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DIFFERENT FACETS OF SCHIZOPHRENIA ILLUSTRATED BY THE ANALYSIS OF THE HOMES OF THREE PATIENTS DIAGNOSED WITH SCHIZOPHRENIA

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SUMMARY

Diagnosis and observation of patients' behaviour during outpatient visits or hospitalisations strips the diagnostic process of the opportunity to consider their places of residence as their natural environment. In this way, patients present their symptoms and problems outside of the context of their daily life. Community-based psychiatric care, on the other hand, provides a chance to include, in the diagnostic process the environment created by a patient in their home. This image of a patient's external reality can reflect a certain mental reality. Such elements as furniture and other objects, their number, quality, distribution may reflect the inner mental world of the objects featuring in a person's mind. In some cases, this can become a valuable contribution to a diagnostic process. A description of three patients, all treated for schizophrenia, has been presented in this paper in order to explore this possible relationship. The first individual, "Patient N" lives in a flat in a state of extreme depletion of elements. "Patient N" suffers from chronic schizophrenia with severe negative symptoms. The second individual, "Patient D", has been also diagnosed with schizophrenia. Yet his home is filled with a huge number of elements, writings on the wall, things, figurines and objects of symbolic meaning. A closer examination of his psychopathological symptoms (fantastic, colourful, bizarre content) and history of his illness (unstable diagnosis of schizophrenia), and unpredictable response to antipsychotics may indicate a dissociative type of schizophrenia. Finally, "Patient K's" main living space is dominated by cats that live with him. Patient K was exposed to physical violence as a child and to him cats represent safe, non-threatening objects. He has been also treated for paranoid schizophrenia. The differences between these patients' personal histories and the courses of their illnesses are clearly manifested in the way they create their immediate environment.

Key words: *schizophrenia - place of living – image - diagnosis*

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INTRODUCTION

The aim of this paper is to draw attention to the possibility of significantly increased understanding of the patient's intrapsychic organisation and of obtaining new diagnostic information based on the image of the patient's place of residence, during home visits in community-based psychiatry.

An image of a patient's home can give a visitor a vivid, visualised idea of what could be otherwise very difficult to understand, empathise with or imagine. In a certain indirect way, it can provide us with an illustration of the sick person's psyche, both in its current condition and in a dynamic mental process taking place in the patient's psyche. An actual examination of the patient's home has the advantage of these aspects being visibly manifested; they do not have to be construed in the mind of the carer through other sources of information. When thinking about this in a right context, without giving in to unnecessary confusion of categories (the image of the patient's home is obviously not the same as the patient's psyche) one can say that the appearance of the patient's place of residence may reflect the image of the psyche in its current state, with its reflection of prevailing psychopathological symptoms, problems that the patient is struggling with, dynamics of these problems, and type of relations with the objects central to the patient's mind. It also introduces new diagnostic information.

On a different (meta-individual) level the appearance of the patient's home can also provide significant diagnostic information, suggestive of certain specific sub-groups distinguishable among patients treated for the same illness and perhaps corresponding to different forms or subtypes of the illness.

Home visits taking place within community-based psychiatry make it possible to obtain a unique knowledge about patients in the context described here. When hospitalized, patients are subject to much more standardization and they are perceived within the context of their diagnosis, revealing a similar range of psychopathological symptoms and behaviours characteristic for a given diagnosis. Although, of course, individual variations in psychopathology and the ways patients establish relations with personnel are visible, and may contribute to the unique perception of a given person and their clinical situation, some areas are under these circumstances harder or impossible to penetrate. On the other hand, seeing the same patients at home, in their natural environment opens to a care provider an entirely new cognitive, emotional and relational perspective, and can introduce additional information regarding indivi-

dual psychopathological symptoms, psychic processes and additional contexts, allowing for an individualized perception of the patient's diagnosis.

The appearance of the patients place of residence can be treated as the illustration of their intrapsychic world in the same way the projective techniques, such as psycho-drawing, are. By way of certain analogy, we can say that this appearance is also a projection, a psycho-drawing but fuller, more illustrative and spatial, reflecting a longer period of time and containing many more aspects of the patient's life and psyche. It is a projective image yet multiplied, reflecting a longer period of time and many more aspects of the patient's life and psyche. It you take this kind of "knowing" into consideration, it renders itself to interpretation and understanding in the same way every image created by a human psyche does.

