas the other one (cronologically the first) was due to extrauterine pregnancy which required unilateral ovariectomy. Two years ago she was admitted to a private clinic for the first time because of not well defined mental disturbances.

Because of psychomotor agitation (she was kicking and punching the cupboard in her room as if she were possesed) she was taken to the Emergency Ward which she left few hours later contrary the doctors' orders.

Few days later she attemped suicide by defenestration. Once admitted to our department it was possible to notice the evolution of psychopathology through subsequent phases: in the first few days A.M. appears alert, oriented, able to give prompt answers to questions. She maintained she had made a pact with the devil, that perhaps she herself was a demon and that she might have drugged even her parents into such a perverse link.

The disquieting story of her experience and her attempted suicide was narrated by A.M. in a detached and a renunciatary tone which pointed out her indifference to reality.

In fact she depicted her story in dark colours making it resemble a sinister and grievious nightmare which she experiences without being able to describe it; moreover she exhibits an attitude of rejection towards the doctor in charge, althought she takes the neuroleptic therapy without rising objections.

A few weeks later A.M. becomes more accessible; along with delusions a new. more adeguate and less anxious way of comunicating accompanied by a marked improovement in social relations appears. A.M. expresses the need to beging all over again. She often asks permission for going out althought she always comes back to the ward before her time is up terrified at the idea of being late and therefore that che may be discharged from the hospital, thus showing her need for protection and help.

As delusional contents progressively fade, A.M. begins to complain of a sense of inner emptiness which prevents her from expressing her feelings. Speaking of herself, of her past and to her relationship with her parents, A.M. weeps showing sorrow and deep depressive anxiety.

In this phase, where the dosage of neuroleptics is reduced and slight doses of trazodone are added, A.M. during an interview, bursts into tears and, regretting her delusion, says that the reality which she experiences is unbearable for her.

The evolution of this clinical case remind us of a situation often reported in literature: the passage from an acute psychotic phase to a depressive one: It is well known that during the psychotherapeutic work it is possible to arrive at the integration of the split parts; this integration enables the patient to modulate his emotions both in the relationship with his innerself and with his environment, but forces the patient to face the ensuing sorrow, which might, in turn, give rise to a vicious circle with new regressions and splittings.

We wish to underline an important point: as pharmacological action tends to modify the inner dynamic balances, altering the balance of defences, leading to a partial integration of the Ego, and reducing the fragmentation of the Self, it may give rise to new psychopathological situation with values and demands different from the initial ones. As a consequences we are faced with the unavoidable need to follow these patients at two levels: that is to say both pharmacological and psycotherapeutic, in order to avoid that a pharmacolo-

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gical intervention may cause unverifiable imbalances among which, in the case reported here, depressions with a suicidal risk.

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