

Psychological Support for a Victim of Paranoid Schizophrenia: Study done at the Neuropsychiatric Center Dr. Joseph Guislain

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Abstract: *Medicine knows, since Hippocrates and in spite of the positive psychology, that psuckhé intervenes in any disease, and that the care lavished on a patient, whoever it is, must involve the body and the spirit. However, there are some complaints and somatic pathologies that impose a focus on psychological or even psychiatric care. To ignore the important part played by a psychic disorder in certain schizophrenia-like disorders is to take the risk of chronicizing the complaint, of getting lost in many long, expensive and even unnecessary additional examinations.*

Keywords: Psychological Support, Paranoid Schizophrenia, Homeostasis, Elsevier, Paris.

1. Introduction

In psychiatric pathology, the intricacies of medical and social problems are common, on the one hand because psychiatric diseases almost always involve a more or less important social handicap (difficulty for schizophrenics to enter the world of work for example), and secondly because social factors can play a very important role in the emergence or decompensation of mental disorders (unemployment and depression for example). However, in current pathologies with potential for chronicization, social strategy can significantly affect psychological support and prognosis.

Paranoid schizophrenia is clinically manifested by delusional episodes, hallucinations, behavioral disturbances and the persistence of various chronic symptoms such as insomnia, delusional persecution, which may be a handicap. It affects about 0.7 percent of the world's population and 600,000 people in Central Africa, says the World Health Organization. It's a culture. It exists all over the world.

The paranoid schizophrenia suffered by the patient subjected to our analysis owes its relation to the Swiss psychiatrist Eugen Bleuler (1911, p 132), who assigns the definitive denomination of "schizophrenia".

It is most disabling, especially among young people, according to the WHO. It affects mainly young people in their late teens at or near 19, or in early adulthood. can last a lifetime if it is not supported as soon as possible. Early forms beginning before puberty are more rare. For example, the World Health Organization (1988) classifies paranoid schizophrenia in the major groups of diseases that cause the most disability. It is a major factor of dissociation and precariousness in that, moreover, paranoid schizophrenia is often diagnosed with great delay because of its often insidious onset, which creates difficulties and misunderstanding of the symptoms on the part of patients. Members of the emotional family of thought. The schizophrenic must be hospitalized for reasons of:

1) Support for a major alternation of behavior, including for the most basic daily needs (eating, bathing, dressing);

2) To prevent a suicidal or hallucinatory risk: supervision of the subject and removal of dangerous objects.

Recent studies show that a regular psychotherapy called "cognitive-"behavioral" or "supportive" can have very beneficial effects.

Our study seeks answers to the question of why, after psychiatric treatment, schizophrenic patients experience relapses and return to the center for psychiatric care.

Our key concern was: "Can psychological support contribute to the recovery of the mental health of a paranoid schizophrenia sufferer"?

1.1 Work hypothesis

Our hypothesis is that psychological support would help restore the mental health of a paranoid schizophrenic sufferer.

1.2 Previous Study

There is a lot of objectivity in cataloging other accumulated knowledge about disturbed behaviors so as not to repeat what is known. In fact, doing the research is also being able to know, understand and evaluate the scientific productions already published in the literature. What good is it to look for what we already have!

This is why J. Rambert (199, p.312) cited by Kambulu KM mentions the advantages of the review of the studies of the predecessors. Thus, for Lissier and I. Stip in their book "Selective Attention, Psychological Support in Paranoid Schizophrenia" (1996) say that a patient with paranoid schizophrenia shows a variety of difficulties with memory function, these include a poor reminder word lists of word pairs, associated words, associated with the encoding rather than the difference of patients suffering from paranoid schizophrenia who show only a slight increase in the forgetfulness rate.

Provided by a professional, this therapy can be simply a moral support, as it can be the starting point of a therapy in

order to be able to accept the disease. It helps relieve suffering.