Secondly, what really attracts our attention during the community-based psychiatry home visits are the differences in the appearance of homes of persons treated for the same illness and correlating these differences with individually different representations of their psychopathological symptoms and different courses of illnesses in the case of these persons. These issues: an appearance of patient's home, psychopathological diagnosis and course of illness eventually come together into a correlated whole. Based on such data one can conclude that there are certain subtypes of the course of an illness or even, perhaps, subtypes of the illness itself (analogously to endophenotypes differentiated within the same diagnosis).

CLINICAL ILLUSTRATION

Below, we have presented the most relevant selected information regarding three patients treated in the Community-based Treatment Team of the Warsaw Institute of Psychiatry and Neurology.. A full comparative analysis of the three patients is impossible here, for example as far as the course of their illness is concerned because they are of different age. At the time of this study (2010) "Patient D" was 48, "Patient N" was 61 and "Patient K" was 38. The differences in their age are certainly significant, and this variable has to be considered in our data analysis.

Patient D was educated to vocational school level. His psychomotor development, as a child, was slower than average. He was brought up by a single mother with an alcohol abuse problem. His first contact with a psychiatrist occurred in the second grade of primary school, for the reasons of school difficulties, hyperactivity, bedwetting, paroxysmal abdominal pains and other symptoms indicating that he was a "nervous child". At the time he was prescribed Diazepam. When he was an adolescent he suffered from the symptoms of psoriasis. When he turned 18 he was a patient in the mental health clinic where he was prescribed Doxepin (Sinequan) and Opripramol (Pramolan). He was hospitalized for the first time at the age of 30 with the diagnosis of anxiety neurosis, following which he was treated in the Anxiety Disorders Clinic for borderline personality disorder. In 1997, at the age of 35, the patient was sent to hospital with paranoid syndrome diagnosis, yet when he was discharged from the hospital his diagnosis was of changed into depressive disorder linked with borderline personality. Since 2001 (the age of 39), the patient was treated for paranoid schizophrenia – the clinical picture during hospitalization, when the diagnosis was reached, included such symptoms as catatonic stupor with fever, resolved only after electroconvulsive shock treatment. Since then the patient was hospitalized five times and treated for schizophrenia with extensive productive symptoms.

The medical documentation dated 1992, held in the IPiN Neurosis Clinic, includes information about serious traumatic events in the patient's life, such as sexual abuse by the patient's mother (including sexual intercourse), which ended only when the mother "entered into a stable romantic relationship with a man". Another traumatic event was described as follows: "In 19. ..., the patient's mother died. The patient still feels guilty because the doctor who arrived with the ambulance stated a heart attack as the cause of death, and added that her condition was made worse by the patient who gave her a back massage." (Table 1).

"Patient N" is educated to a higher education standard. His psychomotor development in childhood was normal. Although formally he was brought up by his parents, it was his grandmother who actually took care of him. He suffered from febrile seizures. His premorbid personality is referred to in the documentation as "schizoid" – "never too outgoing, he was quite alone, (...) had always been the best student, (...) never too emotional towards his parents, kept them at a distance, not cuddling to his parents like other children, (...) parents were also not too emotional with him, they had their way of treating him as an adult, demanding (bring good grades from school, be a good boy), (...) when he was older he became secretive, never confided his troubles in anyone. As far as the data regarding the onset of his illness is concerned, approximately a year and a half before his first hospitalization (at the age of 24) "he became gloomy, broody, lay in bed most of the time". The reason for his first hospitalization was the fact that he became inactive, his contact with his parents deteriorated he experienced first auditory hallucinations and said that he had a mission (he said that he "worked on the concept of how to repair the world"). At the time he was treated with Levomepromazine. Since then he was hospitalized 17 times and his clinical picture was dominated by negative symptoms ("he neglected his personal hygiene, was inactive"), aggressive behaviour towards his parents ("aggressive towards his mother"), autoaggressive behaviour (he jumped out of the third floor onto a snow drift), affective symptoms of tension and irritability. His auditory hallucinations were recor-

ded on many occasions in his medical documentation, however no traumatic events were reported at all in his life although it was noted that there was a history of mental illness in his family (Table 1).

