A Woman Who Refused Treatment for a Paranoid Psychosis

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Dr Muller describes a case of a patient with a paranoid psychosis who clearly needs help, yet refuses treatment.

July 2006, Vol. XXIII, No. 8

The emergency room (ER) attending woke me from a sound sleep at 7 AM to tell me that I had better get there fast. A 49-year-old woman, who had been brought in by her husband 3 hours earlier, wanted to go home and probably would not wait long. "Janice" was convinced that she had been raped in the bed she shared with her husband of 32 years—in spite of the fact that the dead bolt on their bedroom door was undisturbed and her husband had not heard or seen anything that would confirm an attack of this kind. Two months earlier, Janice had had a similar nocturnal experience and called the police. They found no evidence of a break-in or sexual assault.

A florid paranoid psychosis

Janice insisted that the ER staff check her throat for signs of the trauma that would be expected from the oral sex she believed was part of her assault several hours earlier. None were observed. By the time I interviewed her, she had stopped talking about the alleged attack but was eager to discuss in detail the feelings and beliefs that had ruled her life during the preceding 8 months. Janice was convinced that people were watching her and following her because she would see the same people day after day in her neighborhood and in the stores where she shopped. She also thought that her phone was being tapped because she heard an extra click while she was talking on the phone. And she believed that people were coming into her house, in spite of there being no sign of forced entry.

Janice was also convinced that her furniture was being moved during these break-ins. "I can see the marks left on the carpet from where the pieces were before," she told me, taking this as incontrovertible evidence. And then there was Janice’s idea that her computer was being remotely controlled by unknown people and that some programs had been deleted from her hard drive.

"If someone else were saying this, I would think they were crazy," Janice told me, with what seemed like full conviction. Janice did not look at all "crazy." She was well groomed, and her appearance was noteworthy only for a somewhat restricted affect. She looked 10 years younger than her 49 years. Janice's speech was of normal volume and rate. She answered all questions willingly, often eagerly, and responded to each question with at least an average amount of elaboration. Even though the content of her thought was at times delusional, the flow and structure of that thought were normal. Janice knew her name, where she was, and the correct date. Her memory was excellent, and there were no signs of delirium. In fact, her sensorium was crystal clear.

Janice convincingly denied ever having had perceptual experiences that might be construed as auditory or visual hallucinations. She insisted that she had never made a suicide attempt or gesture and that she had never mutilated herself (her husband corroborated this). She vigorously denied any current intention or plan to harm herself. "I'm allergic to pain," she insisted, as if to assure me on this point.

Janice had no significant medical history and took no medication. Despite her age, she had yet to begin menopause. "My periods are as regular as clockwork and last for 5 days," she wanted me to know. A noncontrast head CT scan was normal. Janice had never smoked or used alcohol or illicit drugs. Results of her toxicology screen were negative. The only abnormal laboratory result was a hematocrit of 32% (normal range in a woman, 37% to 47%). Because low B₁₂ or folate levels can cause a macrocytic anemia that has been associated with neuropsychiatric symptoms, including paranoia, I encouraged Janice to tell her primary care physician about the low hematocrit that was found in the ER workup.
Janice had no current psychiatric care. Nine years earlier, after experiencing severe stress from her job, she had seen a psychotherapist 4 times and was prescribed sertraline. She had a partial response to this drug, but she stopped it on her own. At one time, Janice was told that her oldest son was autistic and at another time that he was mentally retarded. Schizophrenia had been diagnosed in a brother.

My questions about stressful and negative experiences elicited a torrent of acknowledgments about what had gone wrong in her life during the last several years. In 1999, the house that she and her husband owned was seriously damaged by a fire caused by a faulty furnace switch. While negotiating with their insurance company and waiting for repairs to be made, she and her family went for a year without a permanent home. During that same year, Janice quit her job as a machine operator at a company that made pharmaceutical products. Later, she worked for a year for a cosmetics company until she was fired. She asked for arbitration and later took legal action, but she did not win the case.

Janice's mother died in 1999, a loss for which her husband said she was still grieving. Then, in 2000, her grandson died. Janice had also been deeply affected by the terrorists' attack on the World Trade Center in 2001.

Janice told me she had always been a loner and that she had become even more isolated during the last few years. She had no friends and gave no indication of wanting any. During the 5 years preceding our interview, she had been unable to hold a job. Because she was no longer bringing in a paycheck and her husband had been demoted and forced to take a salary cut, they had accumulated $14,000 in credit card debt.

Although Janice had had depression diagnosed several years earlier, she did not acknowledge feeling depressed at the time we talked. "I usually feel pretty good," she told me. Her husband said that her mood was "pretty level" and that she did not have mood swings. Janice did admit to feelings of anguish related to what had been going on in her life during the past 8 months. Her sleep had been interrupted for most of that time because she would often get up during the night to check the locks and doors. She described her appetite as "OK now," but admitted to recently losing interest in food for a period of about 2 weeks.

