

UMA REVISÃO EXPLORATÓRIA NA DEMÊNCIA E ESQUIZOFRENIA: SOBREPOSIÇÕES, DIFERENÇAS E PERSONALIDADE PSICODINÂMICA

*AN EXPLORATORY REVIEW ON DEMENTIA AND SCHIZOPHRENIA:
OVERLAPS, DIFFERENCES AND PSYCHODYNAMIC PERSONALITY*

*UNA REVISIÓN EXPLORATORIA EN LA DEMENCIA Y LA ESQUIZOFRENIA:
SUPERPOSICIONES, DIFERENCIAS Y LA PERSONALIDAD PSICODINÁMICA*

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RESUMO

Neste estudo são salientadas algumas das sobreposições e diferenças na demência e esquizofrenia. A análise entre uma estrutura psíquica de personalidade e os respetivos diagnósticos é o objeto de exploração desta revisão. A angústia de fragmentação e a relação de objeto fusional apresentam-se relacionadas com a esquizofrenia e, por seu turno, a angústia de abandono e a relação de objeto anaclítica com a demência. Num *continuum*, a estrutura psicótica surge associada à esquizofrenia e a estrutura borderline à demência.

Palavras-chave: demência; esquizofrenia; personalidade; psicodinâmica; psicopatologia.

ABSTRACT

This study sets out to review some of the overlaps and differences in dementia and schizophrenia, and to analyze the relationship between a specific personality structure and diagnosis. The anxiety of abandonment and the anaclitic object relationship are related to dementia, while the anxiety of fragmentation and fusional object relationship are associated with schizophrenia. On a conti-

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num, the borderline structure appears associated with dementia and the psychotic structure with schizophrenia.

Keywords: dementia; schizophrenia; personality; psychodynamic; psychopathology.

RESUMEN

En este estudio se destacan algunas de las superposiciones y diferencias en la demencia y la esquizofrenia. El análisis de una estructura psíquica de la personalidad y el diagnóstico respectivo es objeto de revisión. La angustia de la fragmentación y la relación de objeto fusional parecen estar relacionadas con la esquizofrenia y, a su vez, el angustia de la abandono y la relación de objeto anaclítica con la demencia. En el continuum, la estructura psicótica aparece asociada con la esquizofrenia y la demencia con la estructura borderline.

Palabras clave: demencia; esquizofrenia; personalidad; psicodinámica; psicopatología.

Background

There is a classical tradition that looks upon neurological disorders as “organic” and psychiatric disorders as “functional”, and this dichotomy has been the subject of numerous debates over the last decades (Baldwin & Capstick, 2007; Cheston & Bender, 1999; Kitwood, 1997; Steen, 2007). According to Damásio (2000), the distinction between diseases of the brain and the mind, i.e., between neurological and psychological disorders, only reflects ignorance of the relationship between the brain and the mind, which are inseparable. This points to an extensive overlap of causes, symptoms and treatments of disorders that, when taken together as both neurological and psychiatric/psychological, will lead to a more comprehensive understanding of the pathologies (Steen, 2007). As with the psychiatric disorder schizophrenia, neurological/organic diseases also illustrate an interaction between the brain and the mind, including Alzheimer’s disease, thought to be a typical neurological disease, thus shedding light upon the complex interrelationships between the various biopsychosocial aspects of human experience (Downs, Clare, & Anderson, 2008; Garner, 2004; Schore, 2001; Waddell, 2007; Steen, 2007; Terracciano et al., 2014). Furthermore, not only is Alzheimer’s Dementia presented as the most prevalent etiology of Dementia and prioritized in research, it has also shown high dependency on psychological aspects and psychiatric symptomatology (e.g., Downs et al., 2008; Garner, 2004; Terracciano et al., 2014).