"Patient K" managed to complete primary education. He has been treated for psychiatric problems since he was 13, with a diagnosis of emotional disorders with prevailing anxiety. In the first years of his life, his family situation was unstable, his parents lived in different places, moving every now then; finally they decided to separate. In his adolescence, his mother was treated for hypochondria. His medical documentation includes information on physical violence that he experienced "Parents argued a lot since he had been born. The father was jealous of his wife's feelings". "Demanding towards the child, he often used physical punishment, treating the symptoms of illness as 'being naughty, misbehaving". "Patient K's" mother was described as prone to emotional outbursts towards the boy, and impatient towards him. His first diagnosis was of neurotic personality, followed by obsessive-impulsive disorder. His first medication was clomipramine and fluvoxamine. Finally "Patient K" was diagnosed with schizophrenia when he was 19. He was hospitallized for psychiatric reasons eight times, with the diagnosis of paranoid schizophrenia and schizoaffective disorder of the manic subtype. For years, he had been treated almost exclusively with olanzapine (Table 1).

The currently dominant psychopathological symptoms are different in each discussed patient. "Patient D's" illness is dominated by productive symptoms of psychosis, which are continually present, with the patient experiencing many vivid auditory hallucinations. The clinical picture of "Patient N's" disease process are controlled by negative symptoms of schizophrenia, and the productive symptoms - although still chronically present - are restricted to persecutory delusions. In the case of "Patient K" it is the disorganization of speech and behaviour,with accelerated speech that dominates but without a formal distortion of thinking or auditory hallucinations. "Patient D's" talk is usually very vivid with a lot of bizarre and fantastic content, drawn from many cultures, religions and other sources that the patient is familiar with. And so the delusional content of "Patient D's" utterances have certain characteristic features, specific to this person. These are not only delusions of reference, control or persecutory delusions, which are typical for schizophrenia, but also delusions with fairy tales, fantastic and bizarre content, with the presence of mythological figures, magic, gnomes or levitation. "Patient N's" utterances are short and their content is limited to two motifs: delusion of being poisoned and statements which are negations, denial of the existence of various facts and objects. "Patient K" usually talks about current problems regarding his difficulties with managing his life, treatment, ambulatory visits. This has been illustrated below.

Table 1. Comparison of the selected information from the patient's interview and the actual condition of the discussed patients

	Patient D	Patient N	Patient K
Personality and premorbid functioning	Emotional instability, somatisation	Schizoid features	Neurotic personality development obsessive-compulsive disorder
Presence of traumatic events in the interview	Yes	No	Yes
Hereditary predispositions	No	Yes	No
Relationship with parents	Very emotional, unstable, chaotic, overstimulating	Unemotional, "kept at a distance"	Unstable, experienced abuse, physical aggression
Education	Vocational	Higher	Primary
Comorbidities	Psoriasis	Febrile convulsions in childhood	Obsessive-compulsive behaviour
The age at which diagnosed with schizophrenia	35	24	19
Initial diagnosis	Anxiety neurosis borderline personality	Paranoid schizophrenia	Neurotic personality disorder
First medication	Sedatives	Neuroleptics	Antidepressants
Course of illness	Changeable clinical picture, various psychopathological syndromes	Fairly consistent clinical picture (relapses)	Changeable clinical picture
Currently dominant psychopathological symptoms	Productive symptoms	Negative symptom	Disorganisation
Current level of functioning	Smooth functioning in matters of everyday life	Large deficits in functioning in everyday life	Serious deficits, inadequate behaviour

A sample of "Patient D's" utterance regarding one of the figures present in his persecutory delusions: "Because he is playing with metals, he flies this metal high above and talks to it. No one on earth knows this metal yet. I am tormented by this all the time, because some of the objects are pierced by thought shapes and, what's more, mountain crystals have now turned black. He told me "To the hospital! Now!" but I refused. He makes these diseases, 90% of all mental and physical diseases are made by spirits and by people who deal in magic. Because a thought shape kyszy (meaningless word) on integrated circuits, this has been arranged by the spirits. The prostitute's spirit is in the kitchen". "He is hovering above the house, levitating because he wants me to know who is my attacker. He teases me because I don't like these voices. It sets up a vortex under the sun so the sun no longer feels joy and he charms it like Ravana who was defeated by Rama." The next statement concerns gnomes who live in the patient's kitchen.: "The small ones, they are kobolds, which are the house spirits who usually live in the forest but they also inhabit human houses".

