© Psychiatr Psychol Klin 2015, 15 (4), p. 162–168
DOI: 10.15557/PiPK.2015.0024

Received: 16.12.2015
Accepted: 23.12.2015
Published: 31.12.2015

Emanuela Atzori

Psychopathological effects of psychostimulant substances and psychotic onset: the difficult process of differential diagnosis between substance-induced psychosis and acute primary psychosis

Psychopatologiczne efekty substancji psychostymulujących a początek psychozy: trudny proces diagnozowania różnicowego pomiędzy psychozą intoksykacyjną a ostrą psychozą pierwotną

Emanuela Atzori – Clinical Psychology, Psychotherapist, Rome, Italy
Correspondence: Dc. Emanuela Atzori, Via P. Maroncelli, 44, 00149, Rome, Italy, tel.: 0655261908, e-mail: emanuela.atzori@tin.it

Abstract

Among the psychopathological effects induced by stimulants there can be a variety of psychotic-like experiences that can resolve in a matter of hours or within a few days without clinical treatment, or can instead constitute initial symptoms of a primary psychosis. The objective of this paper is to focalise on a series of psychodynamic aspects, detectable by the analysis of relational dynamics brought into play by the person who has used substances and suffers a psychotic crisis. These aspects can be used as criteria of differential diagnosis to integrate the first assessment of those psychopathological characteristics described in literature which distinguish a toxic psychosis from a primary psychosis. The diagnostic process is thus developed with the method of clinical observation and evaluation, for which the essential cognitive tool is formed by the sensibility of the therapist and their capacity to evaluate the quality of the patient's mental reactions to the stimulus provoked by the development of the therapeutic relationship, including oniric activity. This paper proposes, on the basis of many years of research and clinical experience, diagnostic criteria also in dream analysis, as oniric images can reveal hidden thoughts and dynamics that could be pathological. The theoretical platform to which reference is made and presented in detail in this paper is known as "Human Birth Theory" (*Teoria della nascita*), formulated by Massimo Fagioli in 1971. The therapist involved in the therapeutic relationship can stimulate the internal mental world of the patient, proposing himself/herself as both a diagnostic and therapeutic instrument. The interpretation can give back to the patient their self-knowledge and the possibility to transform their unconscious relational methods through the therapeutic process, as documented in two case reports presented in this paper. The case reports, explained in a form of single-case studies, describe the application of an integrated method in which the use of standardized instruments of assessment is flanked with the interpretation of oniric images in order to render greater diagnostic certainty as well as more incisive therapeutic treatment.

Key words: psychotic onset, substance-induced psychosis, primary psychosis, differential diagnosis, psychotherapeutic treatment

Streszczenie

Wśród psychopatologicznych efektów wywołanych środkami pobudzającymi znajduje się wiele doświadczeń podobnych do psychozy, które mogą samoistnie ustąpić w ciągu kilku godzin lub dni bez zastosowania leczenia albo mogą stanowić początkowe objawy psychozy pierwotnej. Celem niniejszej pracy jest analiza szeregu aspektów psychodynamicznych możliwych do stwierdzenia poprzez analizę dynamiki relacji interpersonalnych po stronie osoby przyjmującej substancje odurzające i przechodzącej kryzys psychotyczny. Aspekty te mogą być wykorzystane jako kryteria diagnozy różnicowej w celu dokonania zintegrowanej pierwszej oceny cech psychopatologicznych wymienianych w literaturze przedmiotu jako odróżniające psychozę intoksykacyjną od psychozy pierwotnej. Proces diagnostyczny dokonuje się poprzez obserwację i kliniczną ocenę stanu pacjenta, zaś jako zasadnicze narzędzie poznawcze służy wrażliwość terapeuty i jego zdolność do oceny jakości reakcji psychicznych pacjenta na bodźce wywoływane rozwojem relacji terapeutycznej, w tym jego snów. W niniejszej pracy autorka, w oparciu o wieloletnie badania i doświadczenie kliniczne, proponuje zastosowanie kryteriów diagnostycznych w analizie marzeń sennych. Obrazy obecne w snach mogą być przekaźnikiem skrywanych myśli oraz dynamiki o charakterze patologicznym. Teoria leżąca u podstaw niniejszego artykułu i przedstawiona w nim szczegółowo, sformułowana przez Massima Fagiolego w 1971 roku, znana jest jako „teoria ludzkich narodzin" (*Teoria della nascita*).

© Medical Communications Sp. z o.o. This is an open-access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (CC BY-NC-ND). Reproduction is permitted for personal, educational, non-commercial use, provided that the original article is in whole, unmodified, and properly cited.

