# *Sensitivity and Interpretativity - Between Schizoaffective Disorder and Paranoid Schizophrenia*

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**Abstract**

**Motivation**: Making a differential diagnosis between *Schizoaffective Disorder and Paranoid Schizophrenia* is difficult in this case, the patient presenting specific elements of both disorders, requiring both an assessment based on life history information and history of the disorder and the emotional resonance and emotional presence of the patient in the relationship during clinical interview.

**Objective**: This study proposes both a comparative analysis of literature and an evaluation of a type of disorder marked by sensitivity and interpretability in relation to dominated delusional ideas about physical appearance.

**Hypothesis**: It is difficult to emphasize the diagnosis of Schizoaffective Disorder, the patient symptoms oscillating between paranoid elements (*Paranoid Schizophrenia*) and affective ones (Schizoaffective Disorder). These oscillations are based on a fragile Ego structure, together with a kind of rigidity / cognitive reinforcement.

**Results:** The study outlines a profile based on: interpretability, sensitivity, fragile Ego and personal boundaries, addiction *to reflection* (in the light of others), psychotic activity (the intensity of the feelings from the present) and the psychotic elements manifested in the past (auditory hallucinations as commenting voices, delusional erotomanic ideation). Also, based on the transfer and countertransference elements identified, the emotional resonance is low.

**Conclusions:** It is difficult to make a precise differential diagnosis between *Schizoaffective Disorder and Paranoid Schizophrenia*, because of the uncertain dynamics of affective sphere elements in relation to those of the cognitive sphere, while the outside environment is a permanent threat to the structure and the consistency of the fragile Ego.

Keywords: Schizoaffective Disorder, Paranoid Schizophrenia, sensitivity, interpretability, fragile Ego

## Introduction

### General description of the case

R. is a 36 years old woman, who comes from a family with a modest condition, having a brother. She lives in Bucharest, unmarried, she graduated from Faculty of Law and she is practicing in the field, working in a good social position, which involves increased responsibility.
She lives with her mother, her father died five years ago because of lung cancer. She has been in a relationship (for several months) with a man which she describes as having a *contagious optimism* and he offers her support and acknowledgments, in those moments when pre-psychotic fears appear.

**The important current complains**: enhanced sensitivity to comments, criticisms, jokes of the people around, which are addressed to her, and a tendency towards interpretability, cantered on a particular theme → patient's fear that she is ugly, for which she finds confirmations, even in situations not related to the subject.

**Living and working conditions**: She lives with her mother in an apartment in Bucharest, with good living conditions, but in the relationship with her mother there is an over- responsibility and high stress levels: *"I have to do everything alone, mom comes here like she is coming to the hotel to find them ready made."* The same stress factor is the workplace, and because of the co-workers consisting of ten women with constant criticism and an environment marked by social competitiveness.

**History of disorder:** It started at the age of 18, when she was studying for faculty admission exam. Since childhood she presents an exacerbated sensitivity and interpretability in relation to the criticism of others. She had two florid psychotic episodes with hospitalization, the diagnosis was *Schizophrenia*, with good prognosis due to compliance and premorbid personality structure.

**The first episode** occurs in the context of History tutoring, for the admission exam to the Faculty of Law, developing erotic delirium for the professor who was teaching her, with interpretability and hyper-analytic delirium. R. repressed erotomaniac impulses to the point where they escaped control, leading to a confrontation, which made her confess the feelings and the teacher's rejection led to a decompensation manifested through verbal aggressiveness. The situation ended with a period of hospitalization of one month, during which she showed good compliance with treatment, which was maintained structured for 5 years.

The following year of the onset of the disease, she joined the faculty, but starting with the preparation of the graduation paper, the patient tried to stop the medication. As a result, she developed a second episode that required hospitalization. Since then, she has never discontinued the medical treatment, trying some dose reductions, which led to increased symptoms each time, after that higher doses being needed to control symptoms.

**Current condition**: Currently, she is in incomplete remission between episodes, being kept both interpretability and sensitivity particularities to rejection.