"Patient N's" talk is neither so unusual or extensive. "Patient N" talks about food which he thinks is poisoned and therefore he only eats carefully selected meals, always the same products. The second motif of his speech is well illustrated by the following situation: "Patient N" emptied one of the rooms in his flat, because he expected not to pay rent for the empty room, as if this room disappeared and no longer existed in the real world. This is a good illustration of this patient's psychological mechanism. What he wants to do is to cause the disappearance of things (objects) and so he attacks their existence and through this destructive attack he "makes them disappear" in his mind so that they "no longer exist". The patient tries to eliminate certain objects, facts or his own past from existence so he attacks them in order to annihilate them. He talks in the same way about his past "It is not true that I passed any A-level exams although when I was throwing away some things I found a certificate with my name on it" or "It is not true that I have ever studied, although when I was throwing away some things, I found a record of university courses with my name on it".

"Patient K's" clinical picture is dominated by disorganisation of speech and behaviour; he is also loquacious and agitated. "Patient K" brings his dog to the community care visits and the main space in his flat is taken by a large room where he keeps a few cats. He talks about his relations with animals as safe, unthreatening: "When I was down, the cats helped me", "Cats are good for my mental health, when I hurt anywhere a cat will lay there", "I love animals more than people", "Animals are better than people, they never hurt one without a reason", "Animals don't shout, argue, beat or attack you", "People have hurt me a lot". These utterances reflect the way the patient represents his relation with significant others in his childhood and the way he worked out to maintain relations with living objects. As part of his defence, the patient has not destroyed the relations with objects in his surroundings but he transferred them to animals which became unthreatening beings inhabiting his mental space and his flat.

Figure 1. Place of living "Patient D"

PLACES OF RESIDENCE

The patients' homes, as illustrated by the attached photographs, allow us to demonstrate the psychological processes taking place in their minds and also to explain their current condition. They might be described in a number of dimensions: psychopathological, psychodynamic, developmental and diagnostic.

Patient D

- "Patient D's" clinical picture dominated by positive symptoms with numerous delusions with a fantastic content, which is reflected in the patient's place of residence; it is not so much a large number of elements held there but a distinctly visible creation of meanings, "producing", filling the psyche and the surroundings with a multitude of elements;
- the image of the patient's flat illustrates confusion, chaos, excessive excitation that the patient experienced in his life in a turbulent and tragic relationship with his mother;
- there is no attack on objects involved but the desire to own the largest possible number of objects but in a disorganized, desirous and insatiable manner;
- in his relationship with his mother "Patient D" experienced an excessive excitation, confusion and desire for an object but also dissatisfaction; a continued hunger for an object. This is reflected in a huge number of objects, inscriptions and elements that the patient fills his flat with;
- the patient's psychosomatic symptoms indicate strong, primary, unprocessed emotions, their confusion and inability to become aware of them and verbalise them.

Patient N

- "Patient N's" clinical picture is dominated by negative symptoms which is reflected in the way his place of residence is arranged, ruled by emptiness, deficit, reflection of impoverished emotions, desires and thoughts; it is a sterile world which is clearly visible in the patient's immediate environment;
- what is clearly visible is the attack on the existence of objects (presence of darker patches on the walls left after removed pictures, furniture); the patient destructively attacks the existence of objects in his environment and annihilates them (they no longer exist). Wilfred Bion (1957) described features of psychotic personality as "a preponderance of destructive impulses so great that even the impulse to love is suffused by them and turned to sadism: a hatred of reality internal and external, which is extended to all that makes for awareness of it". It seems that the image of "Patient N's" flat illustrates this hateful attack on the existence of objects, a sadistic destruction of objects relating to the awareness of the existence of his parents, and his utterances (quoted above) represent the attack on his own mind, on the knowledge of his own past;