Terapeuta zaangażowany w relację terapeutyczną może stymulować wewnętrzny świat psychiczny pacjenta, oferując siebie samego jako narzędzie diagnostyczne i terapeutyczne. Interpretacja snów może przywrócić pacjentowi jego samoświadomość i umożliwić zmianę jego wcześniej nieuświadamianych mechanizmów obecnych w relacjach międzyludzkich na drodze procesu terapeutycznego, jak to zostało zilustrowane w dwóch opisach przypadków uwzględnionych w niniejszej pracy. Przykłady te, analizowane w formie studiów poszczególnych przypadków, opisują wykorzystanie zintegrowanej metody, w której zastosowanie standardowych narzędzi oceny podbudowane jest interpretacją marzeń sennych w celu osiągnięcia większej pewności diagnostycznej oraz bardziej wnikliwego postępowania terapeutycznego.

Słowa kluczowe: początek psychozy, psychoza intoksykacyjna, psychoza pierwotna, diagnostyka różnicowa, postępowanie psychoterapeutyczne

INTRODUCTION

Among the psychopathological effects induced by stimulants and cocaine there can be a variety of psychotic-like experiences. Some of them can resolve in a matter of hours or days without clinical treatment, whereas other can constitute initial symptoms of a primary psychosis.[1] The objective of this paper is to focalise on a series of psychodynamic aspects, detectable by the analysis of relational dynamics brought into play by the person who has used the substances and experiences a psychotic crisis. These aspects can be used as criteria of differential diagnosis, to integrate the first assessment of those psychopathological characteristics described in literature which distinguish a toxic psychosis from a primary psychosis.

Among them, the following need to be remembered: the absence in a toxic psychosis of affective flattening, the presence of psychomotor agitation, an insistent search for communication channels on the part of the intoxicated subject, as opposed to shutting in and avoidance of relational contacts typical of schizophrenic syndromes.

However, Harris and Batki (2000) detected in some cases only the presence of faded negative symptoms which seem to be connected with a psychotic underlying substrate not diagnosed before.

METHOD

The diagnostic process is thus developed by the method of clinical observation and evaluation, for which the essential cognitive tool is formed by the sensibility of the therapist and their capacity to evaluate the quality of the patient's mental reactions to the stimulus provoked by the development of the therapeutic relathionship, which includes the oniric activity. This paper proposes, on the basis of many years of research and clinical experience, diagnostic criteria also in dream analysis, as oniric images can reveal hidden thoughts and dynamics which can be pathological. This analysis can detect a potential psychopathological nucleus of psychosis hidden by a state of intoxication, and allows the implementation of adequate clinical treatment based on greater diagnostic certainty. The possibility to complete the diagnostic activity including an assessment of the patient's unconscious mental activity is founded on the following basic ideas:

a. A dream is a *thought* expressing itself through the speechless language of oniric images.
b. With the telling of a dream, the patient is trying to communicate something to the therapist.
c. It is necessary to understand how dreams originate, and how their deep sense can be understood.

The theoretical platform to which reference is made in this paper is known as "Human Birth Theory" (*Teoria della nascita*), formulated by Massimo Fagioli in 1971.

Fagioli overcomes the *body-mind* dualism, theorizing that at human birth, light energy stimulation activates simultaneously the mind and the brain through the retinal area.[2] This event causes cortex activation and formation of a non-conscious mental activity. This specifically human thinking activity without articulate speech, conceptualized as the "capability to imagine," allows us to consider the existence of a thought that originates and expresses itself through images. According to Fagioli, human identity originates at birth, with a primal "Birth-Self" which results from the impact that the intense physical stimuli of the external world have on the fragile newborn, and particularly from the first stimulation of the retina by light. According to the author, these new and overwhelming physical stimuli provoke the emergence of what Fagioli called "disappearance fantasy" (*fantasia di sparizione*), through which the stimuli of the external world are made to disappear.[3]

[1] Cf. Addington J, Case N, Saleem MM *et al.*: *Substance use in clinical high risk for psychosis: a review of the literature*. Early Interv Psychiatry 2014; 8: 104–112.

