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Research Article

THE PERSPECTIVE OF CUMULATIVE TRAUMA IN PSYCHOSOMATIC PATHOLOGY

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ABSTRACT

Purpose: Psychology defines cumulative trauma as a mental structure predisposed to suffering that can switch between somatic and psychological. Psychosomatic risk predisposes some patients to balance in pathology, between depressions requiring medication and serious somatic diseases. This paper presents a 68-year-old patient with psychiatric admissions for an organically altered personality, in which prevails a relationship sensitivity, major depression and sensitivity to rejection. In the somatic area, he presents a skin tumor with unpredictable and unknown evolution in the right jaw, BPOC, HTA, left ventricular pertrochanterial MI fracture (migration of the nail implant, atrial fibrillation, HVS), nodular opacities, homogeneous, same intensity as ribs, located in 1/2 inferior lung, with a tendency to confluence.

Methods: hospitalization, psychiatric assessment under antidepressant and antipsychotic treatment with HAM, PANSS, GAFS, life quality scales, lung Rx, basal Rx, ECG, EEG, cerebral MRI, counseling, social assistance.

Results: The view of cumulative trauma explains the psychotic depression in which the externalization of persecutory projections predominates, while a neoplastic pathology of both skin and lung develops in the somatic area. The multiple, painful somatic experiences which are hardly responsive to analgesics (including opioids) amplify the signs of cerebral organicity (supported by EEG, MRI and psychological evaluation), in which the nature of rejection, as well as activation of the paranoid nucleus and the feelings of hatred and revenge are externalized in a pervasive way.

Conclusions: The psychogenic coefficient in neoplastic pathology is represented at the level of primitive defense mechanisms, the personality structure being dominated by the unconscious aggressiveness turned towards himself.

INTRODUCTION

1. ***Reasons for admission:*** 68-year-old patient, known as having multiple admissions in psychiatric institutions, homeless, is brought by the ambulance to the hospital due to a state of psychomotor restlessness, emotional lability, anxiety, asthenia, lack of apetite, insomnia: "I feel sick, shaking, I do not sleep, I'm afraid."
2. ***Heredo-collateral history:*** mother-deceased, father-deceased (stroke)
3. ***Personal, physiological, pathological antecedents:*** Tumor of the skin with unpredictable and unknown evolution in the right jaw, chronic obstructive pulmonary disease, Arterial hypertension, peritoneal cumulative fracture MI stg, scabies.
4. ***Life experiences:*** he is a retiree, he lives at "Speranta" home, from which he states that he was kicked out, worked 20 years as a military pilot, without professional exposure, was not married, lived together with a partner, without children.
5. ***Addictive consumption:*** smoker (50 PA), denies alcohol consumption
6. ***Background medications administered prior to admission:*** Coaxil, Xanax, Trittico
7. ***History of the disease:***

2018: In October, the patient, known for his psychiatric antecedents (about 15 psychiatric admissions), presents himself to the hospital with a depressive-anxious symptomatology re-emerging in a psycho-traumatic context (when he was left homeless).

In June, the patient with a psychiatric history and numerous psychiatric admissions is brought to the hospital by an ambulance, at his request, for psychomotor restlessness, depressed mood, generalized anxiety, emotional lability, easily crying, marked symptoms of non-compliance to treatment and social issues.

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In March, the patient is brought to the emergency room and a police crew from Socio-Medical Central "St. Andrew", following an altercation with another patient at the center (hit him with a walking cane, causing him a cranio-cerebral trauma).

In February, the patient presents himself to the hospital for severe depressive mood, paroxysmal anxiety, mixed insomnia, emotional lability, and easy crying. Under appropriate psychiatric treatment, symptoms temporarily disappear. The patient is relieved and leaves the hospital.

2017: In May, the 67-year-old patient is accompanied by a nurse from St. Andrew's Socio-Medical Center, voluntarily hospitalized for dysphoric disposition, irritability, verbal heterogresiveness towards the medical staff, psycho-motor restlessness, very talkative, ideation of persecution and prejudice, the symptomatology having appeared in a reactive context, on an organic background.

In October, the patient returns to the hospital for a major depressive symptom of the noradrenergic type, characterized by loss of interest, pleasure, decreased appetite of the vital stimulus, maintained by a reactive context (loss of the home, the patient then lives in a night shelter), increased sensitivity to rejection, irritability to minor contradictions, sensation of "not finding his own place". Appropriate treatment is in place, the evolution is favorable.

2016: A 66-year-old patient, known for a chronic depressive history and a chronic somatic pathology, institutionalized at a St. Andrew's House, is hospitalized for a state of psycho-motor restlessness.