**Perception:** Shows no productive type disorders during the examination, but auditory hallucinations (commenting voices) appeared in the history of the disorder, with onset on a fatigue background.
**Attention:** Voluntary hyperprosexia, which operates as a mechanism for adapting to insecure social situations and as a way of obtaining social validation.

**Memory:** Good retrieval background, but she presents temporary lapses during the speech and the update of some insignificant details.

**Thinking:** Flat and slow rhythm and idea - verbal flow, inducing the feeling of ideational mechanization and emotional flatness. Latency in speaking and verbal blockages can be explained by the simultaneous operation of two plans: concrete, situational (conversation as such) and the interior, which is trying to structure the Ego and a verbal censor, being present the phenomenon called mental fading that *"It is manifested by a slowdown of the verbal rhythm, as the patient would be detached of what he/she says for a short period.*" (Tudose, 2011). She presents cognitive *fixation* in relation to concerns regarding physical appearance and an inflexible thinking, which is manifested by the constancy in insignificant and abundant details.

Another essential element is interpretability, a structuring way having as core a fixation on form (whether the form of words or physical appearance). Cognitive inflexibility involves a gravitation of patient's interests around the theme form (insists more on pronouncing certain words, names, the description in detail of certain circumstances, as if their shape defining would bring her own Ego the structure it needs).
Interpretability is predominantly related to its external appearance and cantered by delusional theme:

**** "I heard my boyfriend telling others that, although I'm not beautiful, at least I should realize that he likes me."*
**** " Some colleagues asked me how I can smile in a particular situation, and it seemed they say that because I am not allowed to smile, being ugly"*
**** "My friends may try to support me, but I'm not so geek or stupid... Maybe I'm looking for a different answer from them ..."*

The affective corollary of interpretability appears in phenomena of sensitivity, responsiveness to baffle and suspiciousness. R. presents an increased sensitivity to criticism, jokes and rejection, and also to the needs of others. During a trip to the mountains, she feels hurt by the comments of her partner and friends, to a small, minor fact, from those around. The incident made her recall some childhood memories related to the fact that family would have sent her to seek by herself information, when she didn't know something without explaining her anything. She considers a similar discussion regarding a girl from the group (currently in their group of friends) being specially initiated, suggested, to put R. in a position of inferiority, making direct reference to her childhood. Also in the same context, she tells jokes from friends, for which she manifests rejection and lack of connection to their playful content, convinced that there is a painful and hidden meaning, in order to make her feel bad.

Enhanced sensitivity related to others is what allows her to easily connect, unconsciously, to the needs and preferences of people around: *For example*, she is the one that comes with a very appropriate proposal for the gift that they would make to a friend whose birthday they were celebrating during the trip in the mountains, managed to find something to suit his tastes and concerns, just as she feels the need that her wishes to be taken in consideration by others: *"This is how I wanted to buy me someone a gift, after they study me and see what concerns me. Like I noticed that that boy is interested in Astrology. "*

The inflexibility of thinking is transposed through a reduced ability to answer emotional and cognitive to connotative messages in different social contexts (anecdotes, jokes). Basically, R. fails to understand the difference between a direct message and a connotative one (joke) and, therefore, takes connotative messages, setting rigidly in her allusive commonly reporting system around the main fear linked to self-image.

**Ideation** → Patient currently presents ideation with commonly intensity with symbolic self-harm within the self-image, having minimum criticism that the reality might be different from her own interpretations, which, however, she cannot change. In past episodes, ideation reached delusional intensity, being of erotomaniac nature and persecution-related

**Intellect** → Above average that favoured both treatment compliance and critical illness, it is a positive prognostic factor.

**Affectivity**: Currently, she presents affective flattening, maintaining a slight resonance in speech related to her partner. One also can distinguish moments when she fluctuates from sadness (because of fatigue) to joy, but these fluctuations of mood do not change the meaning of patient interpretability. If in the first episode, delusional ideas were correlated with hereto-aggressiveness and explosive expression of emotional feelings, currently anger was introjected and brought in a symbolic way within her Ego. This may be an argument which advocates for Affective Schizophrenia to the detriment of Paranoid Schizophrenia.