[2] Light is an absolutely new stimulus for the newborn. There is a deep difference in the stimulation of visual system between the intrauterine and extrauterine environments. Depending on the type of tissue, the penetration depth of light wavelenght is less than 1 millimetre for blue (at 400 nm), 2 mm for green (at 514 nm), 6 mm for red (at 630 nm). The incoming light of wavelenghts below 480 nm is not trasmitted in the uterus. Fargnoli F, Gatti MG: *The birth of the human mind: a new integrative model of functional activation of the cortex in the newborn based on Massimo Fagioli's Human Birth Theory*. 19th International Congress of the International Society for Psychological and Social Approaches to Psychosis – From DNA to Neighborhood: Relathionship and Experience in Psychosis. An International Dialogue, New York, 18–22 March 2015. Il sogno della farfalla 2015; 4: 106–112.

[3] This is the only time in the individual's life when the impulse to make something disappear is triggered by a non-human stimulus. A confirmation of the existence of this reflex is provided by the activ-

 DOI: 10.15557/PiPK.2015.0024

Simultaneously, the merely biological experiences of the previous foetal state are transformed into the first mental images, that is a memory (*memoria-fantasia*) of the sensations had through the cutaneous contact between the foetus and the amniotic fluid. The memory of this prepsychic libidinal experience constitutes a "Primal-Self" which is not only the first "sense of oneself" which is fragile but not fragmented, but also, at the same time, an intuition-hope that another human being exists, and that one can relate to him/her, therefore it naturally tends towards relating to others. This human Self stems from the biological premises of the foetal state, which is transformed into human life at birth, due to the "disappearance fantasy," supported by "vitality," namely the ability to respond emotionally to external stimuli, to inter-human relationships and life events, and "the capability to imagine, that is the *capability to form mental images*."[4] During sleep, with the disappearance of consciousness and articulate speech, a particular mode of thought in the first year of life emerges: the capability to think with images.

The patient tells through dreams what they feel in human relationships. This account can have a varying level of intuitions, allowing the possibility of research, or it may be disharmonious, jammed, or fragmented because of more or less deep negations or annulments. The term "intuition" refers to an exact non-conscious relationship with the reality, which allows to understand not immediatly perceptible qualities and intentions in human beings. This non-conscious thinking activity can give a human being a profound and intuitive understanding of what is going on in their life and interpersonal relathionships. The term "negation" refers to a dynamic that produces a warped psychic representation of a person or situation. In Fagioli's view, the concept of "negation" strongly differs from Freudian concept of "*Verneinung*," as it implies that someone or something is unconsciously represented as the negative opposite of what they truly are. This dynamic starts from the intuition of positive qualities owned by someone else but turns this intuition into its negative contrary when the relationship with the other is affected by envy. If the intuition is "The therapist cares about me", the negative contrary thought becomes: "The therapist doesn't care about me." This dynamic distorts the reality perceived by the patient and their ability to interact with others, introducing a prodromic level of loss of contact with the reality, still limited to the non-conscious level. Negation is seen as a milder form of the "annulment drive" which defines the most pathological condition that may occur in the psychic relationship, for which the object is not destroyed, but disappears, and is rendered non-existent by the person in their oniric representation, producing thereby an emptiness and mental absence which can result in psychic fragmentation.[5]

The direct and disastrous consequence of this dynamic is an affectional impoverishment of the person, which can lead to a complete dehumanization in overt schizophrenia. Within this study, published online, "affectivity" is defined as "the capacity to be involved in, and to have adequate reactions, both mentally and physically, to the human relationship stimulus." In Fagioli's perspective, the lack, or the complete loss of affectivity originates therefore from the annulment drive that is a defence mechanism, a sort of internal "black-out," in which human beings, as well as one's relationships with them, are made non-existent, as if they had never existed in the subject's mind.[6] This mental

ity of a diencephalic structure, the so-called reticular thalamic nucleus (RTN), a solid structure in the web of GABAergic neurons (inhibitors) which cover the thalamus, connected through a feedback circuit with various parts of the cerebral cortex when, for example, the stimulation is excessive and the cortical efferents stimulate the RNT to interrupt the trasmission. This action is very fast, and the interruption of the trasmission of sensory signals along the cortical efferents (that all go to the thalamus) can last up to a second and a half. Vezzosi G, Pettini M: *Massimo Fagioli's Birth Theory: a scientific theory of human reality*. 19th International Congress of the International Society for Psychological and Social Approaches to Psychosis – From DNA to Neighborhood: Relationship and Experience in Psychosis. An International Dialogue, New York, 18–22 March 2015. Il sogno della farfalla 2015; 4: 112–116; Pinault D: *The thalamic reticular nucleus: structure, function and concept.* Brain Res Brain Res Rev 2004; 46: 1–31.

