

Psychological Management of a Victim of Dysthymic Schizophrenia at 33 Years of Age; "Experience at the Jason Sendwe Provincial Reference General Hospital"

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Abstract: *Victim of long-term emotional distress and a past tainted by several family problems, stopped his studies very early, living in a modest family, this 33-year-old developed schizophrenic dysthymic disorder is brought to the General Hospital Provincial Reference Jason Sendwe for support. The clinical method, the descriptive method and the psychosocial survey method, supported by several techniques, including the clinical interview, the clinical observation questionnaire, were used to diagnose and treat the various disorders that our patient showed; The cognitive approach associated with group therapy as well as psycho-education and combined with their particular techniques were certainly the best suited to help our patient get out of this situation.*

Keywords: Dysthymic schizophrenia (schizoaffective disorder), bipolar and unipolar disorder, psycho-education

1. Introduction

This study is conducted in the city of Lubumbashi, second largest city of the Democratic Republic of Congo after that of Kinshasa. It is performed at the Provincial General Hospital Jason Sendwe in the neuropsychiatric department coordinated by a doctor. It is one of the services that supports people with mental disorders in this city and elsewhere.

During our internship, we met an interned patient who had a disorder that caught our attention because, The characteristic feature of this disorder was the presence of symptoms of schizophrenia coupled with symptoms of mood disorders (for example, auditory hallucinations, disorganized speech, or episode of major depression) and diagnosis led us to schizophrenia dysthymia; after the pharmacological care we were interested to accompany it with the psychotherapeutic cure.

We will give information about the history of our KK patient, discover his personal and family history as well as the history of his illness, we resorted to the combination of clinical method, descriptive and social inquiry supported by the clinical interview techniques, clinical observation, Cognitive Therapies, group and psycho-education. Note that all information collected comes from our patient. For reasons of reliability, and given his state of health, we used some people in his environment, including his mother and big brother to confront the different information from the patient and those around him to detect the knot of his problem.

1.1 Problematic

The motivation which animated us to take in charge our subject victim of a dysthymic schizophrenia, This patient aroused our curiosity during our of this stage of

professionalization carried out with this general hospital; After the doctors gave him the neuroleptics and other chemotherapeutic substances, we noticed that at times, the patient fell back into his old clinical picture there were no significant changes

As stated. J Audet, the exposure of man to events that exceed his rational, emotional, sentimental and cognitive capacities leads him to an imbalance of cognitive and emotional processes. The latter loses its bearings, its way of acting in a usual way.

Indeed, a schizoaffective subject suffering from personality disorders has enormous concerns for his social integration, his emotional and cognitive balance that lead to social isolation and the avoidance of the entourage. This as well as we asked ourselves questions that are summarized as follows:

- What are the causes of the morbid condition of our patient?
- What are the therapeutic strategies that can help us to help our patient get out of this morbid condition? These questions led us to this hypothesis.

1.2 Hypothesis

Our working hypothesis is posed as follows:

- The morbid state (schizo-affective situation) of our patient would be due to the emotional or organic or psychic disturbance;
- And the cognitive approach associated with group therapy as well as psychoeducation and combined with their particular techniques would certainly be best suited to help our patient get out of this situation.

1.3 Work Objective

Each scientific study has one or more objectives that the researcher pursues. Our work has two objectives, namely:

- Diagnose the different signs and symptoms that appear in our patient who is affected by dysthymic schizophrenia in our environment.
- Providing psychotherapeutic assistance, which would lead to a decrease, or a systematic elimination of symptoms, so that the patient regains his psychic, physical and social balance.

1.4 Method

The method is a quality of mind consisting in knowing how to classify and order ideas, namely to perform a work with order and logic. As part of our investigation, we used the following methods:

- The clinical method that allowed us to apply to the individual case the general information through clinical interviews and clinical observation.
- The descriptive method, it allowed us to make a description of our patient and his disorder;
- The psychosocial inquiry method also allowed us to follow the patient through his story and that of his family.

2. Techniques

To produce the data for our work, we used the following techniques: clinical interview, clinical observation, cognitive therapy and its variants (relaxation, exposure techniques), group therapy and psycho-education.

2.1 The Theory of Schizo-Affective Psychosis (Jacob Kasanin 1933)

The author who inspired us during this research is JACOB Kasanin and it all starts in:

In 1921, George H. Kirby and August Hoche discovered cases of patients with mixed symptoms of schizophrenia and affective disorder (or mood). Since these patients had not followed the deteriorating course of "early dementia", Kirby and Hoch classified them in the Emil Kraepelin manic-depressive psychosis group.

In 1933, Jacob Kasanin introduced the term "schizo-affective disorder" to refer to a disorder characterized by schizophrenic symptoms and symptoms of mood disorders. Patients with this disorder were also characterized by a sudden onset of symptoms, often during adolescence.

Patients generally had a good level of functioning and often a specific stressor preceded the onset of symptoms. The family history of these patients usually included a mood disorder.