2. Theoretical Framework

This first part deals with the theoretical framework. It is subdivided into sections. Input it is a question of defining the basic and associated concepts. The second section focuses on the specific notions of paranoid schizophrenia. The third is the explanatory theories inherent to paranoid schizophrenia.

2.1 Definitions of Concepts

The precision of the meaning of the words contained in our research topic is a very important step because it allows our readers to understand the content of the message we bring them. Thus, we want to allow them to avoid any kind of ambiguity in the exact input of the terms used in order to have the same understanding as us, on the understanding of the key words. These concepts are: psychological support and paranoid schizophrenia because there are several forms of psychotherapy and several forms also schizophrenia that we will clarify in the following lines.

2.1.1 Psychological support

The psychological support is, according to Vital Mangoni T V, (2006, p 234). Help or a load intended for anyone suffering from psychological difficulties to treat mental disorders or somatic of the mind.

Supportive psychotherapies are the most common, the most practiced, but the least theoretically developed. They can be used alone, thus constituting the essential treatment or the only practicable. They can also be used as prerequisites for a very deep psychotherapy in a subject too fragile or initially unmotivated.

Its goal is to quickly restore the psychological balance of the patient and obtain the greatest possible symptomatic improvement. They do not seek to transform the personality of the patient but to strengthen his defenses and to improve his adaptation to the external environment.

Psychological support can relieve suffering, provide moral comfort and quality of life for the patient and his family.

Psychological support, according to Cohen (2004, p 23-24), is also a therapeutic method using means of the subconscious or subconscient. To cope with an illness the patient may need psychological support from a mental health professional, so from all of this we take into account Cohen's definition because being a mental health staffer we're going to look for all the a little bit of time helped our patient to regain his initial health.

As far as we are concerned, Psychological support is a therapeutic method using means of the subconscious or subconscient. To cope with an illness, the patient may need psychological support from a mental health professional.

2.1.2 Notions on psychological support

This section is intended to provide a background and clarification of psychotherapeutic practice.

The term supportive psychotherapy appeared at the beginning of the Second World War, at the same time as that of psychoanalytic psychotherapy became widespread.

Robert Knight (1956 pp23-24), one of the first limit state theorists, clearly differentiates these two modalities of 1945. For supportive psychotherapy, he describes an approach where the psychotherapist is active, encouraging the patient to develop his capacities. Integration of adaptation and evaluation of reality.

The therapeutic objective is to reinforce the control of the patient's ego on instinctive impulses and to educate to use new methods of mastery and adaptation. The psychotherapist expresses more in terms of ego operations than content of the ca and aims to strengthen the first.

In this perceptive, the psychoneurotic defenses and the symptoms are not directly attacked insofar as these operations of the self protect the patient against the psychotic disorganization it is on the contrary necessary to preserve, reinforce and improve the defensive and adaptive functions of the ego in In addition, patients treated with this method, often borderline, need to receive evidence of emotional support.

2.1.3 Paranoid Schizophrenia

For the Grand dictionary of psychology ed 2011, paranoid schizophrenia refers to "certain psychic states characterized by a poorly structured, incoherent delirium that is difficult to penetrate and whose type is found in schizophrenia"

For the American psychologist of the Association of American Psychiatrists (DSM IV), the type of paranoid is a form of schizophrenia dominated by one or more of the following manifestations: delusions, grandeur, persecution, jealousy, hallucination to term of persecution or grandeur. However in spite of this sign and symptoms we want at all costs to find a partial remission why not total of these symptoms. Brief history and notions about paranoid schizophrenia The psychiatrist Emile Kraepelin is the first to have revealed distinctions between the early dementia described fifty years before him by Benedict Augustin Morel and Al (2011 Pp.123, 124 and 125). Other forms of madness. It is then renamed schizophrenia by psychiatrist Eugen Bleuler when it becomes clear that Kraepelin's designation was only an adequate description of the disease. It was in 1898 that Emile Kraepelin, starting from early dementia, found three variations: - Hebephrenia: (Hebe: adolescence, pre: spirit): qualifies an intense Disintegration of the personality; - Catatonia: The most serious form; - Paranoid: the less serious form based on delusions and hallucinations.