[4] Fagioli M: *Death Instinct and Knowledge*. Excerpt published online at: http://www.lasinodoroedizioni.it/catalogo/libro/23/istinto-di-morte-e-conoscenza. Human Birth Theory asserts that the embryo and the foetus are biological existences without psychic activity. Nonetheless, during the last months of gestation the foetus is supposed to develop what Fagioli called a prepsychic "libido capability," in particular due to its cutaneous contact with the amniotic liquid. Fagioli states that this "libidinal" experience could leave traces, that it could be somehow "stored" at a subcortical level. At birth, this prepsychic libidinal storage is transformed in each human being, through the activity of the somatosensory cortex, into mental contents, into "images." Fagioli's Birth Theory strongly affirms the biological origin of the psyche. This theory, developed forty years ago, has recently received strong confirmation from medical research. Neonatologists now know, for example, that surviving after birth is only possible if the pregnancy is at least in its twenty-fourth week of gestation, as it is precisely during this phase that the connections between the retina and the visual cortex are formed, even though the foetus continues to be a mere biological existence without any mental activity until birth, when this *possibility* of human life *becomes* human life. Recent neurophysiological research has confirmed that the brain functioning changes radically at birth with the activation of the *Immediate Early Genes* which are not expressed in the foetus and with a small temporal range of activation, can be activated only by light. Cf. Vandewalle G, Collignon O, Hull JT *et al.*: *Blue light stimulates cognitive brain activity in visually blind individuals*. J Cogn Neurosci 2013; 25: 2072–2085.

[5] In the therapeutic relationship we often notice the situation where the overwhelming stimuli, those felt by the patient to be too new and too strong to bear, relate to *positive* human qualities, particularly the positive characteristics and the care shown by the therapist, features that the patient thinks they will never be able to posses or develop.

[6] Fagioli links the concept of *Annulment Drive* to the one of *Death istinct* which is seen as an equivalent of the annulment drive and, differently from Freud's conclusions in his 1920 essay *Beyond the Pleasure Principle*, has nothing to do with material destruction and disintegration of life into inorganic matter. In Fagioli's theory, death istinct is conceptualized as an "omnipotent" psychic impulse which annuls, within the unconscious mind, the representation of certain elements that belong to external reality and always refer to interpersonal relationships and human qualities. Thus, death istinct alters the individual's relationship to human reality at an unconscious level, as the conscious thought and behavior may still seem appropriate. Death instinct is also a component of what Fagioli called "disappearance fantasy," that is the mental reaction of the newborn when the retina is stimulated by light, but in that case the first psychic act is to render non-existent the intense physical stimuli of the external world that, given

defence mechanism can be activated in response to stressors that hurt human beings in the first years of life, as well as mourning, child abuse, or relationships with non-responsive mothers not able to respond to the needs and requests of interest coming from the newborn and the young human being in evolution, and produces a progressive loss of vitality and affectivity, namely a progressive loss of the ability to respond emotionally to inter-human relationships with sensibility and interest toward human beings. So a lacking, discontinuous, or insane relathionship with unaffective caregivers can modify the human psychic health, producing mental illness.

The therapist involved in the therapeutic relationship can stimulate the mental internal world of the patient, proposing himself as both a diagnostic and therapeutic instrument. The patient's unconscious reactions to the therapist may be expressed through oniric images that can be evaluated each time, and interpreted if the right level of receptivity is present. The interpretation can give back to the patient their self-knowledge, and the possibility to transform their unconscious relational methods through the therapeutic process, as reported in the following cases.

CASE REPORT 1

A patient called C. dreamt to be working, and saw himself reflected in a pane of glass. The glass began to crack, with flaws branching out as a net. C. could control his anguish reminding himself that he knew what was happening, because he was in treatment with Dr A. At that point, the glass reassembled.

In this case, through the oniric activity, the patient was able to represent symbolically a difficulty dependent on the sensory-consciousness of his *Psychic Self*, and his somatic part seemed to be exposed to a psychopathological break down.