**Instinctual life:** R. presents a strong control of the aggressive impulses, for which she finds a motivation inside her Ego without projecting it outside.

**Critical illness** is present, the patient admitting several times that it is possible that the ideas might belong to her or that her excessive sensitivity might cause her pain, and not the feedbacks or negative intentions of others.
*** *"Doesn't she look at her to see how ugly she is, how can she smile, since she's so ugly ?!"* → in the context of the interpretability related to appearance, she understands that the message she heard might ~~to~~ be only partially true, supplemented with *part of her imagination* or speculation and personal associations: *"I do not know if they said that, but this is what I believe and that's important to me, what I think."*

**Personality:** R. has a structural vulnerable side, with enhanced sensitivity to rejection and negative evaluation. However, she doesn't require the attention of others, confirmation, affection, but it makes her feel good to accept them. In childhood, it was marked by multiple *fears*, also by the desire to be awarded and liked by others.

Currently, she is characterized by conscientiousness, compliance, cooperation, and also fear of the new, the need for stability and structure, organization (evidenced by the way she plans her live, by the attention she gives to details): *"The unexpected scares me a little... I like stability and all that drives me out of my pace and of how I think is good and right, makes me sad."* (given that she would be late only for a single therapy session in seven years due to the clocks that were behind, which she realized later).
**Self-Identity:** A fragile Ego, with a poor image and dependent on others' feedbacks, which came on a self-critical structure, which favoured the lack of borders and indiscriminate taking over of the others' point of view.

**The particularity of the case:** sensitivity, fragile self-image, productive symptoms centred around physical appearance *("The voices are always telling me I'm ugly! Never tell me something else..."*).
**Medication:** 3-4 mg Risperidone constantly over the past ten years. Although she is trying to reduce the dose to 2 mg, she fails, psychotic dismantling appearing.

**Interpretation of the case**: Coming on a fragile Ego, the patient interpretability sensitivity become structured, making her personality inflexible, similar from some points of view to the hardening / stiffness of the obsessive - compulsive, with obsessive *fixation* on her self-image.

The fixation on form, whether it is beauty, appearance, the form of words she uses, or about the fixation regarding the correctness of the insignificant details of life, involves, *in fact and in practice*, a lack of form, and partially, a lack of content of Ego. This lack of structuring also implies an inability to distinguish, both in concrete terms, regarding the inability to distinguish between the basic meaning and the connotative one, the playfulness of words, and emotionally, by the inability of separation from ideational and valuable content of the others.

Thus, the centripetal force of the Ego is so small, that it fails to form a coherent and structured image of her identity. If we turn into a metaphor R.'s Ego image, it is like a divided structure, without borders, whose elements gravitate around the others, without rendering a coherent content. It is this cognitive reinforcement of the patient that tries to compensate for the lack of form of the Ego.

And, because R. cannot build an internal structure by herself, she relates to the people around to reflect her Ego as a whole, hoping to get coherent whole. But, reflecting occurs fragmentarily, resulting in an even higher inconsistency to her self-valorisation system and personal identity. So that, from this point, occurs the patient ideation of self-deprecation, which interprets the inability of others to reflect her a consistent and positive image, as having a personal, internal motivation →namely, the fact she is u*gly* (that she is not uniform and harmonious). Following an evolution in the emotional and cognitive trajectory, a self-reported episode is recalled, in which her father showed her only pieces of physical attributes (telling her she has *nice hair and beautiful eyes*), but never including the whole. Exactly the elements mentioned in the speech about father are found in other episodes of illness, saying that her eyes were complimented (the partner) and hair (by a co-worker).