Schizoaffective disorder, manic type, disorder in which schizophrenic symptoms and manic symptoms are jointly at the forefront of the typology during the same episode of the disease, the pathological episode also justifying a diagnosis of schizophrenia neither manic episode,

While we note in the depressive type, schizophrenic symptoms and depressive symptoms are jointly at the forefront of the symptomatology in the evening of the same episode of malaria, pathological episode thus justifying a diagnosis neither schizophrenia nor episode depressive. Dysthymic schizophrenia is defined as a disease that disrupts the individual's life and therefore reduces his or her self-fulfillment. ([http://www.schizopreniez.fr / PDF / course-psi-chiatry-students-inf.](http://www.schizopreniez.fr/PDF/course-psi-chiatry-students-inf/))

Dysthymic schizophrenia by affecting more particularly cognition and emotion; it is still accompanied by auditory anomalies, paranoia, delusions, where language and thought disorganize with social and personal dysfunctions are frequent. Symptoms usually appear early in adulthood. Htt: [//www.schai-journal.com partial 80920-9964% 2900349-8 abstracts.](http://www.schai-journal.com/partial/80920-9964%2900349-8-abstracts)

The schizo-affective disorder is distinguished from "mood-related psychosis" in the context of a psychotic disorder or long-term mood. Psychosis disrupts the cognitive and emotional criteria of personality which involves delusions, hallucinations, thoughts, words and disorganized behaviors and other negative symptoms. Mood disorders are also present: mania, hypomania, being mixed or depression, and they are usually episodic rather than continuous. Vassilis Kapsambelis (2012p.484) states: the longitudinal clinic achieves atypical bipolarity. The manic episodes are often very superactive, even agitated, but often with delusional ideas that may be great, but also persecutory or mystical; hallucinations are constantly present, sometimes typical of a paranoid syndrome. Mood is often not congruent with the content of thought; in any case, one never meets the frank euphoria that characterizes certain manic states; she is unstable, morose, dysphoric, aggressive, aggressive; behavioral disorders are common.

Around 1970, two facts produced a turning point in the schizo-affective disorder's vision: whereas it was seen as a variant of schizophrenia, it was then considered a mood disorder. On the other hand, lithium carbon has demonstrated its effectiveness and specificity in the treatment of bipolar disorder.

Then, a joint US-UK study showed that the variation in the number of patients classified as schizophrenic in the United States and the United Kingdom was the result of a bias. In the United States, the presence of psychotic symptoms as a diagnostic criterion for schizophrenia was emphasized.

How is schizoaffective disorder diagnosed?

Since in the concept of schizoaffective disorder are included the diagnostic concepts of schizophrenia and mood disorders, the evolution of the criteria of this disorder also reflects the evolution of the criteria of the other two, as we have seen previously .

The main criteria that must be met for a schizo-affective disorder is that the patient must meet the prerequisites of a major depressive episode or a manic episode (the person is full of energy, she is just asleep, she sets up big projects or spends a lot of money, etc.) as well as the criteria for the active phase of schizophrenia (delusions, hallucinations, etc.).

The symptoms of the mood disorder must also be present as a substantial part of the active or residual phase of the psychotic episodes. The DSM (Diagnostic and Statistical Manual of Mental Disorders) also makes it possible to specify whether the schizo-affective disorder is bipolar or depressive. A patient is classified as having bipolar schizoaffective disorder if the episode is of mixed manic type (with or without major episodes). In any other case, the patient is classified in schizoaffective disorder of the depressive type.

Criteria that must be met by a person to be diagnosed with schizoaffective disorder. According to the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders IV), the criteria that a person must meet to be diagnosed as having this disorder are:

- a) A continuous period of illness in which she has at any one time a major, manic or mixed depressive episode, as well as symptoms that meet Criterion A for schizophrenia.
- b) During the same period of illness, the person had delusions or hallucinations for at least two weeks in the absence of affective symptoms.
- c) The symptoms that meet the criteria for a mood alteration episode are present for a substantial part of the total duration of the active and residual phases of the disease.

How does schizoaffective disorder manifest itself?

The signs and symptoms of this disorder are all those of schizophrenia, manic episodes and depressive disorders. Symptoms of schizophrenia and mood disorders may occur at the same time or in different phases.

The evolution is variable: cycles can be instituted during which the person's condition improves and worsens at the level of the manifestation of his symptoms, until giving rise to a gradual deterioration. Many researchers and clinicians have speculated about psychotic symptoms that are incongruent with mood. The psychotic content (hallucinations or delusions) does not match the mood of the subject. Generally, the presence of this type of symptoms in a mood disorder is probably an indicator of a poor prognosis. It is also possible that this association is true for schizo-affective disorders, even if the information available to date is very limited.

2.2 Symptoms of Schizoaffective Disorder

As we said earlier in this article, the symptoms of this disorder are those of depression, mania, and schizophrenia:

1) Symptoms of depression

- Loss or weight gain
- Little appetite
- Lack of energy
- Loss of interest in pleasant activities
- Impression of lack of hope and value
- Feeling of guilt
- Tendency to sleep little or too much
- Inability to think or concentrate
- Dark thoughts

2) Symptoms of mania

- Low need for sleep
- Restlessness
- Self-esteem affected
- Tendency to be easily distracted
- Increase of social, professional or sexual activity
- Dangerous or self-destructive behaviors
- Fast thoughts
- Trend to speak quickly

3) Symptoms of schizophrenia

- Hallucinations
- Delusions
- Disorganized thinking
- strange or unusual behavior
- slow movements or immobility
- Low motivation
- Language problems
- Does substance abuse affect the onset of schizoaffective disorder?