Some overlaps and differences between schizophrenia and dementia

Although schizophrenia and dementia are two different conditions, they sometimes touch and overlap at both cognitive and organic levels, and at the psychopathological, functional level (e.g., Andreasen, 2010; Fatemi & Folsom, 2009; Keshavan & Jindal, 2010; Lewis & Levitt, 2002; Owen, O'Donovan, Thapar, & Craddock, 2011; Sachdev, 2010; Urfer-Parnas, Mortensen, & Parnas, 2010; Vannorsdall & Schretlen, 2013). Both the development and the profile of late-onset cognitive impairments in schizophrenia appear to be inconsistent with Alzheimer's disease, however, it may be that the acute cognitive decline in some schizophrenic patients is a result of comorbidity between schizophrenia and Alzheimer's disease (Cardinal & Bullmore, 2011; Harvey, 2005). However, the prevalence of neuropathological evidence in post-mortem studies, consistent with Alzheimer's disease, has been found, for the most part, to be consistent with that of the general population (Cardinal & Bullmore, 2011; Harvey, 2005). On the other hand, neuropsychiatric symptoms are common in Alzheimer's disease, but these psychotic symptoms may differ from those in schizophrenia (Lautenschlager & Kurz, 2010; Vannorsdall & Schretlen, 2013). There is a current debate which sets out to ascertain whether the psychotic symptoms displayed in Alzheimer's disease represent a subtype of this dementia, or whether genetic factors determine vulnerability to these psychotic symptoms (Lautenschlager & Kurz, 2010; Vannorsdall & Schretlen, 2013). More recently, it has been suggested that the psychotic symptoms must be present before the diagnosis of dementia, as part of a prodromal syndrome or as part of a subsyndromal personality structure (Lautenschlager & Kurz, 2010).

It should be noted that around 100 years ago, Kraepelin originally conceptualized schizophrenia as dementia praecox, placing it in the same category as degenerative disorders and, thus, sparking a heated debate in psychiatry (Barak, Swartz, & Davidson, 1997; Cardinal & Bullmore, 2011; Ferrey & Le Gouès, 2000). There is seemingly a neuronal model of cortical modulation of base acetylcholine that is common to both schizophrenia and dementia. However, subsequent bi-directional deviations underlying the development of schizophrenia and dementia must occur, since there is some evidence of genetic commonalities (Barak et al., 1997; Gelder, Mayou, & Geddes, 2002; Karon & VandenBos, 1998). The pathological and biochemical markers of dementia are not conclusively demonstrated in elderly schizophrenics, and there is a body of evidence which tends to suggest that dementia is not an outcome of schizophrenia (Harvey, 2005; Gelder et al., 2002; Karon & VandenBos, 1998).

Neuropsychological and neurological evidence

We are currently faced with an issue that has led to extensive research and which continues to generate considerable interest, namely the fact that the distinction “cortical” and “subcortical” dementia is also applicable to schizophrenia (Hill, Ragland, Gur, & Gur, 2002; Turetsky et al., 2002). In other words, it is clear that in neuropsychological and neuroanatomical terms, schizophrenia may correspond to the pattern of “cortical” dementia (e.g. Alzheimer’s) or to the pattern of “subcortical” dementia (e.g. Parkinson’s) (Turetsky et al., 2002). The fact that there are schizophrenic patients who do not present any type of neuropsychological deficit should also be noted (Palmer et al., 1997), so seemingly the mechanisms that underlie neurocognitive functioning must be distinct from those involved in the production of psychiatric (psychopathological) symptoms. This is currently an open scientific question (Karon & VandenBos, 1998; Palmer et al., 1997; Steen, 2007).

Some studies report that it is possible to have healthy ageing even when there is a pathology of the brain, since there is post-mortem evidence of neurodegenerative disease in people who were cognitively and mentally intact and resisted the effects of the disease through mechanisms that are still unknown (Steen, 2007; Terracciano et al., 2014). There are also individuals who mimic Alzheimer’s disease and show no neurodegenerative disease in the post-mortem (Evans, 2008; Terracciano et al., 2014), which leads to a questioning of whether the neurological lesions are the “cause” or “effect” of dementia (Chevance, 2005).

Overview of the psychodynamic perspective

Turning to the classical discussion and indistinctness between schizophrenia and dementia (Barak et al., 1997; Balfour, 2007; Urfer-Parnas et al., 2010), it should be noted that there is an interesting parallel with the fact that, initially, the term borderline was equally considered an attenuated form of schizophrenia or hebephrenia (psychosis) (Bergeret, 2008). In psychological terms, for some authors, dementia presents clinical symptoms resembling the psychic structure of borderline pathology, as shall be explained further ahead.