Professor Pierre Lorca in his article (2010 p 6) summarizes paranoid schizophrenia as follows: "Schizophrenia is manifested by acute episodes associating delusion and hallucination, behavioral disorder and the persistence of various chronic symptoms that may constitute a handicap. It concerns about 0.7% of the world population and 600,000

people in Central Africa. It is a disease "Ubiquitous" that is to say presented at all altitudes and in all the cultures, it exists in the whole world.

The symptom may be difficult to detect until an advanced phase of the disease. However, the association of the three fundamental psychopathological dimensions is often found:

- The delusional transformation or distortion of reality expressed by delusional and hallucinatory experiences;
- affective impoverishment ideo-affective manifested by the symptom called "negative" as abolished, retreat apathy, reduction or absence of affective modulation capacity of thought;
- The disorganization of thought with disorders of ideation, language and disorganization of behavior.

The disease usually evolves with relapses of acute psychoses from the first years, then stabilizes with residual symptoms of varying intensity depending on the subject.

The prognosis depends mainly on the quality of psychological support, access to psychiatric care and adherence to the proposed care. Conventional neuroleptic antipsychotics have revolutionized the evolution of paranoid schizophrenia by improving patients' clinical condition and reducing relapse rates .

Social psychological care is necessary, including rehabilitation programs, psychological support, psychotherapy and the use of support groups. The etiological factors of this pathology seem multiple. It is a disease with complex heredities, poly-factorial and interacting with environmental factors. It is appropriate to be updated, to be extremely careful in genetic counseling that can be given to the parent.

2.2 Forms of Schizophrenia

Augustin Morel and Al (1982, p.123) state that one can also distinguish several forms of schizophrenia rather poly forms:

- Simple schizophrenia: the negative symptoms are in the foreground: the impoverishment of the socio-occupational relationship, the tendency towards isolation and autism in an inner world there are few or no delusional syndromes. This form evolves slowly, but very often towards a deficit more and more marked.
- Paranoid schizophrenia: This is the most common form of schizophrenia. Delusions and hallucinations dominate the clinical picture, megalomania, and subject most often responds to antipsychotic treatment and psychological support.
- Hebephrenic schizophrenia: The dissociation of the subject's unique psychic is predominant. It is the most resistant form to therapies this form of schizophrenia mainly affects adolescents.
- Catatonic Schizophrenia: The patient is physically frozen and the attitude imposed on him, like a doll of wax. He is locked in himself a mutism, or he always repeated the same phases.

Currently, this form is treated and is rarely final.

- Schizophrenia Dysthymia (schizo-effective disorder): Acute attacks have the particularity of being accompanied by depressive symptoms with suicidal risk of manic

symptoms. These forms respond at least in part to thym-regulatory treatment (such as lithium).

- Pseudo psychopathic schizophrenia or "hebidophrenia" This state is considered to be a pre-schizophrenic disorder in which the adolescent has significant opposition to the presence of a thought disorder; build a phase. It coexists with very violent acts of acting and dissociative symptoms, such as affective coldness.

3. Methodological Framework

3.1 Field of investigation

This study is carried out in the city of Lubumbashi. We were interested in the patients of the Neuropsychiatric Center Joseph Guislain because it is the only neuropsychiatric center in Lubumbashi that receives psychiatric patients who are very interested in our scientific research. In fact, our target population consists of 14 male subjects, of whom only 2 are schizophrenic paranoids and the remaining 12 are schizophrenic schizophrenic and catatonic schizophrenia.

In October and November 2013, some schizophrenic patients received outpatient treatment and others were still hospitalized at the Neuropsychiatric Center. Based on this population of two cases of paranoid schizophrenia, we chose a subject that interested us from its admission to the center and during our training course.