2.3 Diagnosis

The diagnosis is based on the observation of clinicians regarding the behavior of the patient when he suffers from these symptoms. It is also based on symptoms reported by the patient's entourage. The diagnostic criterion depends on the duration, clinical signs and symptoms.

2.4 Causes

Although the causes of dysthymic schizophrenia are still unknown, there is a valid diagnosis concerning a heterogeneous group of individuals, some with severe forms of schizophrenia, and others with very severe forms of mood disorders. There is some evidence that schizophrenia dysthymia is a psychotic disorder.

Different genes are at the origin of this disease, interacting with different biological and environmental factors. The physiological state of patients with schizophrenia and a serious form of bipolar disorder, but studies conducted on these physiological states have not been conclusive.

A clear association between drug use and schizophrenia spectrum disorders, where dysthymic schizophrenia, has been noted, but the causal link remains difficult to prove, except in the case of cannabis. For example, a 2007 meta-analysis shows that cannabis use is statistically associated with a high dose-response risk in the development of dysthymic schizophrenia. Another meta-analysis from 2005 shows that cannabis is a huge independent risk factor in the development of psychotic symptoms and psychosis.

2.5 Prevalence

The prevalence of this disorder averaged at least one percent, around 0.5 or 0.8 percent. The diagnosis is based on the experiences of the patient and the observation of his behavior. There is currently no clinical test performed on schizoaffective disorder, although some abnormalities in the metabolism of tetrahydrobiopterin (BH4), dopamine, and

glutamate persist in patients with schizotypy dysthymia. As a group, individuals with schizophrenia dysthymia have a more favorable prognosis than those with another form of schizophrenia, but a less favorable prognosis than patients with mood disorders.

Genetic, environmental, neurobiological, psychological and social factors play an important role in the development of symptoms. Some medications can cause or even worsen the symptoms.

2.6 Genetic Approaches

It has long been known that schizophrenia tends to be transmitted genetically (Bleuler, 1978, Allman 1946). Three independent lines of family research, twins, and adoptations led to a common finding that people who were genetically related to an affected individual were more likely than others to develop the disease (on and O'Donovan, 2003). Inking Gateman (1991, Key et al., 1994); These authors have each worked on the European population data compiled from different family and twin studies conducted on European populations between 1920 and 1987. The level of risk has a strong correlation with the degree of genetic proximity. In particular, Ketty et al's study evaluated the incidence of thinking disorders in the biological and adoptive parents of schizophrenic patients. The data reflect the relationship between a given individual and a diagnostic subject as schizophrenic. Thus, for example, the HTZ twin of an affected person has 17% risk of sharing the same diagnosis.

2.7 Cerebral Functions and Biological Markers

According to Saymanski et al. 1991. P.99 and R. gerris and P. Zimbardo (2008 P.423), Another biological approach to schizophrenia is to look for possible abnormalities in the brains of affected individuals. In this approach the essential brain imaging that can directly compare the structure and function of the encephalon of schizophrenic individuals and healthy subjects. Magnetic resonance imaging has revealed that the ventricles-structures of the brain through which cerebral-spinal fluid flows are often enlarged in individuals with schizophrenia (barataiet al.2006). MRI studies also show that that affected individuals have significantly finer regions at the frontal and temporal lobes of the cortex, the loss of neuronal tissue likely being related to behavioral abnormalities characteristic of the disorder (Kuper berg et al., 2003).

2.8 Family Interactions as Agent of Environmental Stress

The sociologist, family therapists and psychologists have all studied the influence of role relations and communication patterns within the family environment, their hope being to identify the environmental circumstances that increase the probability of developing schizophrenia and to preserve individuals at risk.

To appreciate the role of family communication in schizophrenia, the researchers defined the concept of emotion expressed. One study collected data on the families of 59 patients with schizophrenia who were living with them during a period when they were considered stable. We

measured for each family its level of emotion expressed; when the condition of the patients was evaluated nine months later, 50% of those from a strong emotional family experienced a relapse, compared with 17% of those from low-emotionally-expressed families. R. Gerrig and P. Zimbardo 2008, p.424).

Statistically, it is observed that in men the disease is clinically pronounced during the end of adolescence, whereas the older ones are more statically affected; none of these arguments argues for a genetic origin:

The risk of schizophrenia higher in the subject related to schizophrenics;

- When a brother or sister is affected, the risk is 6 to 14%;
- When a parent is affected, the risk is 7 to 16%;
- When the two homozygous twin brothers, the risk is 90 to 70%;

Certain environmental factors contribute to the onset of the disease especially in the first weeks of development.