The "anguish" she readily acknowledged was a far cry from what may well have been an unacknowledged major depression. Janice's world was a swirl of the painful events that had overtaken her, and she did not know where or how to begin to address these losses.

**Depression and "de-differentiation"**

In an article on the meaning and structure of major depression,¹ I drew from the ontology of the French existential philosopher Jean-Paul Sartre to set forth the idea that depression is often the result of a choice that a person makes not to overcome a loss or negative experience. Someone with a euthymic mood lives (predominantly) in an instrumental world of cause and effect that is a direct consequence of what Sartre calls differentiation:

[P]rojects are started, goals are set, risks are taken. One is willing to be patient, to tolerate setbacks, to overcome obstacles, to defer gratification. In the instrupharmental world, individuals act as if what they do—how they choose to use the freedom that allows them to construct a world—will influence their fate.

The differentiated world responds with what amounts to an invitation to pursue what has been singled out as interesting and worthwhile. Confronted with a loss or negative experience, some people will follow a rejection by the world with an even greater rejection of their own. Implicitly they will say, "If plan A is off, I don't want plan B." They make what Sartre calls a magical transformation of their formerly instrumental world and "de-differentiate" their experience, reconstructing whatever falls within their horizon in a way that makes it unworthy of their pursuit.

[I]f I have learned that I am [financially] ruined I no longer have the same means at my disposal (private auto, etc) to carry them out. I have to substitute new media for them (to take the bus, etc); that is precisely what I do not want. Sadness [clinical depression] aims at eliminating the obligation to seek new ways, to transform the structure of the world [into] a totally undifferentiated structure. In short, it is a question of making of the world an affectively neutral reality, a system in total affective equilibrium, of discharging the strong affective charge from objects, of reducing them all to affective zero, and, by the same token, of apprehending them as perfectly equivalent and interchangeable. In other words, lacking the power and will to accomplish the acts which we had been planning, we behave in such a way that the universe no longer requires anything of us.²
Sartre and the existential psychiatrists and psychologists who base their view of human nature on Sartre's ontology believe that, through a series of choices, we use our freedom to construct our world. Sartre understands depression as an ongoing pathologic mode of this construction, one that rejects what the world continues to offer even as it denies us something we badly want or after it has taken away something we once valued highly. His theory of depression implies that the right mode of response to negative experience—what the instrumental, differentiated world is calling us to and expects of us—is a heroic overcoming of that experience.

Sartre read and admired the work of the 19th-century German philosopher Friedrich Nietzsche. He was surely influenced by Nietzsche's idea of the "will to power"—our capacity to use imagination and will to overcome the ambivalence and hesitancy that mark all human enterprise and to prevail over the tough breaks and injustices that life invariably throws our way. The word depression itself reflects the existential meaning of this pathologic mood state. A world that one de-differentiates is going to press down ("de-press") because differentiated structures, which formerly supported a euthymic life, have ruptured and collapsed. Unlike instrumental structures, depressive structures do not permit a person to derive the sustenance necessary to function effectively by pursuing the components of normal life, such as attending to work, seeing friends, handling the inevitable problems that always come up, and sustaining interest and hope when the going gets rough. As the de-differentiated world comes crashing down, elements of the formerly differentiated, euthymic world realign pathologically. Perhaps it is one's proclivity to de-differentiate a formerly instrumental and euthymic way of constructing the world that is the endpoint of everything thought to compose a diathesis for depression: genetics, environment, development (which includes the continuous use of freedom in a face-off with one's unfolding, unique situation in the world), medical illness, and substance abuse.

The choice made to de-differentiate one's world in the wake of negative experience is not made directly, but indirectly. Much of the psychological transformation and related structural realignment associated with the posited process of de-differentiation occurs subconsciously. No one says, "I'm tired of struggling with my life, and I'm now going to de-differentiate it." What people probably ultimately do is surrender to their negative experience by choosing not to overcome it. Undoubtedly, the world transformation that is being posited here—which, it must be acknowledged, has not been empirically validated—almost certainly drives derangements in brain structure and function. Some individuals are probably more prone to the de-differentiation response because of their epigenetic course in general and early psychic trauma in particular. Put another way, the brains of some people may have less "ballast" to help them stay in the instrumental mode when life goes sour.