3.1.1 Study population and research sample

Nicolas Gueguen (2005, p.103), in his book Statistics for Psychologists, states that people tend to associate the word population with certain demographic aspects: the French population, the population of Brittany agglomerations, and so on. In statistics, the meaning given to the population is much less restrictive than called population, all individuals who share the characteristic defining the basic individual of the population: this individual having been previously characterized for example on all patients psychiatrist found in the center. We chose as the population the schizophrenics who benefited from the treatment provided by the neuropsychiatric center Joseph Guislain.

As we carry out a detailed and detailed study of the cases, it does not require the presence of a sample. To understand psychosocial and somatic problems and to explain them, our study focuses on Gaulois, a patient hospitalized at the neuropsychiatric center Joseph Guislain for symptoms of paranoid schizophrenia.

Our patient is a man over 24 years old, a member of a wealthy family of the place. He manages in a butchery his father gave him when he won his state diploma. He started university at the University of Lubumbashi at the Polytechnic Faculty, but he was very smart, but when he took down his state diploma he started to break up with a bad company of friends.

According to the complaints of her mother-in-law who would have brought her to the center, the third of a large borderline family of 10 children from three different mothers, the first two of whom have already died one of the other, the third she is alive ; the subject is long in size

"schizoid". He is quiet smokes and drinks too much alcohol, he also takes drugs that we do not know because the person who testified to us was seeing drugs but only did not know what kind of thing he was doing. became very aggressive afterwards.

3.1.2 Method and Techniques

a) Method

The method is defined by Winnicott, (1985, pp198-199) as a set of steps that the mind follows to discover and demonstrate the truth. It is also a set of reasoned steps, followed to reach a goal heard. He later says that the method is the quality of a person who acts with logic and organization. In the end Winnicott says that is called method the main rules on which the teaching is based. The practice of an art of a technique. As part of our research, we used the clinical and experimental method. According to Jean Piaget (1985, P165), the clinical method is more flexible. It is intermediate between simple observation and the actual experience. It consists essentially of an interrogation. It cannot therefore prove the existence of laws, but it can provide clues and create hypotheses.

b) Techniques

If the method is a road to go to reach a goal the technique is on the other hand a tool, a means, a set of the processes to collect the information, which relates to the practice, the know-how in an activity a discipline, which concerns the applications of scientific knowledge. As part of our research, we used the following techniques: interview technique, clinical, observation, psychotherapy support Manual Diagnostic and Statistical of Mental Illness (DSM IV).

c) Technical maintenance

According to Carl Rogers (1977, p244) the clinical interview allows us access to the most personal representation of subjects: history, conflicts, representations, beliefs, dreams, lived events, etc. It is an irreplaceable tool in the field of the human sciences and even more so in the field of clinical psychology where it is necessary to understand the origin of different psychopathologies and to understand the psychological functioning. Indeed, only the patient can to say "where" and "how" it suffers, so you have to listen to it.

d) Observation:

The notion of observation, as pointed out by Kohn RC and Negre P (1988, p 41-42), in their study on "The ways of observation" indicates both an action, its result and the technique used. Observation refers to a time in a knowledge process (usually the first, the exploration phase) an instrumentalisation, that is to say the type of action developed by the observer, as well as the data collected. In fact, the purpose of observation according to the above definition is the acquisition or development of knowledge, the creation of new meaning. The observation supposes to go to the real, to discover a novelty, beyond what appears under the appearance of already known. Observer supposes a new position, breaking with what has hitherto turned the gaze.

e) Documentary (DSM IV TR.)