(Messrs. Pallone, R.M. Murray in <http://www.Puf.Com/edge/continueextract/3357610/91BMJ.2007.p335>)

2.9 Modalities of Appearance

A) Progressive and insidious modalities

In the first place, there may be direct disturbances, likely to take several aspects and which did not immediately enter into the anxiety of those around them. A decline in academic or professional performance, a change in the character of hypochondriacal lifestyles, a quest for bizarre, inexplicable isolation are all signs likely to characterize an onset of dysthymic schizophrenia, in addition to the mood is always morose, alexythymia s' observe at times, a feeling of depressive attitude at times divided into episodes.

When the subject tries to draft explanatory conclusions on these expertises, he then shows, according to Minkowski's formula (1927), morbid rationalization. One can also meet in these delusional beginner topics, a primer of mental automatism described of dispossessions or failure of the thought.

V. FATTORUSSO / O. Ritter (2004, p769.) States that neurotic, phobic, hysterical, or obsessive disorders can also be observed. But as time goes on, these pseudo-neurotic pictures put at a distance from the external reality can account for the modalities of entering dysthymic schizophrenia.

B) Brutal appearance

V. Fattorusso / O.Ritter (2004.p.769), Late-onset schizophrenia is observed at age 45, 3 to 5 times more often in women than in men, and is often characterized at the beginning by:

Cognitive disorders, with interferences (thoughts, images, impulse that invade the course of thoughts), haunting ruminations appalling banal events,

Disorders of perception that do not hinder the recognition of changes to the distortions of the intensity or quality of perception, for example photopiles (elementary visual

hallucinations, morbid or immobile flashes, stars, triangles, etc.). And cosmos hallucination aoristic, elementary, nonverbal, beatings, clicks, hisses, etc.);

The disorders of the mood are constant the adherence to the delirium being total, the subject oscillates between extreme poles of the euphoric exaltation and the sneering of oppressive and anxious. In fact, the mood undergoes the successive fluctuations of delusional vogue and disorder of ideas.

C) Dopaminergic mode

Schizophrenic disorders are common related to mesolimbic dopaminergic pathway dysfunction. This theory is conceived under the name of "dopaminergic hypothesis of schizophrenia" antipsychotics have an action on the system of dopamine. It is the fortuitous discovery of a thing of drugs, phenothiazine which is at the origin of this discovery.

However, this theory is currently considered too significant and incomplete especially since new drugs (atypical antipsychotics) such as haloperidol, are as effective as typical, such as haloperidol.

2.10 Psychiatric Co-Morbidities

The co-morbidities to the associations to other pathologies are frequent in the dysthymic schizophrenia:

- Intoxication;
- Abuse of dependence on addictive substances;
- Mood disorders ;
- Suicide; social disability;
- Symphonies of oppressive
- Manic tunings
- Iatrogénies

3. Case Study

In this part, we will give information about the story of our patient KK who was interned at the General Provincial Hospital Jason Sendwe in the neuropsychiatric department coordinated by the doctor Jean Paul MANDE, to discover his personal and family history as well as the story of his illness. Note that all this information collected comes from our patient. For reasons of reliability, and given his state of health, we used some people in his environment including his mother and big brother to confront the different information from the patient and his entourage to identify the problem node.

3.1 Anamnesis of the Patient

Our patient KK is thirty-three years old, the fifth child in six, including four girls and two boys. Here are the great painful and emotional events that our patient has known that have weakened his psyche. In 1989, he was damaged by a Gecamines officer's vehicle and was taken to the hospital for injuries to his head. The scanner had revealed nothing on this occasion as a result. This situation has been trivialized. In 1998, he dropped out of studies because of repetitive headaches, and despite the different medical products no

improvement was reported. As a result, he eventually dropped out of secondary school. He had started small business and sold candies, cigarettes, soaps and more to support himself.

3.1.1 Hereditary antecedents

No case to report, he was born in good conditions.

3.1.2 Family history

His only brother also suffered from a mood disorder (Alex Thymie) and was taken to the hospital and after his treatment he was recovered, three of his sisters are not married. Of these, one suffers from back pain. His paternal uncle suffered from schizophrenia and died untreated. His father was paralyzed (hemiplegic) and died after long suffering. It is the mother who deals with the survival of the family whose conditions are very modest. It should be noted that the patient's mother told us that there is no good relationship with members of her extended family; it is befitting that one of the paternal uncle of the patient had entrusted his two daughters to the patient's family to keep them and his two daughters had died, since then there are no good expectations with other members of the family. These conflicts total at least 12 years.

3.2 Presentation of Symptoms

We present the different symptoms and clinical, physical and psychological signs that we observed and detected after the evaluation in our patient.

3.2.1 Psychomote symptoms

Echopraxie (imitation of gestures);

- hyper-kinetics (excess of movements);
- Para-kinesis (lack of coordination of voluntary movements);
- Episodic stupor or muteness; Catalepsy (disorder of tone and motor initiative) with waxy flexibility and attitude retention.

3.2.2 Psychosomatic symptoms

- Sleep disorder (insomnia);
- Stomach aches.