Many authors describe the pre-dementia personality as traumatophobic, given the analogy of symptoms between dementia and post-traumatic syndromes, which occurred throughout life, beyond childhood (Clement, Darthout, & Nubukpo, 2003; Hybler, 1998; Vignat, Bragard, & Suchet, 1987). In a study

by Clement et al. (2003), individuals with dementia exhibited personality traits of dependency, avoidance, obsessive symptoms and alexithymia, and were subject to a higher number of traumatic memories/situations throughout life. There seems to be considerable evidence of dementia being related to anxiety and the anaclitic object relationship and to the fear of abandonment/loss of the object, which are pathognomonic characteristics of borderline pathology (Abraham & Walter, 2008; Chevance, 2005; Gerardin & Maheut-Bosser, 1998; Myslinski, 1994, 1998).

Importantly, however, the investment in internal objects is conserved in dementia up to an advanced stage of the disorder, while in schizophrenia the loss is total and premature (Abraham & Walter, 2008; Evans, 2008; Garner, 2004). The anxiety of the psychotic is fragmentation – withdrawal and death, strangeness, persecution. It is also the anxiety of annihilation, depersonalization and unfulfillment (Bergeret, 2008; Coimbra de Matos, 2002; Grotstein, 1989; Spear & Sugarman, 1984; Steiner, 1991; Willick, 2001).

The anxiety of the borderline is the anxiety of loss of the object (narcissistic incompleteness) – anaclitic depression, despair and helplessness, fear of abandonment; it comes before the separation-individuation (Bergeret, 2008; Coimbra de Matos, 2002; Masterson & Rinsley, 1975; Spear & Sugarman, 1984; Tuttmann, 1990; Westen, 1990).

Such risk factors, experienced as early trauma, may cause continued stress reactions throughout the life cycle. Associations between this phenomenon and the early and pathologic mental aging have been established (e.g., Wilson et al., 2003, 2006).

The psychotic object relationship remains fusional to the object, leading to the expression of negative symptomatology, divestment of the objects of reality and an object neoconstruction. A unipolar record, in which there is a somatopsychic indifferenciation, lacking a boundary between the “I” and the object, is characterized by not exceeding the pre-object recording, absorption and dissemination mechanisms, lack of distinction between the “inner” and “outer” (Bergeret, 2008; Coimbra de Matos, 2002; Grotstein, 1989; Spear & Sugarman, 1984; Steiner, 1991; Willick, 2001).

The object relationship of the borderline remains a two-way relationship, but differs from the primitive psychosis dyad; cleaved object/anaclitic relationship. In anaclitism, there is separability between the “I” and the object, although the limits are perforated or permeable (Bergeret, 2008; Coimbra de Matos, 2002; Masterson & Rinsley, 1975; Spear & Sugarman, 1984; Tuttmann, 1990; Westen, 1990).

Moreover, the defense mechanisms of the psychotic structure are mainly splitting, projective identification and omnipotence, while projection, withdrawal from reality and denial are equally important (Bergeret, 2008). The defense mechanisms of the borderline structure are mainly splitting, projection and acting-out, while denial, projective identification, omnipotence and avoidance are equally important (Bergeret, 2008). Some researchers have tried to establish a distinction between the use of defense mechanisms in both groups, arguing that the borderline structure has a specific and identifying spectrum/style. The borderline tends to make greater use, above all, of splitting and primitive devaluation, idealization, denial and projective identification than the schizophrenic (Lerner, 1990; Lerner, Sugarman, & Gaughran, 1981).

Conclusion

In the psychodynamic construct, object relationships are viewed as structuring the organization of past and future experiences (e.g., Kandel, 1998, 1999; Priel, Kantor, & Besser, 2000). There is a continuum between the representative function of internal objects and representations, namely a continuum in the diachrony of child development and a continuum in the unconscious processes of adult thought (e.g., Imbasciati, 2003; Kandel, 1998, 1999; Schore, 2001).

In addition to a possible genetic background common to schizophrenia and dementia (e.g., Barak et al., 1997; Hill et al., 2002; Karon & VandenBos, 1998; Keshavan & Jindel, 2010; Palmer et al., 1997; Turetsky et al., 2002; Urfer-Parnas et al., 2010; Vannorsdall & Schretlen, 2013), it may be that different personality structures are associated with different diagnoses, whereby the psychotic structure emerges as being connected to schizophrenia and the borderline structure to dementia.

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