Objective clinical examination: normal colored skin, whole body wounds (history of scabies), right jaw tumor formation, hypertrophied taste buds, poorly represented skin tissue, musculoskeletal system: left hip surgery two years prior, Gamma screw implant, normally conformed chest, normal cardiac sounds, breath sounds present bilateral, basal diminished,rough breathing, SaO2 = 95%, equidistant cardiac sounds, equipotential, no overloaded heartbeat, palpable heart rate in the periphery, HR = 74 bpm, BP = 150/90 mmHg, slim abdomen, mobile with breathing, spontaneously painless, liver with lower edge at the rib cage, low inferior pole of the spleen felt in the deep inspiration, physiological urination, Giordano negative bilateral, temporal and spatial oriented, auto and allo-psychic, walking antalgic, preferably goes with support, deep tendon reflexes are present, right knee swelling, no signs of meningeal irritation, no neurological signs of outbreak. (Dunkel-Schetter & Feinstein & Taylor & Falke, 1992)

Paraclinical examinations: biologically: in normal limits, EKG shows irregular rhythm, paroxysmal atrial fibrillation, left ventricular hypertrophy, normal spirometry, pelvis radiography shows migration of the implant and its destabilization, pulmonary radiography shows nodular, homogeneous, opacitieswith same intensity as ribs, located in 1/2 inferior pulmonary area, with tendency of merging, negative bacillusKoch fromsputum examination.

Psychiatric examination

Observations: patient in hospital attire, relatively neat, temporo-spatial orientations of others and himself, quiet, cooperative, intellect according to school education, relatively good hygiene, voice of medium intensity, establishes and maintains visual contact with the examiner, hypomobile mimic, pantomime: gestational activity reduced in amplitude, slightly disorganized.

Sensation: mild hypoesthesia.

Perception: denies illusions, hallucinations and cenestopathies (Espinosa-Fernandez & Miro & Cano & Buela-Casal, 2003).

Attention: spontaneous and voluntary hypoprosexia, memory: hypomnesia of fixation and evocation.

Thinking: discursive issues in thinking, with slow thinking, sometimes incoherence, a delusional idea of prejudice and persecution (accusing nurses that they do not want to give him food, he thinks that all bad things happen to him and that everyone has an issue with him), lies a lot, sometimes verbal aggression and physical.

Affectivity: depressed mood, anxiety, loss of interest, uselessness (refuse surgery to stabilize the femoral implant and to treat the maxillary tumor considering that it does not matter anymore, that he no longer serves society and that everyone already considers him a burden and no one wants to help him).

Activity: poor capacity for effort, aggressive and uncivilized behavior against medical staff, does not accept refusals and any gentle observation is interpreted as anoffense - behavior which intensifies at the time of tobacco withdrawal and inadequacy to the socio-economic condition (for example, he asked a doctor for cigarette money and because he did not receive it, he started spitting and cursing, lifted his walking cane to hit him, then went to the accounting office to ask for a loan to buy cigarettes. Not having succeeded this time either, he became hetero-aggressive, so the office staff locked themselves in the offices. (Bandura, 1992) When he was made to give a statement, the patient vehemently denied what had happened, saying that everyone is lying).

Low appetite and refusal to eat in the dining room (when he eats, he does it in the sleeping quarters, leaving a mess behind so that the nurses can be summoned, and he could be able to make fun of them).

Sleeping pattern: mixed insomnia, is conscious of the disease.

Positive diagnosis

- ***Main:*** recurrent depressive disorder, current moderate secondary episode
- ***Secondary:*** Right maxillary tumor with unpredictable and unknown evolution

Chronic obstructive pulmonary disease
Primary essential heart hypertension
Cardiac arrhythmia
Ischemic cardiomyopathy
Post comutational fracture left pertrohantheria
Chronic smoking

Treatment of psychiatric illness

The following treatment is recommended according to rp:

1. Tianeptine cp 12.5 mg tb 1 + 1 + 1
2. Gabapentin cp 300 mg tb 1 evening

3. Trazodone cp 150 mg tb 1 evening
4. Cinolazepam cp 40 mg when needed
5. It is forbidden for him to consume alcohol and psychostimulants, work at height, drive during the psychotropic treatment.
6. Avoid conflicting, stressful and psychotraumatic situations.

Differential diagnoses for psychiatric illness:

1. Normal sadness

It is normal to feel sadness when you have a responsible cause (a professional failure, a difficult period of time), but it is abnormal to not react positively to learning about a happy event; it is normal not to show interest in certain areas, but it is not normal for these areas to not be replaced by others over the course of time; asthenia is normally felt in some stressful periods, but it is not normal for it to be prolonged, for no reason and especially in the morning. (Cain, 1998) The duration of all these symptoms should not exceed 1-2 weeks in a person with regular sadness. (Elm & Willich, 2009)

2. Depression of mourning

Following the death of a loved one, the symptomatology should be resolved within 6 months.

3. Affective disorder induced by a substance

The patient denies the use of substances and alcohol.

4. Dysthymic disorder

Characterized by a depressive mood for most of the day, for several days, either by subjective report or by the observations made by others for at least 2 years.

5. Depression associated with somatic disorders

Common in hypothyroidism, diabetes, neoplasms, HIV, obesity, neurological problems (stroke, epilepsy, MS, Parkinson's disease). Our patient does not have any of these conditions, except for the right maxillary neoplasm, but which appeared after the onset of depression.