3.2.3 Psychological symptoms

On the psychological level we have identified the following symptoms:

- A mood disorder with signs of atypicality;
- manic episodes;
- Depressive episodes;
- Mixed episodes;
- agitation;
- Onirism (types of automatic mental activities comparable to dreaming occurring outside of sleep);
- difficulty concentrating;
- hallucinations;
- aggressiveness;
- Delusions ;
- Avoidance (mistrust).

3.2.4 Functional and social level

At this level our patient presents:

- Difficulty doing income-generating activities (doing small businesses);
- The difficulty of planning for one's life;
- The difficulty of thinking about one's future married life;
- the difficulty of starting a relationship;
- The difficulty of sharing ideas with others;
- The difficulty of being together with others;
- The impossibility of visiting people because of their health.

3.3 Analysis and Understanding of Data

All these data obtained come from the different interviews conducted in front of the patient and the different observations made around our patient. To carry out the diagnosis, we based ourselves on the various symptoms and signs presented by our patient and his various reactions to the affective situations he was able to cross: Stopping studies in progress following illnesses; Hemiplegia and the disappearance of his father in whom he was dependent; Her unmarried sisters; The very modest standard of social life Various headaches and headaches; Dislocation and various conflicts with the extended family, the taking of tobacco. Given these different symptoms obtained and the theory relating to schizoaffective disorder such as the DSM-IV-TR and authors present it; this led us to consider that our patient had psychological problems due to the different situations presented above.

3.4 The Results of Medical and Psychiatric Examinations

Nervous systems: Alcd: - 5 ° / 6 E

- Student abandoned

tobacco (++) , alcohol (°°)

- First crisis at least ten years ago

Para-clinical examinations: behavioral disorder in his brother, his paternal uncle,

Psychiatric observation

- Normal expression mimicry;
- Clean clothes, wash alone;
- Contact pseudo;
- Inadequate gestures;
- Languages vociferating and incoherent at times,
- Psychomotility: agitation
- Noetic: unconscious of his morbid state, of his disorder;
- It is delusional, he wants to live in Canada, he is white;
- Somatic: insomnia ++

Medical clinical conclusion: dissociative disorder; Dysthymic schizophrenia; the list of medications proposed by doctors:

R / Haldol 3 X5 / J

R / Tegretol 3 X1 cés / J

R / Nozinan 2 X 50 mg / J

R / Artane 1 X 5 mg / morning;

TAS S / Without complaint;

O / EG: canned;

OP: good, conscious contact, adapted gestures, conscious of his morbid state;

A / good clinical evolution S / T3

P / Attitude

4. Approaches Used

The cognitive approach with its techniques;

- Group therapy;
- Psychoeducation;
- And we also proposed occupational therapy

4.1. The application of psychotherapeutic maneuvers

4.1.1. Cognitive therapy

The various approaches to cognitive therapy focus on thought processes and share the following considerations:

- The human body responds to cognitive presentations of its environment rather than to that environment.
- Cognitive representations are related to processes and parameters of learning.
- The majority of learning in humans is mediated by cognition.

During the course of the therapeutic treatment, this therapy helped us to modify the negative thoughts of our patient vis-à-vis his environment, which itself was the source of delusions and hallucinations.

The application of Group Therapy has allowed us to bring patients together to share their experiences during different episodes that can help them normalize their situation and cognitive therapy supported by his techniques (narrative exhibition, psycho-education and relaxation exercises) is justified by the cognitive distortions observed in our client and his goal is to modify his negative thoughts:

- The client thinks he is completely destroyed, no way to hope for something from him yet and for that he took tobacco and think that it can reduce his grief and allow him to sleep deeply and avoid hallucinations;
- The client's family and himself think that it is an evil spirit that bothers him and resents his life.
- Then, the psychological disorders to be improved by the learning of an adapted behavior at our client are the following ones:
- The client and his family think that it is an evil spirit that captivates him and wants to his life and while he sleeps there are people who come to take his mind to go to use it elsewhere and accuse for that his paternal uncle whom they consider a real catastrophe of the occurrence of the disorder of this patient.
- The client goes to bed at late hours and is afraid of sleeping because of illusions and hallucinations that enter his mind.

a) The narrative exhibition

We presented to our patient the enigma of the 100 euro bill described by Christian H. GODEFROID in "magical stories of the Positive Club" (2004, p.52)

A well-known speaker begins his seminar by holding a ticket of 100 euros. He asks people, "Who would like to get this ticket?" The hands start to rise, so he says:

"I'm going to give this 100 euro bill to one of you but before you let me do something with it." He then crumples the

ticket with force and asks: "Do you still want this ticket?" The hands continue to rise. "Okay, okay, but what if I do that?" He throws the wrinkled note on the ground and jumps on it, crushing it as much as possible and covering it with dust from the floor. Then he asks: "Who still wants to get this ticket?"