C., twenty years old, was a strong cocaine abuser who had started therapy with Dr A. during his stay at a dual diagnosis psychiatric ward for detoxication. The patient had been in treatment with CSM (public centre of mental illness) since the admission into SPDC (public psychiatric service of diagnosis and cure), due to a psychotic episode following a cocaine binge. The psychotic episode was characterised by a delirious belief to have been poisoned, which he had developed about three days after the cocaine binge episode. He believed that a friend had tried to poison him with a coffee, and he fell in a state of acute agitation. The colleague who treated C. described him as anguished, inadequate, but collaborating. He reported in the clinical record that C. suddenly became still for short periods of time, stopping to respond to the stimuli received, with a modality bordering between an epileptic absence and a psychotic perplexity. In a short time, he overcame the initial sense of disorientation, acquiring the certainty "to be trapped in an enigma" and that to overcome it would only be possible if he was able to solve a series of rebuses he "saw" scattered in magazines that his parents brought him to hospital. C. was successfully treated with risperidone, biperiden hydrochloride and escitalopram, discharged, and referred to CSM after a week. The delirious belief to have been poisoned, accompanied by delusional perception, disappeared twenty-four hours after its onset. After six months of controlled behaviour, C. embarked on cocaine binges again, and was voluntarily placed in a dual diagnosis ward. The colleagues of CSM asked for his complete assessment to overcome the diagnostic uncertainty concerning the isolated psychotic episode reported in the patient anamnesis.

The assessment was carried out through clinical interviews, the observation of relational methods and social skills in the ward group therapy, and the use of the following standardized diagnostic tools: MMPI, TCI, TAS-20 and Barrat questionnaires, and Addiction Severity Index (ASI).

From the structured ASI interview it emerged that C. had started the abuse of alcohol and cannabis at the age of fifteen. Subsequently, he started the use of cocaine, a substance that he considered his main problem, at the age of eighteen, after the end of a two-year relationship with a young woman, and learning that his father was suffering from cancer. C. had finished his school education, had worked occasionally, and had no criminal record. He said he had a conflictual relationship with his parents with whom he lived, and had a good relationship with his sister. C. said he spent his leisure time with friends who also had problems with alcohol and drugs, and stated that he was unhappy with that situation. He said that none of his family had problems related to mental illness or drugs, apart from his paternal grandfather who had problems with alcohol. At the end of the interview, C. said he suffered severe depression, intense anxiety, and difficulties with his memory and concentration not exclusively linked to substance abuse. He said he was very worried about these problems, and considered treatment for them to be very important. During the interview, he looked blatantly depressed, introverted, and expressed poor social interaction.

From the MMPI a symptomatic profile revolving around the dimensions of psychopathic deviation, depression and anxiety emerged.[7] Based on the scores obtained in Novelty

its physical reality, the newborn cannot cope with. At the same time, the memory of the sensations of correspondence had in the uterus orientates the newborn to seek a human reality beyond itself which can respond to its needs to survive and to develop. Only after a non-response from the caregiver, the newborn reacts with the annulment drive, rendering non-existent a disappointing human reality, and because of that, affecting its capability to have a relationship as well as its capability to imagine.

[7] The high score in the Pd scale (79) of MMPI showed a predominantly psychopathic aspect in the psychopathological profile of the patient, in which also strong depressive and paranoid aspects were present. The test result highlighted the presence of conflict with relatives and the possibility of problems with the authorities. It showed along with a social impassibility the presence of psychic aspects that seemed in contraposition with it, such as ingenuity and susceptibility, together with sensations of discouragement, pessimism, feelings of unworthiness and inadequacy, unhappiness, poor self-esteem, withdrawal and social isolation that blended with a sense of lack of un-

© PSYCHIATR PSYCHOL KLIN 2015, 15 (4), p. 162–168 DOI: 10.15557/PiPK.2015.0024

seeking, Harm avoidance, Reward dependency scales of TCI, we assumed a hypotymic personality. The temperamental profile was characterised by a tendency to explore and to be curious, excitability and impulsiveness, and, at the same time, to be preoccupied and anxious about novelty, as well as insecure and pessimistic. The conflict between these two tendencies produced discontent and intolerance in C. His personality appeared maladaptive and immature, although he manifested an ability to cooperate, to be honest and discreetly empathetic.

The score which emerged from the TAS-20 questionnaire was above the cut-off point: his thinking was concrete and lacking in its symbolic functions. There was also a difficulty to understand emotions and feelings. The score which emerged from the B-11 questionnaire was within the norm (P = 73): a balance was present between the polarity of motor and attentional impulsiveness, and the ability to reflect, mantain his attention and plan his behaviour.

During his recovery, C. initially reported serious difficulty in taking part in group therapy. When in a group, he felt a sense of inadequacy and a lack of social skills that made him feel insecure, thus choosing to remain silent. In individual therapy, he established a deeper relationship with the therapist, with whom he reconstructed his personal and clinical history, and started elaborating on the psychic crisis that had resulted in substance abuse.[8] After about a month in the clinic, C. asked the therapist if it was possible to continue psychotherapy with her after his discharge from the dual diagnosis ward, and during individual therapy he started to tell her his dreams. In this paper, we will focus on some of them.