6. Drug-induced depression

CS, cyclosporine, Rital, some drugs used in Parkinson's, MS, thyroid diseases, alcohol addiction treatment, some anticonvulsants, barbiturates, benzodiazepines, beta blockers, bromcriptine, interferon alfa, statins, estrogens, Roacutanes, calcium channel blockers.

7. Bipolar affective disorder - depressive episode.

The patient had no manic episodes in the background.

8. Personality disorder

9. Schizoaffective disorder

The overlap of schizophrenia elements with affective (depressive) elements in the same episode. (Carlson & William & Neil, 2000)

10. Evolution and prognosis

The evolution is satisfactory, biological status improved.
Prognosis:

Positive prognostic factors

- good compliance with current treatment;
- the absence of a family history of depression.

- Negative prognostic factors:
- unmarried;
- has no social support (family, friends)
- multiple relapses
- multiple comorbidities (neoplasm, the need for a wheelchair to carry out activities)
- social status: without shelter

Complications

- major cause of stigmatization;
- the impossibility of keeping a job;
- integrative-relational difficulties;
- low life expectancy, mainly due to the correlation with obesity, sedentary and careless lifestyle, smoking and other addictive behaviors, decreased immunity (Trifu & Trifu & Trifu, 2017);
- Increased suicide rate.

Psychoanalytic perspective

Active trauma control*:* during each hospitalization S. tries to actively control the traumas previously experienced passively = reactivates problematic relationships, putting in play conflicts with other patients or with the medical staff in order to acquire control over the past or to acquire the sensation of power.(Alexander & French, 1948)

Maintaining attachments: Fragments from previous object relationships were reproduced with the attending physician, the resident, the two psychologists, even with the students who were attached to him. (Montreuil & Doron, 2009)(phenomenon of projective identification = he "spreads" the fragments of himself to the people around him and he finds each one with a particular spiritual state - the patient has a heightened sensitivity in feeling who can take on his bad mood through resonance from one unconscious to another unconscious, to empathize and resonate with himself; heprojects differently depending on each person = projection mechanism + projective identification. (Aspinwall & Taylor, 1997) The projection is what the patient actively does, "throws" his feelings towards the people around, and the projective identification it is the state that the one in question induces on the others around him, how he somehow manipulates them into feeling what he feels. However, the projective identification is of two types: "good" - the one listening becomes empathetic and understands his suffering and the projective counter-identification - the one listening looks at him with repulsion. (Lungershausen & Barocka, 1989) Coming back to the patient, he, through the projective identification, in all the environments where he had walked - multiple asylums, doctors, students with whom he communicated, etc.-evoked negative experiences - rejection. And from his point of view, these people had become "persecutors" because they did not understand him - going so far as to develop a relationship sensitivity. (Akiskal & Rosenthal, 1979)

These mechanisms are forms of withdrawal of abusive traumatic relationships with important people from his childhood. The paradox is that for the patient these

relationships had become sources of pleasure (th of Pine 1990), similar to Gabbard's, according to which a sadomasochistic relationship is better than the absence of any relationship. (Birchood, 2000)

In addition, for the suffering S. patient, a distressing relationship brings him relief by the fact that it is predictable and reliable (if he knows that things are bad, he has already gone through a lot of bad things and he begins by forming a negative hypothesis from the beginning, because the sense of evil is reassuring for him = trauma, abuse, persecution) and provides the patient with a sense of continuity and meaning. (Elliot, 2005) Otherwise, he would live permanently with the profound feeling of separation and abandonment anxiety. (Trifu & Brăileanu & Carp &, Chirilescu & Mihai, 2015)

***Shout for help**:* Marriage, resumed by Gabbard and Ogden, postulates the idea that the person who is the target of the projected material (fragments of negative experiences inside the patient) feels this as a form of communication. (Gabbard, 2007) The patient's anxiety, related to his entire medical history, causes him to feel an extraordinary pressure to get rid of the affections that he cannot control (including his representations of himself in different disease states over the years). He feels somewhat relieved when a specialist is forced to live with the projected material, which is overwhelming to one's self. He tries to externalize his suffering in an interpersonal context, as a way to seek help, through a rudimentary form of empathy. (Kaplan & Sadock, 2000)

Sandler and Sandler in 1978 described that such a patient internalizes an interaction he or she desires, then fantasizes about it and responds accordingly, as if responding to the most important person in his or her life (the doctor taking the form of this person). (Lungershausen & Barocka, 1989)

The previous relationships are repeated with the unconscious hope that this time the end will be different, ie both the object - the doctor, and the self - the patient, will transform together to build a fantasmatic relationship for which the patient longs.

A new hospital or a new asylum offers each time a new and different form of interpersonal relationships. A good case-management should not let specialists be challenged by the patient and to fall in the trap of projective counter-identification. (Henry & Prosperi & Giudicelli, 2002)

By the fact that the patient does not behave like everyone else in the patient world, from the desire of being interesting, he gets rejection. As a specialist, one must know how to break the vicious circle of such patients, who unconsciously ask you to behave in a „rude" fashion with them, because they need a persecutor to make them suffer. These psychological characteristics define the organic personality disorder (sensitivity, sensitivity to rejection, display of disability).

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