The phenomenon of interpretability appeared since childhood and now works afterthought, R. telling an episode in which she was deeply disturbed by remarks (real or not) of some children: *"We do not throw snowballs at her, she's ugly! "*. It also highlights the importance of the evaluations coming from strangers, considering that close people can deceive her about her real image: *"Perhaps these are the most sincere opinions, jokingly discarded by strangers, at first sight."*

Another issue regarding patient interpretability and the **projection phenomenon** refers to the idea that some people born under Gemini are superficial, who judge and insult her: *"They try to get to me, but they fail, because they are not able and then they are the ones who say such things about me!"*

R. seems to feel safe in the world of children, which resonates with her tendency to immaturity. Given this feature of infantilism, we can further evaluate the patient trend to take, in a non-discriminatory way, the assessments not only from others, but also their states, which leads to a contextual and limited poikilothermia. Thus, after a relaxing time spent in the mountains with her partner and friends, having a positive humour, the remark a co-worker on her emotional state - "*I'm not feeling as good as you!"* – perturbs her, inducing her the obligation to change the status: *"I have no right to be joyful when others are sad."* This phrase serves as a rule of social behaviour, which R uses as a way to define the Ego (in relation to others) and as an attempt of social integration.

Also within the area of interpretability and cognitive rigidity, R. recalls an episode that took place during the trip in the mountains, together with her partner and some friends, an episode during which she says she surprised them talking about her beauty. Moreover, we can observe an inability of emotional resonance and of understanding the connotations, in relation to the remarks of others.

Given the lack of form of the Ego, the patient's need for stability and organization is structured. Any interference in her schedule and life makes her feel unstable, *an example* being the perception of the trip in the mountains as a relaxing and pleasant time, but at the same time as being a disturbing factor of her balance: *"It was a relaxing trip, yet there were new things and new people and I tried to deal with..."*

Sometimes R. accuses commenting voices, which occur when she is overstrained, tired, referring to her ugliness. Throughout life, there were two clear florid psychotic episodes: the disorder onset (with delusional erotomania) and another one, which started in the bus returning from a trip to Greece, being with a friend and her daughter. Being very tired (trip lasting 12 hours), the patient began to hear the voice of a man who was talking about how ugly she is, other passengers contradicting him or asking him to stop *"Change the subject, we are bored and this is an offense."* R. asked confirmation of these words from her friend, who has denied, later the daughter told her mother *"If you tell her she didn't heard, when in fact everyone has heard, she will think she is crazy"*. In this situation, the clear psychotic elements were the commenting voices, as well as the patient's interpretability in relation with little girl's answer.

Crying very easily and enhanced sensitivity to the separation (even for a short period of time) from the partner is another argument in favour of immaturity: *"Even the thought that he will go makes me start crying..."*

At least at the moment, the relationship with the partner is a support for R., he managing to support her emotionally and validate her qualities, being available to offer her explanations and reassurances regarding her fears. Although gestures of tenderness, affection and valorisation from him do not destroy the common system of beliefs, however, the patient assigns to him positive intentions, to the point of doubting the authenticity of her *fears*. Thus, during the trip to the mountains, when her partner has expressed excitement over the two pictures that came out great, R. says: "*I think I'm not a beautiful girl, I am really ugly... and from that picture it seems only that we are in love ... But it's good so, too! "*

Although the patient did not disclose to her partner the diagnosis (saying that it is just a mental *breakdown because of stress, strain and failure in love*, for which she takes medication), this is nevertheless a positive element regarding the criticism on the disease and to the protection of a vulnerable side. She wants to tell him and she believes he could help her, but she is not sure yet that he will cope.

Although there are times when she feels misunderstood and even ridiculed by her partner because of her excessive sensitivity, R. manages to admit her mistakes and face the fears: *"Maybe there are just simple jokes and are not to be taken seriously and I must not cry because of them."*

In conclusion, the patient presents a **fragile Ego, partially destructured within interpretability and sensitivity area**, with negative prevalence ideation regarding the self-image, but with a limited disruption because of the positive prognostic factors, such as high intellectual level, compliance to treatment and emotional support from the relationship with the partner, R. being socially and professionally integrated. Also, positive prognostic factors are the two of her hobbies: *"After all this stress, after all that happens to me, after that it seems to me that everybody…. the only things that make me relax are reading an Astrology book and put me up to date ...with this issue of human relations ... "*

A psychotherapy session with R. will centre around the concept of **content** and much less around the **interpretation** one, because, for her, **the interpretability** mechanism is the dike that punctuates her mind. At the same time, R. is immature, dealing with a sort of *infantilism* in cognition and emotions, specific for the former little girl, who currently feels comfortable only around ten years old children. R. interprets everything: both the phenomena of the external world and those of the inner world, using arguments like "to split hairs", which is how the *network* delirium is formed, which gathers inside any unimportant information of the outside world, which is taken as an argument in chaining delusional ideation.