Obviously, the hands continue to rise! "My friends, you just learned a lesson ... No matter what I do with this post, you still want it because its value has not changed, it's still worth 100 euros." After this enigma we told him that there is still a possibility to rebuild his life and realize some of his dreams if he became aware of his current life and find a solution for the future; as indicated by the technique of mental imagery which consists of the internalized and structured representation of an object or event, previously perceived or constructed by the subject.

b) Relaxation

It is one of the strategies of behavioral therapies that seek to achieve physical and mental relaxation through the conscious control of physical and mental tone in order to soothe internal tensions and to consolidate the mental balance of the subject (Psychology Review, 2006). Being a natural remedy for feeling good, relaxation has been effective for the dysthymic client to decrease his depression. The relaxation exercises taught to our client during his psychological care are:

Get up and stretch:

- The patient gets up and exercises movements in the different organs of his body: stretching shoulders, hands, hip, etc.
- Relaxing cervical tension: only the neck and shoulders are moved;
- Diaphragmatic breathing:
- Put your hand on your chest and another on your stomach;
- Try to inhale through the nose by inflating your stomach without moving the chest muscles too much;
- Inhale slowly while saying to yourself in your head: i - repiiiiiiiiii-re;
- Slow down the rhythm of your breathing;
- Exhale through your nose and say: aaaaaaa-a;
- Start slowly again.

c) Regressive muscle relaxation:

- Focus all your attention on the muscles of your left arm;
- Give a signal: begin to contract the muscles of the left arm by firmly squeezing the first; feel your muscles contract, feel the tension and leave them tight (5-7 seconds);

4.1.2. Psycho-education

This strategy has allowed us to educate the patient about his disorder and to recognize and normalize the symptoms: your hallucinations and illusions that you know seem like normal reactions to the painful events you have known. These reactions occur in many people after experiencing horrific moments and stressful events in their lives;

Providing the tools to the client: we proposed to the client to do relaxation exercises; to remember moments of the joys

experienced by the family before their trouble; listen to the encouraging voice during moments of despair etc.

Based on the therapeutic model of the hospital's clinical program, our client's care took place in ten individual sessions and ten in a group and each session dealt with a different theme whose duration generally did not exceed 90 minutes. The various themes used with the subject constitute the basis of the following sessions:

At the first session of the individual therapy, our concern was to take cognizance of his case, to discover the pathological behaviors and their exact origin, while signifying our role with the patient; At the end of the session, we let the patient know that we are available to help.

The second session was based on establishing a good therapeutic relationship between him and us, through which we had to help him get by; and the end, he gave his opinion for the collaboration.

The third session was based on the analysis of the cognitive situation and the profitability of his motor project which were disturbed by the intense emotions and the depth of the disorder. We obviously discovered that his cognitive life was affected and his motor project because he had trouble identifying his body.

The body exercises and the relaxation technique were the subject of the fourth and fifth session, because we set ourselves the goal of excitement of his motor project through body exercises and relaxation to enable him to develop a good recognition of his body and the stability of his cognition.

The sixth session was intended to know the different situations that the patient has known in his life and the history of his illness, discover the irritating thorn that is the cause of his illness. In this session we asked him to accept his situation and make the effort to find another solution.

The seventh and eighth sessions were based on knowledge and discussion of his family's situation because we were searching for the etiology of his disorder, and we found that his family's situation was also among the causes, of his illness.

The purpose of the ninth and tenth sessions was to explain to the patient what he was suffering from, to explain what dysthymic schizophrenia means and how to deal with psychology, and how to prevent this disease from completely affecting him.

The first session and the second session were aimed at creating a climate of trust and collaboration. Make the patient aware of the importance of the group and tell each member what to do in the group during the therapeutic sessions, also try to help the patient to renew his collaboration with his family.

The third session pursued this goal, talking with the group about how the patient's illness started, what they observed, and about various known family disruptions, how to cope.

The fourth and fifth sessions were intended to share the difficult moments that the family experienced and this should allow both the family and the patient to know how to control their emotions through the reactions of others and make an emotional abreaction to the suffering of the family, using the psychological advice that we had to give them.

The sixth and seventh sessions focused on reducing anxiety in the patient by helping to strengthen the inner bonds with his family, consider that his family members want him to recover, because his illness has caused grief and sorrow, which is why in these sessions the members of his family expressed what they felt for him around his illness.

The purpose of the eighth and ninth sessions was to enable the patient to become aware of and be aware of the different behaviors during his crisis and what that has done in their hearts provided that, by becoming aware and aware of what he has done, his actions and thoughts around that.

The tenth and last, it was articulated around the constitution of the feeling of confidence and hope. That there is still a way that things change and the main thing is to accept what has happened and see how to think about the future knowing that if we decide to change things, they will change, but if we let's say it's over for us, there's no way we can do it, so it'll be over for us.

It should be noted that the last evaluation after the cure reveals a considerable decrease in symptoms and emotional, behavioral, cognitive, and physiological manifestations of manic and depressive reactions. This observed change is more interesting obtained in a fairly long space (sixteen weeks in individual and eight weeks in group).

5. Components Obtained Using Clinical Observation

5.1 Situations before and during the interview sessions

During the individual interviews with our patient, he presented the attitude of avoidance, isolation and did not want us to spend too much time with him; he was all depressed; he remained fixed on one point for ten minutes; then sighs; he was too selfless, withdrawing into himself.

When he was trying to tell us about his problem, he had too much restraint. The voice that started high at a given moment, then dropped more and more, from where it was always necessary to raise again to be able to catch something. At first it was difficult to grasp it because it went beyond; we have observed it in visits; in therapeutic interviews; in the pre-assessment and during the actual evaluation.