For each mental disorder, specific diagnostic criteria are proposed to guide the diagnostic process. Indeed, their use increases the agreement between the investigators. The correct use of these criteria requires a specialized clinical training to acquire specific knowledge and clinical skills. The purpose of the DSM IV (1993, p. 41) in our research is to provide clear descriptions of the diagnostic categories of disorders, so that clinicians and investigators can diagnose various disorders such as paranoid schizophrenia, let's finally say that the DSM IV is a tool that has guided us even before approaching our subject by giving us a classic identification of existing psychiatric diseases.

f) Descriptive analysis

The description of the data serves to structure a portrait of the results of the research that is such that it allows to understand qualitatively as well as quantitatively the behavior of the subjects. Two extreme strategies must be added: the first is to focus all its attention on so abstract statistics or numbers that one must lose touch with the psychological significance of the phenomena observed; the driving lesson to be poured into the study too detailed details each recorded performance; which is better suited to a clinical report than to a scientific research (www.doctimopsychologie.fr, p12-22)

4. Description of the Patient Examine

4.1 Presentation of the sick subject

a) Identity

Penon: Gaulish (pseudo)

Place and date of birth Lubumbashi the 17-11-1988 size one meter eighty long

Tribal and religious affiliation: Kasai luba and Catholic

Socioprofessional ambition: complete your university studies in Romania via a scholarship.

b) Antecedents

Organic antecedent:

Hospitalization for malaria at the Sendwe referral hospital three times;

Hospitalization for alcohol overdose

Antecedent marital:

Nothing to report, our patient is single with a child he was at the age of 16, and who stays with his mother-in-law; Orphaned mother since the age of eight.

Personal antecedent:

Studied second at the University of Lubumbashi at the Faculty of Polytechnic and salesman in his butcher shop.

Psychiatric history

Two consultations and two hospitalizations in psychiatric for behavior of manic pace.

His paternal tent living in the nearby town of Likasi reportedly suffered from Manic-depressive disorder at a young age (17 years). She was treated at the neuropsychiatric center in Kinshasa for three weeks.

Family history

Borderline family, reconstituted several times.

c) Biography

Our patient named Gaul is 24 years old, until then studying at UNILU at the Faculty of Polytechnic in second graduat, he comes from a family of 10 children, two of them for the first woman, four for the second woman, and the last fourth are for the third woman who is alive and the two previous ones already deceased.

The first died in 2001, the second in 2007 and currently Gaul remains in his tent because the relationship between him and his mother-in-law is not very successful.

In 2007 his father offered him a trip to Belgium to refresh his memory, where he went for a training as a hotel chef where he started his training after a period of three months of training, Gaulois integrates a gym where he finds a company of drug addicts and succumbs to the consumption of strong drugs the faster he becomes addicted, almost before the end of his stay in Belgium he falls ill after the examination, psychiatry, the doctor detects a disorder of behavior, and his father requests a repatriation to Kinshasa at the neuropsychiatric center. After a long period of care under NosinantTegretol, Aldol and Largatile. He regains his health in partial remission, he returns to Lubumbashi. He resumed his studies at the Faculty of Polytechnic and housing the university cities. For him, it is a debauchery and will dive again into the catch of toxic substances such as hemp, cigarette and alcohol. He will end up relapsing.

His tent and his father take him to the neuropsychiatric center where we met him for the first time, observed: disorganization of language is striking here. Without reaching the degree of a schizophasic where the language becomes totally indecipherable, nor to constitute a glossolalie invasion of a personal language, this one is very particular. We will note the disjointed and often incomprehensible character of the cock-to-the-body, sudden stops, verbal stereotypies, the impression of a monologue, addressed only to himself and where the language has lost its function of communication with others note also the absence of neology in these remarks.