In the therapeutic approach, the focus is shifted from thinking on living, making R. easier to accept auditory and visual hallucinations, that are the result of her unexplained fears, and to believe that everything happens because of a **particular sensitivity,** rather than to believe that her thinking and perception are distorted, getting to work not in accordance with reality. Hallucinations and delusions come

from the most hidden feelings of defeat she had early in childhood: *"I heard A. saying: Although she is not beautiful, I wish she at least realized that I love her."*

The patient has many deficiencies, not only related to the feminine part (in which the perception of self-beauty is an important attribute) but including the acceptance of **competitiveness.** *Friendship, comparison, to become a wife*, bring in R.'s mind other dimensions. Then, she adopts an ironic tone to everything that femininity means and believes that it does not worth to enter the competition. Emotions are from the area: *dissatisfaction, frustration and irritation*. R. is unable to perceive herself, outside the cohesion between her and A., which for the future (if the partner can remain constant in her psychic life) can be repaired. A. will have to struggle, as in fairy tales, with hallucinations and delusional ideation and, also, with mechanism of interpretability from R.'s mind. Her love and gratitude because A. showed up in her life seems to help her to trust him. In other words, she gives him the chance he could function restoratively!

The question remains whether, at the limit, first (in her psychopathological disorders appearance) was changing the mood (and we find in her emotional history a real period of time changed in a depressive way) *or* if the thoughts were the first which distorted, from the interpretation of reality to the delirious pole. R. says: *"Some people talk like they breathe"*, remaining on the use of **projection** in relation to *what others think of her*. Somehow in a primitive registry, where *only beautiful people can write nice!* Together with bantering, subtly, R. feels indignation: "*Some people, whom I see superficial, are the ones who find me ugly! For them, the external image of someone matters very much! Emotions or feelings do not matter under any circumstances."*

In the description of this case, an important aspect is the urgent and commenting tone of the voices, when R. is in the bus, after a tiring period of time, which reduces her reception thresholds and makes possible the exacerbated perception of the sensorial inputs. The accusatory voices talk with the rescuing and repairing ones. Somewhere, law-like and logic appearance, prohibition, restriction of aggressiveness against herself (also related to the para- side and the operation *as of right*) are introjected in the hallucinations that defend her, saying: *"This is an offense! You will go to jail for the denigration of this girl! ".*

To hear or perceive things that are out of reach of others, for R. gets the character of functioning in *the mirror*, in the sense that everything seems *reversed*, even the madness and her own beliefs on her perceptual disturbances. The patient hears voices that others do not hear. The two friends try to convince her (empirically) that what happens to her is unusual and inaccurate. R. interprets distortedly and "upside down" and, namely, that everyone has heard something evil and slanderous and that the two women are trying to convince her that she is the only one that should not hear! As if she would remain forever a child of ten years*, sentenced* to not reveal how cruel and painful big reality is → *"Now she will think she's crazy, if you say it's not true what she heard, when everyone around realized what was happening! "*

Delusional interpretability works being correlated to visual or auditory illusions and always around the concept of "being ugly": *"I was walking on the street smiling. And I heard: How can she afford to smile, since she is so ugly?* In psychodynamic sense, the two major dimensions that represent the foundation of forming the **sensitive**

**ideation of relationship** are: **fragile personality structure** (regarding psychotic decompensation risk) and the **envy mechanism and managing it trough projection**. R. feels guilt related to any moment of joy (no matter how minor it may be), this stopping her from being happy: *"I was so cheerful in the morning ... when my friend came and told me that I do not well what I do ... "*. R. is fragile and sensitive, with an artificially upgraded Ego and exaggerated so as to cope with. But success is illusory, any little intervention of someone from outside seeming to "deflate" her and make her unable to enjoy and to face the reality. These movements, transgressions and regressions of R.'s Ego between **trust** and **self-disappointment** are immediately noticed by her partner, who feels the changes from her soul (which are not equivalent to exclusively dispositional changes!), who tells her: *"You're not the same like this morning! It seems you are no longer YOURSELF!"* The claim is made in a metaphorical context, but in relation to a human being which is so fragile, it refers to a concrete way of changing the Ego, even in her physical functioning context.

