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ANTISOCIAL PERSONALITY IN PARANOID SCHIZOPHRENIA - THE FORENSIC RISK

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Abstract

Motivation: The concept of paraphrenia is preserved for the chronic forms of schizophrenia and denotes a systemic delirium with hallucinations, its nature being a magical one, a pathology of imagination. Objectives: Presentation of a 35-year-old patient requiring treatment with Clozapine, followed by electroconvulsive therapy due to the persistence of pseudo-hallucinations and the delusional idea of both macromaniac and micromanic, the adjoining experiences being aggressive and violent. The premorbid personality of the patient indicates towards the antisocial zone. Hypothesis: The 7-year detention for acts dictated by antisocial personality disorder was the trigger for decompensation in an Axis I pathology, the patient developing a delirium centred on aggression and violence, by replacing behavioral acts with the pathology of imagination through the disease. Method: prolonged admission, clinical interview, psychological tests (PANSS, BPRS, GAFS, life quality scale), observation, clozapine treatment, ECT. Results: The onset of the disease was at the age of 24, the patient presenting 27 admissions, the latter being dominated by hallucinations and pseudo-hallucinations, xenopathy, cryptomnesia, neologisms, along with formal and content disorders of thinking (circumstantial thinking, tangentiality). He was treated for six weeks with Clozapine 400 mg + Amisulpride 400 mg + Flupentixol 20 mg 1 capsule every two weeks, after which the electroconvulsive therapy sessions were started. Conclusions: The paraphrenic form of schizophrenia responds better to ECT than to line II neuroleptic, with the particularity of rapid action on denial and cosmogonic delirium.

Keywords: Paranoid schizophrenia paraphrenic type, Cotard's syndrome.

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1. Introduction

Schizophrenia and antisocial personality, as autonomous disorder have been associated with a higher risk of violence. Numerous studies in the field of forensic psychiatry have confirmed a close causal relationship between the violent offender and comorbid psychiatric disorder. It confirmed that individuals with antisocial personality disorder in comorbidity with mental disorders are more criminally active than other perpetrators of violent acts. Comorbidity influences the assessment of criminal responsibility but may also affect the outcome of treatment and risk of relapse. The criminal activity of this comorbidity is interpreted as a result, among other things, of the fact that antisocial personality traits are regarded as being almost untreatable (Filov, 2019).

Patient I.A. comes from a socio-economically modest family, composed of a mother "without soul" ("Mother no longer has a soul, the soul is a component part of which another world benefits, the soul is divided into a thousand parts"), and a father whom the patient describes as such "Father was small, very small with a very small head" and a brother with a similar psychiatric diagnosis ("He sees things too, but other than the ones I see").

He graduated 12 classes, passed the graduation exam on the second attempt, obtaining the grade 6; asked about the school situation, he says about himself: "I was uncultured, I had to repeat, I was handicapped" (his entire delusion seems to overcompensate the intellectual deficit). Later, he settled in Madrid, Spain, where he received a seven-year criminal conviction at the age of 24, cumulated for several deeds, the first being for verbal and/or physical violence towards the police and the next for violent theft.

The patient is currently retired medically.

2. Problem Statement

The 35-year-old patient has a psychiatric record in a psychiatric hospital from 2014, with multiple admissions, approximately 30. He tells about the onset of psychotic phenomena through auditory hallucinations following the commencement of detention. The first psychiatric consultation takes place during detention, concluding the reduction of the sentence from 7 to 4 years with execution. In 2013 he is sent back to Romania and in 2014 he presents himself to the psychiatric hospital for the first time, brought by the Police for acts of violence with bizarre behavior, then receiving the diagnosis of an acute psychotic episode.

Subsequently, with the persistence of the psychotic behavior modification, in 2014, at a new admission, the diagnosis of paranoid schizophrenia is outlined.

There have been a number of admissions through non-compliance to treatment, where, in most cases, the patient was brought by the police for acts of verbal and physical heterogression, namely, psychomotor agitation on a psychotic background, driven by alcohol consumption.

In the case of the current episode, the patient is brought to the Emergency Room, accompanied by the Police, along with his mother, presenting: psychomotor agitation with physical and verbal heteroagresiveness, ideological and verbal incoherence, disorganized behavior, symptomatology induced by non-compliance to the treatment. He is admitted non-voluntarily in an urgent matter, according to Law 487/2002. About the current admission, the patient states, "I did not slap, nor did I swear at any neighbour."

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3. Research Questions

The present case raises forensic problems, given the patient's degree of danger, which is why the main question is whether long-term admissions are useful in the Chronicle of a normal psychiatric hospital or if it would not be more appropriate to trigger the procedure for final medical admission to recovery or the removal of any state of danger.

This is a necessity because multiple admissions were spread out by short periods of time spent outside the hospital, all the presentations in the Guard Room being due to acts of aggression on the family (due to affective inversion) or to neighbours (the patient having delusional interpretations about the fact that they were his persecutors).

Until now, the person in question has never committed a particularly serious murder, but his 27-year-old medical history, as well as the seven-year detention period, has brought the case to a judicial perspective.

Another research question is related to the possibility of coexistence of an Axis I disorder (in this case schizophrenia) with an Axis II disorder, as is the case with the Antisocial Personality Disorder. It is worth mentioning that the specialized literature postulates how the antisocial phenomenon can be found in many psychiatric pathologies, criminality not directly related to the axis I disorder, but to the dynamics of personality. Thus, there are multiple medical quotes in which such patients commit crimes not due to psychological pathology (such as the imperative auditory hallucinations or delusional idea that dictates the gesture), but because of the antisocial personality, characterized by the absence of empathy, the lack of remorse, the inability to conceives guilt, conceptualizes the consequences of actions, mentality deficiency.