A delusional activity exists here, but the patient's comments are a reflection of a profound disintegration of the course of thought, so that no coherent delirious organization exists. One could certainly raise the presence of ideas of influence, of duplication of bodily transformation and even of persecution, or even emphasize the existence of visual auditory verbal hallucinations, to see cenesthetic (what one does to him during the night)

One could still try to make it part of hallucinatory and interpretative mechanisms, illusions or intuition. However, this semiological analysis, which would have all its value in systematized chronic delusions, risks masking here the essential constituted by experiences of fragmentation and depersonalization whose expression remains vague and imperfect. This highlights the interest of the concept of delusional structure in this case paranoid.

d) Clinical Diagnosis According to the DSM IV

Indeed, we note that the patient has a symptomatology of paranoid schizophrenia that has been manifested for more than five years: withdrawal, dysphoric mood, isolation, indifference, mistrust, insomnia, decreased appetite, fatigue, isolation, logorrheic and incoherent language, autism, difficult contact, inability to do less work in a concentrated way; lack of communication with the entourage, the presence of persecution delusions and auditory and visual hallucinations.

So says:

Axis I:
Paranoid schizophrenia

Axis II:
Schizoid personality disorder;

Axis III:
Malaria poorly treated and taking toxic substance such as high-effect drug, advised against it by his psychiatrist and psychologist.

Axis IV:
Pressure and disagreement with her stepmother and half-siblings
His withdrawal into everyday life;
Missing his cooking training in Belgium;
The Deceit of his regretted mother from his infancy;
Their family rank and their behavior in the sick period.

Axis V:
Based on the information obtained from Folstein's Mental State Examination assessment test, we found that the patient currently has a mild deficit after a four-week period in the middle and at the end of ten weeks. support psychotherapy sessions on our part and treatment by the psychiatrist.

4.2 Conduct of supportive psychotherapy sessions

In this part we will present the succession of psychotherapeutic support sessions we had with our patient Gauls

1) Purpose of psychological support sessions

Supportive psychotherapy sessions aim to achieve symptom improvement or a relaxation of rigid attitudes, often in combination with other therapeutic means (Psychotropic Drugs). The psychological action is carried out by reinforcing the mature and adapted psychological defenses of the patient and without looking for an in-depth reworking of the personality. The method used is variable according to the therapist: it is above all to establish an open and warm relationship with the patient, based on tolerance and empathy (the therapist wonders what his patient feels) . The therapist's interventions are active: counseling (the use of which must remain cautious and nuanced, otherwise the child will be excessively infantilized), encouragement and promotion of positive attitudes, suggestion and persuasion, help verbalizing feelings. The interviews may also aim to inform or even educate the patient about the disorder he is facing in order to strengthen the therapeutic alliance with the psychiatrist or doctor.

2) Conduct of the sessions:

At the heart of our psychotherapy we have scheduled ten sessions with a duration of 45 or 50 minutes each, it should be noted that other sessions did not even 30 minutes saw the fatigue due to psychotropic

a) First session of October 20, 2017

It consisted in getting to know our patient who was at his first consultation and hospitalization, this first was not successful following the aggressiveness of Gaulois who was increased catatonic look, we just got his name and the following n was insults and monologue. This session was facilitated by his father:

To have the demographic information of the client the history of the patient, the psychological support, the access to the specific problems of the client (psychosocial problems), the knowledge of the physical health problem. All this information coming from her dad who brought her to the center.

b) Second session of October 24, 2017

This session, a little fruitful because after a sedation by psychiatric nurses, Gaul became a little aware but accused his dad of malice because he brought to the center of fools (according to him). That day, we started again with the identification of our patient, we asked him the reason for his hospitalization, he told us that his parents say he talks too much, sings too much, he gets too angry, they even say that "I strike on the passers-by". After a period of forty minutes, Gaul told us that he needed a break, and we had stopped the session.