R. gives a whole speech during the session about the confusion caused by changing the time zone and all the emotional and administrative consequences arising therefore (including sending two messages to ensure that the meeting remains valid). *"This unpredictable situation ... I like stability ..."* →she states proving a desperate attempt to anchor in reality. For R., fatigue is always a trigger to decrease sensory limit. Also, stimuli or situational situations that for other people are considered within the great range of normality or pleasant, are experienced by R. with high energy consumption and exacerbated desire *to handle*: *"New things, new people ... I tried to face them..."* → she refers to the event related to her leaving to the mountains, which was for her a relational adventure.

In a perspective that we would like to discuss the **para- side** present in R., we could place it on a direction that starts from normality and that moves to the psychotic zone. First, R., is a master of **empathy**. She has good intuition, with fine nuances, what things are pleasing those around her (as the friend to whose birthday they is going, offering him a gift he liked, in a manner in which she herself would like others do to make her happy). At this level of functioning in the empathy area, R. impresses and delights her friends. Later, talking of **sensitivity**, a kind of emotional fragility, the remarks from others, even the innocent ones, seem to touch and to destabilize her (R. is hurt that *she didn't wash her hair with shampoo three times, as her friend does, so that means there is something wrong with her, she is excessively careful to an invitation to the wedding of her boss and she is wondering if she reacted right or not*).

In this type of relationship, the game is always within us, with the unconscious involvement of the other, who gets to interact at a much deeper level than she would want at a first interaction. Going further, toward extreme psychopathology, we find again **sensitivity**, when in R.'s interpretations regarding ordinary phenomena, *a danger wind is blowing*. The patient's speech is representative for the **relationship sensitive delirium**, when the allusions of her colleagues are made in order to highlight her deficient existence, in relation to anyone with whom she could be compared. The sensitive level refers to the area of living and feeling, the immediately following one, of **interpretability**, inserts thinking, cognition and introduces evaluative judgment over data, facts and events that were previously only experienced.

Returning to the beautiful side of empathy, present in this patient, by the gift that she makes to the friend whose birthday party she is invited, R. expresses her own fascination with the stars, a typical feeling for a ten years old girl, who wonders about everything that can be beautiful in the world. It is a true joy, coming from that she sees in the book of Astrology, an Encyclopaedia of human relations, a Dictionary to which she must appeal in difficult moments, just like in childhood, when upon any request of communication and need to discover *anything* together with her parents, is sent to learn by herself from the books.

R. has the princeps psychiatric diagnosis of **Paranoid Schizophrenia**, but it is worth to discuss the **Affective Schizophrenia**, and the **post-psychotic Depression**, at times, directly the next acute episodes, overlapping schizophrenia evolving from the age of 18, even in the continuous presence of the drug treatment. As a psychological problem (not in the sense of psychiatric diagnosis), the case raises discussions on the pathology of **dysmorphophobia,** as well as to the personality functioning in a primitive, narcissistic – paranoiac context. **The size of beauty and corporeality** is always related to the ideal image regarding physical Ego, and primary weakening is initially related to the body, subsequently extending to the spiritual and intellectual functioning.

Although the psychiatric diagnosis made by the doctor who has her under observation for 19 years is the Paranoid Schizophrenia (with incomplete remission between episodes), we consider that, at the moment, the case is structured more in the area of Affective Schizophrenia, having as argument the easy emotional fluctuation between states of sadness and joy, especially in relation to the partner. Another argument is the fact that a patient with Paranoid Schizophrenia would project aggressive drives to exterior and he/she would place their motivation there too, while R. is living painfully the motivation of her misery, watching them through their own inadequacies: *"I think I'm not beautiful girl, I'm really ugly ..."*

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