Figure 2. Place of living "Patient N"

Figure 3. Place of living "Patient K"

- an information obtained during the interview with the patient leads us to a conclusion that his relationship with his parents was dominated by emotional indifference and a distance, and that any vivid, strong and binding emotions (emotional ties) failed to be formed. His place of residence also reflects this lack of relations, emotional coldness;
- no vivid emotions, variety or vibrancy of experience or a flow of thought can be found reflected in "Patient N's" flat; instead note the absence of objects with its adequate lack of psychosomatic or neurotic (corresponding to the dissociative) symptoms that occur in "Patient D's" case.

Patient K

- "Patient K's" psychopathological picture is dominated by disorganisation, agitation and anxiety which is reflected in his place of residence as the lack of overall organization in his immediate living space: disorder, chaos, lack of care for the objects in the flat or their position;
- in the relationship with his parents there was a clear lack of the parents' regard for the child's needs – the father being jealous of his existence and the mother wrapped up in their frequent moves, a relationship with his father, hypochondria and the lack of patience for the child, as described above. "Patient K" occupies a small room with a mattress in his flat, whereas the main living space is occupied by cats. The main part of the living space is taken by other objects, just as before it was taken by his parents/mother. The patient, as he grew up, had not moved into the large room - it is still occupied by someone else, although at present they are unthreatening objects;
- there is no attack on objects in the clinical picture. The objects are present, vivid and emotionally safe. This is the only flat, out of the three, where living objects are actually present;
- - the patient fills his mental and physical space by so much desired and safe objects, keeping his relations with the objects but forming it not on the basis of the relationships with people but with animals. He perceives human objects as dangerous and threatening, aggressive.

DIAGNOSTIC ISSUES

In spite of the same diagnosis of schizophrenia, all three persons described here demonstrate a number of differences relating to, among other things: family history, developmental history, premorbid personality, course of illness, stability of diagnosis, current psychopathological image, level of functioning in everyday life, comorbidity. One can say that in spite of the same diagnosis the patients are differentiated by different history and different clinical pictures of the current condition. Whereas "Patient N" seems to suffer from more stable and unambiguous symptoms of schizophrenia, reflected in the fact that he had never had

any other diagnosis, the issues of "Patient D's" and "Patient K's" diagnoses require more attention. There are many studies published both in Poland (Kotlicka-Antczak & Rabe-Jablonska 2008, Murawiec & Kotlicka-Antczak 2006, Kotlicka-Antczak et al. 2010, prot et al. 2010) and abroad (Read et al. 2005, Winkel et al. 2008) regarding the issue of schizophrenia and psychosis in case of the patients with experience of trauma. Research shows that accumulated exposure to many stressful events may increase the risk of psychosis (Winkel et al. 2008). Perhaps this is what happened to "Patient D" who experienced many traumatic events at the developmental stages, as described below. In case of this type of patients it is perhaps helpful to apply Ross' proposal (2006) and use the term of dissociative subtype of schizophrenia. According to Ross, it is characterized by a predominance of positive symptoms, less marked by the presence of negative symptoms, more comorbid disorders of Axis I DSM-IV and greater presence of dissociative symptoms. In this subtype of schizophrenia we would have to deal with the presence of a greater number of traumatic events in the patient's history and, therefore, lesser presence of neurobiological abnormalities characteristic for schizophrenia, and a higher degree of neurobiological effects of trauma. As far as treatment is concerned, this subtype of schizophrenia may be described as susceptible to therapy aimed at addressing the problems associated with traumatic events, but an incomplete response to antipsychotic drugs, particularly those with high affinity for dopamine receptors (but better response to clozapine).

Many of the items listed above can be found in the information concerning "Patient D", so perhaps he suffers from another subtype of schizophrenic disorders than "Patient N". "Patient K's" psychopathological picture is different; his history is also marked by mental trauma but different from the case of "Patient D" as it involves more physical violence. Yet his clinical picture, contrary to "Patient D's", does not involve as many productive symptoms. No auditory hallucinations are present, though it is dominated by disorganization and agitation. These various clinical facets of schizophrenia are visible and easily perceptible in the patients' homes.

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