c) Third session of October 28, 2017

At this session, we called on Father de Gaulois to give us his version of facts about his son's illness from the beginning of the disorder until the reappearance of new symptoms. His Father came five days after our invitation. And according to him, his son is responsible for his suffering because he does not respect his cure and appointments with his medical team and he proposes that for him to give up toxic substances, that he stays a little longer in the center, this time can help him to take his products and respect the appointments of the clinical psychologist. After an hour of maintenance, We ended the session there. The father promised to answer us about his son's move to a foster family soon;

d) Fourth session of December 02, 2017

We arranged a meeting with his small family which was composed of two parents and his two brothers, in which, we wanted to have their versions about the suffering of their child, or brother and try to study in a fast way, the affection they bear in their brother suffering. We noticed that the mother-in-law of Gaulois did not show affection towards this one because it gave only bad sequences of facts during the suffering of Gauls, that in the concern to ask that the center keeps it during a long time, so that he does not enjoy the goods of his Father, for the benefit of his child

e) Fifth session of December 07, 2011

Here, we started the support itself, after explaining to Gaulish why his unusual symptoms. Just after this explanation, the patient became gradually aware and

confided that "if I took drugs it was because my father, although occupying a good place in the Provincial Government, He offered me not even a workstation. He wants to believe too much in what his wife tells him about me; He does not offer me a job and always likes me to reach out and ask him everything. This situation makes me sick and too furious when I think of my Mother. If she were here, I should not suffer. That's what makes me go off by taking toxic substances. "When he said this last word, it was noticed that he made a kind of intrusion and started to cry. This meeting took us all hours and ten minutes.

f) Sixth session of December 15, 2017

At this meeting, we had his father come again to inform him of his son's grievance. The father came with his younger sister. We prepared Gaul because he did not get along with his father all this time, and on the parent side we did the same, so that our meeting, which was also important is going very well. We explained everything that Gaul told us about what motivated him to take toxic substances, and not want to successfully follow the appointment with all his medical team. The father acknowledges that his son had asked him, since his return to Lubumbashi, a job to support him, and that he was independent. The father acknowledges all these complaints and testifies that he has never responded positively, he adds that "if I take into consideration what his mother-in-law tells me, it's because she spends a lot of time together the House with Gauls and that it checks any exit and entry of Gauls in the parcel ". This is how we suggested to the father of Gaulois to seek an occupation for his son to fill the holes he feels. Since her mother-in-law is blocking contact with her father, she wants to look for a warm family where her son will stay after hospitalization so that our supportive psychotherapy will bear fruit.

g) Seventh session of December 26, 2011:

The patient, thanks to the care administered and thanks to the psychological support and the daily interviews which we took with him, he began to see things in their realities and we noticed a spatio-temporal recovery and the absence of hallucinations and delusions. He becomes aware, and seems to listen to us, he testifies that he was very happy when his dad listened to him, because it had been three years since they collaborated more. So, we also reminded him that his father was also delighted to hear this grievance again and promised to solve some problems so that he recovered his health. Very happy, Gaul began to evolve very well on the mental plane. Very cooperative at this session, we took advantage of this time to explain to him that if he suffers, it is because he does not have several times to respect his cure, and that against the malaria. He remembered, and acknowledged once again for the behavioral disorder dealt with at the Neuropsychiatric and Psychological Center of Kinshasa. And this time, he no longer abandons his cure and follows with interest, especially the advice we gave him: "You will not come back here to the center bound by your brothers, but you will come to see us for control peacefully ».

h) Eighth meeting of January 15, 2018

At this meeting, his father came back to tell us that he found an occupation for his son. He says he has increased the items in the Gaulish butcher shop, bought a new freezer. And in

this regarding his move to another family he agrees he says: "the trip will be done at the desired time and he would like to stay in the center for his health ..."

i) Ninth meeting of January 30, 2018

At this session, Dr. Bora finds that after a period of internment of two months in the center and noticing well on a good evolution towards a cure, proposes that it can leave. While responding to medical appointments. For our psychological support, the Doctor suggested that we make appointments at home to continue the psychological work. However, before his departure, we talked with him and his father about the respect of the instructions given by ourselves and to respect the cure of his son, by not attending his old friends. We have listed the misdeeds of the drug on a person who consumes pharmaceuticals.