C. was outside a discoteque with another young man. They saw C.'s mother walking in front of them, and the man made an unpleasant comment about her. C. punched him to the ground.

After about a month and a half since his recovery, C. dreamt to have a son of four or five months. The baby seemed smaller than the norm, and he sat the baby on a chair in the group therapy room, putting some pillows around the baby to steady it. He recounted afterwards a series of dreams in which he drank milk, fruit juice, and ate good food. After about three months in the clinic, he told a particularly significant dream.

Another patient in the clinic had stained C.'s room with excrement. Full of anger, C. put him in a hole in the garden and kicked him in the face.This dream anguished C. very much, and in an acute state of anxiety he tried to tell it during the group therapy but he was stopped and appointed an extra individual meeting.

In the first dream, the patient started to represent an anguished, ambivalent and conflictual relationship with his mother, that he had experienced since his childhood, which he had not previously mentioned. After C. had developed a stronger relationship with his therapist, he told her about a postpartum psychosis that his mother had suffered after his birth, about his growth difficulty in the first year of his life, and his subsequent childhood obesity which had been treated by a psychologist.

He also told her about his childhood fear when his mother suffered from extreme anguish and screaming fits.

In the second dream, C. seemed to express a growing receptiveness in a human relationship in which he felt able to develop himself. Nevertheless, this openness was still *in nuce* and perhaps feeble, since the dimensions of the baby dreamt were smaller than the norm. Moreover, the baby was not able to sit steadily on its own, and needed some pillows around it on the group therapy chair. With this oniric image, C. seemed to express that he needed an external and active intervention of the therapist that could help him to maintain the relationship. In effect, he attended exclusively group therapy sessions held by the therapist, and he also pursued individual treatment with her. C. did not trust other therapists, and remained shut in in contact with them. The increase of C.'s receptiveness in respect to the verbalization of the therapist was confirmed by the dreams in which he received milk and food, and absorbed nutrients. At a certain point of the therapeutic progress, C. had a dream imbued with anguish, with which he was able to represent through an oniric image what he experienced about himself and inter-human relationships. The patient that C. dreamt of was schizophrenic. C. feared to be psychotic, and said that he would prefer to die rather than be seriously mentally ill. Nevertheless, during the telling of the dream, C. seemed terrified of himself. He said he was becoming aware of being judgmental, and he was determined to change. His request to be treated, initially thought to be a reduction of the symptomatology, was at that moment perceived by C. as the disappearence of inhuman dimensions in relationships. Moreover, the dream he had after a patient had really stained C.'s towels with excrement, constitutes an important evolutive movement for therapeutic aims because of the restoration of a symbolic-representative modality of thinking that gradually reduces the eventuality of acting out. Additionally, the interpretation of transfer allows the patient to direct the "disappearance fantasy" to their own relational methods with human beings, based on a general "blindness," and to evolve gradually into a relational modality more "seeing" of their own and other humans' reality. The recovery of the reflective and symbolic capability, lacking in the patient when he was admitted into the dual diagnosis ward, was expressed with the reactivation of oniric

derstanding with other people, and consequently, a sense of distrust about them, accompanied by persecutory thoughts. The high scores obtained in D scale (Depression = 71) and Pa scale P (Paranoia = 71) are supported by the high scores of content (Anxiety, Depression, Anger), and by several critical items in the area of depressive ideation, concern, state of acute anxiety, strain and somatic symptoms. The traditionally high Ma scale together with the Pd scale in psychopathic personality, resulted in C.'s profile being considerably subthreshold.

[8] The definition of "abuse" has disappeared in DSM-5. Along with several authors, in this paper the term "abuse" is maintained, because it is considered empirically and clinically more valid. Cf. Frances A: *Essentials of Psychiatric Diagnosis. Responding to the Challenge of DSM-5*. The Guilford Press, New York 2013.