Depression and paranoia

It has long been recognized that psychotic symptoms, including paranoia, occur along with severe depression. It seems reasonable to propose that paranoia can be a consequence of the pathologic realignment that accompanies de-differentiation. Making connections that would not be made by a normal person is one way of understanding what the paranoid person does. All of Janice's paranoid ideas have this kind of distorted structure: She believes that people are following her because she sees the same people day after day (so do most of us); she believes that her phone is being tapped because she hears stray clicking sounds (these sounds are common now and are mostly due to the failure of automatic-dialing computers to complete calls); she believes that people are breaking into her house, even though there has never been any sign of forced entry (a normal person would reality-test this hypothesis and dismiss it for lack of evidence); she believes that she had been raped twice (again, this hypothesis doesn't match up with the evidence, because her husband would have had to have slept through these attacks not to notice what was happening and there were no physical signs of a sexual assault found either by the police or by the ER staff).

The paranoid person's world is one in which the control of everyday events has been largely ceded to others and to outside forces. Paranoia in a depressed person can be understood as a distorted cognitive component of a highly de-differentiated, "de-pressed" world. This is especially likely if that person is experiencing severe anxiety. I can imagine a very anxious Janice, struggling with pathologically altered meanings and structures, implicitly and subconsciously reconstructing her world according to the following schema: "If nothing is working for me, at least I can have people in my life who are working against me." Recalling what the psychoanalyst Erik Erikson said about negative identity, this kind of self-made anguish may trump the lack of identity that someone living in a seriously de-differentiated world might be expected to experience.

Since Janice reported being a lifelong loner, the possibility that she may have a schizoid or...
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Published on Psychiatric Times
(http://www.psychiatrictimes.com)

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schizotypal personality or a schizophrenia spectrum disorder must be considered. That Janice may have a primary brain illness responsible for both her depression and her paranoia cannot be ruled out. A late-onset paranoid schizophrenia needs to be kept in the differential until the course of her illness plays out a bit further—particularly considering Janice's denial of significant mood symptoms and her brother's schizophrenia diagnosis. (Many diagnoses of schizophrenia are wrong; her brother's diagnosis would have to be confirmed before considering it a possible risk factor for Janice.) It is not easy to know what to make of Janice's acknowledgment that she would consider anyone else who was thinking and acting as she was to be "crazy." Perhaps she simply does not want to see herself, or be seen by others, in this way. Or maybe, through some schizotypal process, she has succeeded in detaching herself from her situation.

My best therapeutic guess is that Janice was in the grip of an unacknowledged major depression, which was a psychological and biologic response to a plethora of losses she suffered during the previous several years, and that her depression had spawned a paranoid psychosis. Among the possible reasons she did not see herself as being depressed was that she had never learned to put words to her feelings, a condition known as alexithymia, and that her depression was "masked."

May Janice refuse psychiatric treatment?

Even before I recommended that Janice sign herself into a psychiatric hospital, she shot down the idea: "I came to the ER to see if this was due to something medical. If it's psychological, I can deal with it myself." She was covered under her husband's insurance, and I gave her the name and phone number of a female psychiatrist, whom she promised to call. I told Janice that if she felt she could not handle her situation at home, she could return to the ER and be evaluated again for hospitalization. Everything I have learned about working with psychotic patients says that someone who presents the way Janice did should be treated. After Janice rebuffed my suggestion that she be hospitalized, I briefly considered an involuntary hospitalization, but it was clear to me that she did not meet the criteria for this drastic imposition on her freedom. She left the ER with her supportive and long-suffering husband, who at no time had pressed for her hospitalization, voluntary or otherwise.

Although Janice did not reveal the ultimate reasons for refusing the help that we offered her, she gave me the impression that she had her reasons. Outside of her paranoid beliefs, Janice's mind seemed to be working rationally. "It really helped getting this all out," she told me near the end of the interview. To some degree, we were able to talk rationally about her irrationality.

One month after I saw Janice in the ER, I called her at home. In a bright but quivering voice she told me that things were all right, though she would not provide any details. Janice had not followed up with the psychiatrist I recommended nor with any other clinician. She thanked me for my interest, and then asked why I had called "so late in the evening." Although she seemed reassured by my explanation that 9:30 PM was not that late for someone who routinely works the night shift, I had the feeling that some lingering doubts remained about my intentions. The night has its own demons, even more so for those who are anxious and paranoid.

I suspected that Janice was as paranoid as ever, but that she had decided to go it alone. As much as I wanted to question her further, I felt she would very likely take this as a sign that I, along with most of the world, was against her and meant her harm.

I was now staring down a paradox I had confronted in the ER many times before: A floridly psychotic patient was refusing any kind of psychiatric treatment. In the end, the need to allow Janice the autonomy to deal with her illness or not to deal with it took precedence over my desire to act on her behalf and for her presumed good.

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**Drugs Mentioned in This Article**

Sertraline (Zoloft)

**References**


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