5.2. Evaluation followed and changes recorded

At the end of the course of treatment with the patient, we carried out regular evaluations to check the effects of

psychotherapeutic techniques used; as a result, we used the arithmetic progression technique, the questions of the evaluation of his situation were administered to him. These issues identified the situation of the following: psychotic, psychological, functional and social.

The following mentions and scores allowed us to assess the intensity levels of each problem of the subject:

- Scores Mentions
 Not at all 0
 A little 1
 Many 2
 Excessively 3

5.2.1 The graphic presentation of the reduction of symptoms

5.2.1.1 Psychosomatic symptoms

This table gives us an overall life on the reduction of psychological symptoms at the evaluation one month before the cure, three months and six months after the therapeutic cure.

Table 1: level of intensity of the subject's psychosomatic symptoms

Month		1Month	3Months	6Months
Scores		0123	0123	0123
1	Do you have insomnia	3	2	0
2	Lack of appetite	2	1	0
3	Excitation	3	2	1
4	of vertigo	2	1	0
5	To mimic the movements	3	2	1
6	To keep a long silence	3	2	1
7	Aggression	3	2	0
8	Do you have headaches	2	1	0
SCORED RATE		1Month=21	3Months=13	6Months= 3

The comment of this table comes after its graph.

Graphic evaluation of symptoms

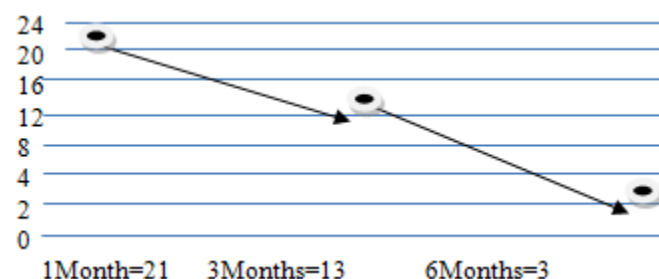


Figure 1: Psychosomatic symptoms

This graph and table 1 show that the psychosomatic symptoms of our patient were higher at the beginning of the therapy; thus, with the strengthening of the therapy, we found already in the third month, a reduction of the symptoms after a few therapeutic sessions. This positive evolution of our patient is due to the decrease of the hyper-emotional manifestations which were caused by the negative sufferings: hallucinations, delusions, anguish, mood morose.

5.2.1.2 Level of social operation

Table 3: level of intensity of the subject's social functioning

Month		1Month	3Months	6Months
Scores		0123	0123	0123
1	Do you have difficulty recognize family members	3	2	0
2	Do you have difficulty sharing your situation with others	3	2	1
3	Do you have difficulty doing the activities generators	2	1	0
4	Do you have feelings of hopelessness	3	2	2
5	To take care of you	2	1	0
6	To do some activity	2	1	0
7	To feel like others	2	1	1

RATE 1Month=17 3Months=10 6Months=4

Graphical Evaluation of the Level of Social Functioning

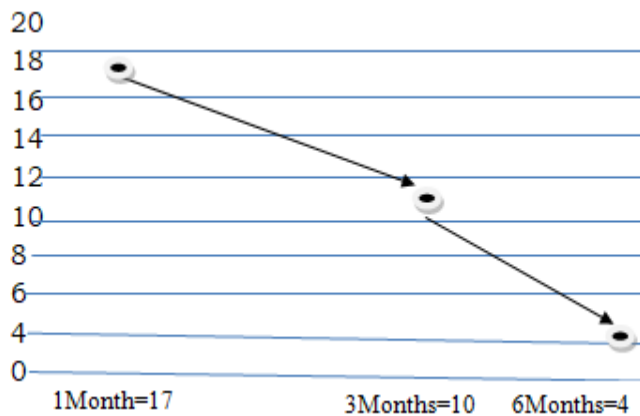


Figure 3: Social operating state

In this table 3 and this graph3, we notice that the social functioning level of our patient at the beginning was too small, this could be justified by the loss of confidence to others and to oneself; At the assessment three months later, the social level of our patient began to increase by the fact that by sharing with family members in group interviews; he had a little confidence in others and in himself. Gradually until the sixth month of care, he began to build relationships with his entourage. Recall that our goal was to eliminate all the symptoms and emotional, psychosomatic and social manifestations but to reduce them because, we pointed out at the beginning of this work that the management of a subject suffering from schizophrenia requires a large team, because the etiological factors are numerous that everyone has a part to do, we did what we could, the rest requires a continuous support in order to be able to reduce more and more the suffering of the subject. All in all, the changes in the patient revealed the need for and the effectiveness of the therapy, without taking into account other parasitic variables that may cause these results to vary, and these results confirm the achievement of our research objectives. as a result, our initial assumptions. Therapeutic sessions were organized successively to allow, during different sessions, a good recovery and good progress of the patient. The time varied depending on the patient's condition, from 60 minutes to 90 minutes depending on the patient's progress. Because, at

first, the patient is wary more of us, until the moment, when a good relationship was established.