DOI: 10.15557/PiPK.2015.0024

activity, and confirmed by the re-test results before his discharge after six months of treatment in the dual diagnosis ward. The score (P = 34) in TAS-20 re-test questionnaire did not exceed the cut-off, so a diagnosis of alexitimia was excluded. Moreover, TCI re-test showed an increase of C.'s sensibility to social recognition, and an increase of imaginative and creative capability.[9] The dream in which C. saw the glass with the reflection of his image crack, described in the opening of the case report, was told during a session of psychotherapy about eighteen months after his discharge. It could be considered as a significant attempt of an oniric elaboration of a crisis, due to the difficulties experienced in participating regularly in the psychotherapy sessions because of unmodifiable shifts, of which the most evident sign was a relapse in using cocaine. The limitation and the overcoming of the critical episode through the oniric activity of elaboration, was due to the quality of the relationship that the patient was able to achieve with his therapist in the course of treatment. Despite the phenomenological characteristics of the psychotic episode reported in C.'s anamnesis, presumably due to the state of intoxication, this oniric image allows to consider C at that time as a clinical high risk (CHR) patient, and points to a possible aetiological hypothesis about the cause of his cocaine abuse that may have originated due to psychophysical sensation-seeking aimed at overcoming an unusual and abnormal own body experience. The development of the therapeutic relationship in which the annulment drive is directed outwards was continually interpreted, allowing the patient to maintain a mental representation of human relationships and of himself, and to overcome the eventuality of psychological fragmentation with an evolution towards a primary psychosis. After a further year of psychoterapy in which C. kept himself abstinent from drugs and maintained his job, achieving a progressive material autonomy from his family, he told the following dream.

He moved away from his mother who seemed to smell badly. He went to a bathroom where he found a big mirror and a clean shirt. He washed, and looked at himself in the mirror. The image reflected was clear. He found himself to be slimmer, and perceived himself as more harmonious. With this oniric image, the patient seems to represent a separation from his psychotic mother. This separation constitutes a possibility to define himself as different to her. The image reflected in the mirror is this time clear and strong, and tells how the initial difficulty of the patient with the sensory perception of his Self, for which the internal image of his body and person did not result "founded" as solid, seems almost overcome. Consequently, the relationship between the conscious and the unconscious psychological part of his Self (psychic-Self), and the somatic part of it (somatic-Self) which appeared problematical and continuously exposed to a psychopathological break-down seems to have become much more solid as a result of the terapeutic work. This solidity has facilitated and currently supports the balance in relationships and working life that C. has gradually achieved, as well as the end of drug abuse that can be speculated to have originally been due to an abnormal experience of his own body, founded on the loss of personal and interpersonal sensitivity.

CASE REPORT 2

A patient called T., twenty three years old, was admitted into a dual diagnosis psychiatric ward after a failed admittance into a rehabilitiation centre. During the psychological interview it emerged that before his access into the rehabilitation centre, T. had smoked crystal meth. This drug shares with amphetamine a mechanism of action based on a relapse of catecholamines at a synaptic level, in particular of dopamine. Its prolonged use causes confusion, anxiety, insomnia, paranoia, distress, and paranoid delusions. The symptoms overlap with thosed induced by cocaine, yet last longer because of the greater half-life of amphetamine. Depending on the duration, intensity and modality of consumption, the chemically induced psychotic symptomatology could persist for months. While being admitted into the rehabilitation centre, T. suddenly believed that some gypsies were waiting in the centre to kill him. He wanted to run away, and, in an attempt to escape, he punched the glass door in the hallway. The operators in the rehabiltation centre stated they were unable to deal with the severity of the psychopathological condition presented by the patient, so T. was admitted into the dual diagnosis ward with a request for a complete assessement to be conducted with the aim of defining adequate treatment. From the ASI it emerged that T. had started using alcohol and cannabinoids at the age of fourteen, and at eighteen he had started using nose-only cocaine and abusing alcohol. At the age of twenty two, he had started using amphetamines, and at twenty three, sedatives. At twenty three, he had used nose-only heroin once. He had been living with an aunt since the age of eight because of the psychopathology of his mother who was an alcoholic. He never knew his father, and had an older brother, born from a different relationship of his mother's, who was a significant figure in his life. He attended state school until the age of fourteen, then worked for a short period in a butcher's shop. The addiction to methamphetamine was immediate after the first use, forcing him to interrupt his work, and ask for admission into a rehabilitation centre. The psychopathological profile emerged from the MMPI evidenced a *tendency to depression* (D = 61/Ma = 52), a *tendency to impulsivity* (Pt = 64/Pd = 80) and a *tendency to social opposition* (Hy = 62/Pa = 71).[10] The TCI result highlighted a profile

[9] The patient obtained an average score in Self-trascendence scale.

[10] Depression felt by the patient expressed also with physical dysfunctions accompanied by a costant feeling of fatigue and discomfort (Hy3 = 75), and of an intense need for affection (Hy2 = 71). A high score in the Pd scale was especially supported by Self-alienation (Pd5 = 72), whereas the Pa scale was elevated by susceptibility (Pa2 = 61) and ingenuity (Pa3 = 65). Cf. Hattis and Lingoes scales.