j) Tenth session of June 26, 2012

This is the one where we administered the Folstein test to our patient in the host family he chose in the city of Likasi from one of his maternal aunts. Gaulois recognized us. He asked us if we were also residents of Likasi or if we came to check if he continued to consume toxic substances. After a while, he began to tell us that he is fine now, but only the drug he continues to take is too much. And his aunt revealed to us, that Gaul is gradually going well and that he no longer manifests a recurrence After a two-month period of psychotherapy with ten sessions each of which took 45 to 60 minutes we noticed a considerable improvement in Gaulois say that other symptoms have disappeared, it was revealed to us by the Folstein test and the evaluation test of Mental Deterioration, we noticed through the score obtained, that the patient currently has a slight deficit. . So to be more explicit , the symptoms such as: isolation, indifference, insomnia, delirium, auditory and visual hallucinations, lack of communication with his entourage, logorrheic language, spatio-temporal disorientations have disappeared.

5. Conclusion

This study concerns the application of supportive psychotherapy strategies to a victim of paranoid schizophrenia interned at the Joseph Guislain Neuropsychiatric Center in Lubumbashi.

We were concerned to know what psychological maneuver would be of great necessity, and of great efficiency in the gradual recovery of the frequency and intensity of the symptoms causing this paranoid schizophrenic disorder.

We hypothesized that psychological support would help restore the mental health of our paranoid schizophrenic patient.

In carrying out this study, we pursued a primary objective: that of providing psychological support in order to help the victim of Paranoid Schizophrenia to recover his health. And as a goal to produce a support that will allow researchers in clinical psychology and care staff of the Neuropsychiatric Center to properly care for the mentally ill. In doing so, scientific interest lay in the contribution of the techniques and processes of supportive psychotherapy. Based on the

results obtained, we say that our objectives have been achieved.

Our research was conducted at the neuropsychiatric center Joseph Guislain. This delineation was motivated by the ease we had during our professionalization internship at the Joseph Guislain Neuropsychiatric Center. Given the quality of our work and also the object of clinical psychology that of the study and the total understanding of the subject in its singularity; we worked with a case. Because each suffering subject is "unique" and presents his own problems, which differ from those of other subjects. Thus, to achieve the expected results, we used the clinical method. This approach was based on the following techniques: clinical interview, clinical observation, documentary technique (DSM IV), descriptive analysis and supportive psychotherapy.

Apart from the general introduction and conclusion, our work is structured around four chapters that explain this research in detail. The first chapter deals with the theoretical and conceptual framework, the second with supportive psychotherapy, the third with the methodological framework, and finally, the fourth chapter with the results of the research. Before our intervention we find that our patient is characterized by isolation, indifference, mistrust, decreased appetite fatigue, logorrheic language and incoherence autism, difficult contact, inability to do a little work so concentrated presence of persecution delusion and visual auditory hallucinations. Before the therapy, our patient had the following symptoms.

Thus, a therapeutic diagnosis was made which led to the therapeutic objectives. In view of this situation, ten sessions of supportive psychotherapy were organized, followed by an evaluation five months later, following a management of permanent supportive psychotherapy and adapted psychiatry in the complementary application of the various strategies. The remarkable changes observed in the patient are as follows: The patient no longer hallucinates, he no longer hears the voices and sounds he heard before, He no longer deliriums he is able to count his story correctly. He is no longer aggressive, he controls everything that comes out of his mouth and no longer monologue.

At the end of this result which we used as verification, we confirm our hypothesis by saying that the psychotherapy of support, supports the recovery of the mental health of a paranoid schizophrenic patient called Gaulois. On the emotional and sentimental level: we noticed the decrease of grief, guilt, and feeling of helplessness. On the behavioral level: the subject has readjusted his maladaptive behavior. He locks his door before going to bed. Functionally: the increase and harmonization of social relations with his father and his brothers, as well as the desire to go about daily activities. So we can say that our patient regains his normal mental health and leads a life without complaint.

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Works

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