5.2.1.2. Psychological symptoms

This table above reveals the progress of our patient on the psychological level.

Table 2: Level of intensity of psychological symptoms of the subject

Month		1Month	3Months	6Months
Scores		0123	0123	0123
1	Do you feel sad?	2	1	0
2	Lack of interest	3	2	1
3	Do you hear voices and do not you see people	3	2	0
4	Are you afraid	2	1	0
5	Do you like being alone	2	1	0
6	Do you have difficultiesto reason	3	2	1
7	Your thoughts, are they troubled	3	2	1
8	Are you guilty of guilt	2	1	0
9	Sometimes you think of family	2	2	1
10	Do you feel alone in Some moments	2	1	0
11	Do you have difficulty calculating	3	2	0
12	Do you have any thoughts negative on others	3	2	0
13	Do you have difficulty to be in contact with others	2	1	0

Graphical Evaluation of Psychological Symptoms

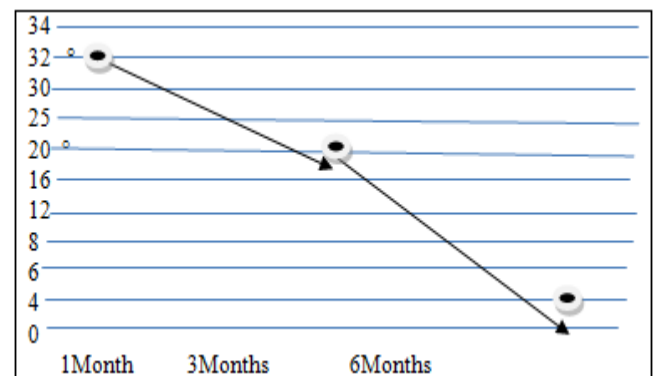


Figure 2: Psychological symptoms

In this chart, and this graph, we see that the psychological symptoms of our patient were very high and intense at first, and his mental health was so disrupted (in the first month before the cure). While in the third month, we notice a very large decrease in symptoms or even the disappearance of certain symptoms after the individual and group care. Through the manipulation of exploration and intervention techniques, some symptoms have gradually disappeared. There was a progression, a relative mental stability. The ability to calculate, fear, sadness, anxiety to diminish, avoidance and isolation have disappeared. This shows better the effectiveness of the care we started.

5.2.2. Global changes recorded

Moreover, the manipulations of all the psychotherapeutic strategies in our patient, and the positive modifications of the recorded subject prove that the psychological care was essential for the patient with the following plans:

- Psychomotor: the reduction of symptoms (insomnia, echo praxis, hyper kinetics, paraphenias,);
- Psychological: the appreciable diminution of symptoms (fear, agitation, hallucinations, delusions, depressive, manic episodes, ...);
- Social functioning: there was an increase in family ties, because the patient begins to support the presence of his family, he shared his feelings with others;
- Behaviorally: there was also a considerable change in the pathological behavior of the patient including parakinesia, dreaming, avoidance, ...

These global changes prove that the therapy we used was effective and allowed the patient to have a change to look for and restore the lost balance.

6. Conclusion

This study is the result of a practice based on the management of a victim of dysthymic schizophrenia. This is a 33-year-old boy who experienced several painful events that affected his affectivity, his cognition, whose mood was deeply disturbed and all this has caused hallucinations and delusions to settle down giving rise to depressive, manic and mixed episodes;

The treatment for which we opted allowed us to access the use of clinical, descriptive and psychosocial investigation methods. The clinical observation technique and interviews helped us achieve our goals.

Indeed, the objectives of this study are summarized in these terms namely:

Diagnose the different signs and symptoms that appear in our patient who is affected by dysthymic schizophrenia in our environment. Provide psychotherapeutic assistance, which would lead to a decrease, or a systematic elimination of symptoms, so that the patient regains his psychic, physical and social balance.

The cognitive approach used and other psychotherapeutic techniques allowed us to analyze the subject through functional evaluation, functional analysis, goal planning and to propose care to administer to the subject.

At the beginning of our study, the subject summarized the following issues:

On the mental plane: lack of concentration, lack of interest, agitation, the presentation of hallucinations, delusions, ...

Emotional: fear, sadness, grief, mood disorder, depression,

Physical plan: echopraxia, para-kinetics, aggression;

At the end of therapy therapy based on individual and group activities (self-help), counseling, relaxation, we arrived at the following results:

- A noticeable reduction in physical symptoms: getting enough sleep until the early morning;

- The disappearance of erroneous thoughts, hallucinations, delusions and manic-depressive episodes;
- Serious commitment to collaboration and undertaking new relationships with his family;
- A considerable change in the different symptoms;

There is therefore a positive and profound modification of the subject on the mental, physical and social levels which makes it possible to believe that the cognitive-behavioral approach has been beneficial for the subject. Thus these results better confirm the hypotheses formulated at the beginning of the study and reassure because the objectives are reached.

As we can see, our study is very beneficial for everyone. It provides researchers with useful information for the well-being of the brothers and sisters of our community, not to mention the fact that it is an urgent need to enrich the literature on dysthymic schizophrenia, and even less of the thinkers.

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