© PSYCHIATR PSYCHOL KLIN 2015, 15 (4), p. 162–168 DOI: 10.15557/PiPK.2015.0024

characterized by oppositional, hyperthymic and self-efacing traits. The TAS-20 test result did not evidence the presence of alexithimia, though the patient seemed to exhibit strong impulsiveness in Barratt Impulsiveness Scale test result.[11] The patient seemed motivated about treatment, and participated in every session of group therapy. During the first days in the dual diagnosis ward, he appeared highly anxious, and displayed paranoical signs: T. said he did not dream, and felt worried about the admission of each new patient into the ward. He was still afraid of the possibility that someone could enter the ward to hurt him, hence the psychiatrists introduced a neuroleptic into his pharmacological therapy. The observation of T.'s relational modality in group therapy and individual interviews allowed to consider the psychotic episode verified during the admission in the rehabilitation centre as a chemically induced psychosis: the patient did not reveal affective flattening, or schizophrenic concretism; he looked eagerly for support coming from the therapeutic relationship to help him face intense craving, and distanced himself from those who were oppositive to the therapeutic intervention. The psychopathological diagnosis masked by substance abuse was dysthymia. The quality of the relationship he built with the therapist during the three-month recovery can be synthesized with the following oniric images, told before his discharge from the dual diagnosis ward and admission into the rehabilitation centre:

- In the first dream, he was in front of a big open window from which he could see a flourishing garden below. He stood close to his therapist and he "felt well."
- In the second dream, he was going to have his dinner in the ward, when an unidentified operator told him to go out for dinner, and took him on a pier in front of the sea to fish.

With these oniric images, the patient described the opening of his eyes (the open window), and perceived his evolvability (the flourishing garden) through the development of a therapeutic relationship (to fish as a possibility of nourishment, of internal enrichment through a human relationship) in rehabilitation centre treatment. These elements were correlated to a progressive decrease of anxiety present in the patient at the beginning of the treatment, and to a significant decrease of Barratt Impulsiveness Scale re-test score which did not exceed the cut-off in the average of controls.[12] When he was discharged, his persecutory ideation present upon admission into the dual diagnosis ward three months before, had not completely disappeared. The continuation of the antipsychotic treatment was justified in the medical records as a containment strategy of psychotomimetic symptoms due to the prolonged use of methamphetamine. The subsequent follow-ups conducted at the rehabilitation centre confirmed the diagnosis of "toxic psychosis in dysthymia."

[11] Scoring = 73.
[12] Re-test scoring = 60.

Conflict of interest

The author does not report any financial or personal affiliations to persons or organisations that could adversely affect the content of this publication or claim to have rights thereto.

References

Addington J, Case N, Saleem MM *et al.*: Substance use in clinical high risk for psychosis: a review of the literature. Early Interv Psychiatry 2014; 8: 104–112.

Fagioli M (1971): Istinto di morte e conoscenza. L'asino d'oro, Roma 2010. Excerpt published on line at: http://www.lasinodoroedizioni.it/catalogo/libro/23/istinto-di-morte-e-conoscenza, with the title: Death Istinct and Knowledge.

Fargnoli F, Gatti MG: The birth of the human mind: a new integrative model of functional activation of the cortex in the newborn based on Massimo Fagioli's Human Birth Theory. 19th International Congress of the International Society for Psychological and Social Approaches to Psychosis – From DNA to Neighborhood: Relationship and Experience in Psychosis. An International Dialogue, New York, 18–22 March 2015. Il sogno della farfalla 2015; 4: 106–112.

Frances A: Essentials of Psychiatric Diagnosis. Responding to the Challenge of DSM-5. The Guilford Press, New York 2013.

Harris D, Batki SL: Stimulant psychosis: symptom profile and acute clinical course. Am J Addict 2000; 9: 28–37.

Pinault D: The thalamic reticular nucleus: structure, function and concept. Brain Res Brain Res Rev 2004; 46: 1–31.

Vandewalle G, Collignon O, Hull JT *et al.*: Blue light stimulates cognitive brain activity in visually blind individuals. J Cogn Neurosci 2013; 25: 2072–2085.

Vezzosi G, Pettini M: Massimo Fagioli's Birth Theory: a scientific theory of human reality. 19th International Congress of the International Society for Psychological and Social Approaches to psychosis – From DNA to Neighborhood: Relationship and Experience in Psychosis – An International Dialogue, New York, 18–22 March 2015. Il sogno della farfalla 2015; 4: 112–116.

DOI: 10.15557/PiPK.2015.0024