The person concerned does not have the moral or social features, the community milestones or his human social identity, for such pathologies to be taken into account and the opportunity of a year-old hospitalization in a hospital for special security and protection measures against a penitentiary hospital

4. Purpose of the Study

We are trying to show that in such a patient, the Supra-Self is missing, and this absence is somewhat ahead of the development of the Axis I disorder so that the schizophrenia damage overlaps from the start without the absence of personal and social identity.

Consequently, prolonged admission in a context of supervision and even detention replaces the symbolic "walls" of an Eu Supra, containing the aggressive destructive pulses of the patient.

Although one of the purposes of the study is to demonstrate that with the development of a more imaginative and confusing delusion, the degree of danger and the passage of act (by symbolic devising devastating actions for humanity) decreases the degree of danger of such a patient remains a widely debatable notion, whose degree of fidelity depends on the security of others.

The patient has a hilarious delusion that might make you think of a "Gulliver in the Land of the Dwarves," a mask under which danger can be hidden until a crime is committed.

Cognitive impairment and conceptual disorganization dictated by schizophrenia does not reduce pulsatility but, on the contrary, it accentuates it, making it capable of moving to excitement explosive acts, by shorting the field of consciousness, and acting like it / do". The patient, with the antisocial personality

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of the personality, the rudimentary development of the Self and the absence of mature defense mechanisms, is able to live exclusively from the primary sphere (anger, hatred, revenge), all of which is developed on the size of a negative charge, in which he remained incapable of expressing affections in the mercy range, emotional adherence to another, experiences of gemelarity and identity with suffering.

The purpose of presenting such a patient is to delimit vermouth psychiatry from forensic psychiatry and demonstrate the benefits of long-term institutionalization.

5. Research Methods

5.1. Observations:

At the time of the admission, the patient was conscious, presents psychomotor agitation and poor cooperation. He is oriented in time and space and has the ability to recognize himself and others. His clothes are relatively neat with partial hygiene. There is a shallow scar of the face. There is a hypermobile mimic, accompanied by large gestures, the tone of the voice is high, with particular inflections that are consistent with the content of the speech (Öhman, 2008).

There is a smile of superiority, loaded with particular meanings. During the medical interview, he stood up eagerly at least once, continuing to gesture broadly in relation to the speech (APA, 2013).

5.2. Perception:

When it comes to perception, both quantitative and qualitative disturbances are noted.

Quantitative disorders include irritability, hyperesthesia.

The qualitative disorders that were noticed:

- hallucinations and auditory pseudohallucinations of the complex type, presented in the form of imperative voices with rich content, causing the consecutive change of behavior: "We are on this side, we hide the truth about you and the House of the People" (the patient claims to scratch his head as a defensive behavior to get rid of these voices). The risk we face in the face of such imperative hallucinations is self-aggression: "The Devil came and said to me, climb up to the 7th floor, then down, then sit on the window, then drink juice " (note the change of content from a neutral, familiar one to a self-aggressive one and vice versa) (Davies, 1983)

- visual hallucinations

- proprioceptive hallucinations

- visceral hallucinations of the zoopic type, with experiences of changes to the body scheme: "I'm transforming into an animal"

- auditory pseudohallucinations, in the form of a unilaterally present voice: "A part of my head tells me to rape a little girl"

- tactile pseudohallucinations felt in the intimate area: "I did with Cleopatra from a distance, she gave me this feeling and something beautiful was tied"

- illusions of changes to the environment, psychotic feelings of derealization: "I was sleeping in a room and waking up elsewhere"

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- illusions of change the body scheme, macropsy related to one's own person ("I had 15 times larger legs") and micropsy related to other people ("Dad was small, very small, with a very small head, with his little hat") (Frick, 2014

- illusions of people: "The bayonet Jesus took, he gave it to me, and then I turned to Jesus"

- a synesthesic outline: "Sing a symphony of 100,000 towers and I saw all these things at once."

5.3. Attention:

There is a dissociation between spontaneous and voluntary attention, the patient is easily distracted by insignificant peripheral stimuli.

5.4. Memory:

Quantitative difficulties present within patient I.A. are fixation hypomnesia, coupled with selective hypermnesia with the exaggeration of certain dates, facts, and integrated interpretive-delusional events (Trifu, 2014).

When it comes to qualitative difficulties or paramnesias, we encounter both disturbances of the instant memory synthesis, the so-called "memory illusions", such as cryptomnesia or the theft of memories ("You do not know, I'm Predator 3, I did everything they show in the movie"), as well as disturbances of remembrance of the past, allomnesia, Pick confusions or "hallucinations of memory" ("I was sent to Balaceanca Hospital because I wanted to rape a little girl") (Mar, Oatley, Hirsh, de la Paz, & Peterson, 2006).

5.5. Thinking:

Analyzing the central cognitive function of mental life, we find shortcomings in the thinking operations, such as the weakening of logical associations, with disruptions of the abstraction-concretization ability, the patient sinks rapidly from reality to a metaphorical world and vice versa: "I am a devil everywhere because I have seen the movie with the Devil's Lawyer." We also report quantitative rhythm disturbances (accelerated ideological flow) and coherence (Gabbard, 2013). The incoherence of thought is supported by the disorganized discourse with tendencies to changing often, alongside illogical constructions: "I want to take my Clopixol without the Police, and that means they did not terrorize my neighbours." We note the existence of circumstantial speech ("The police took me away for nothing ... because it was a plate ... there were two women with fake breasts ... that is, from aluminum ... I actually just passed by them") and the tangential answers (to the question "Do you hear voices in your ears? ", the patient responds," That part of me changes, being demons").

In addition to the quantitative disturbances of thought, we also draw attention to the content disorders in the patient's speech:

- delusional interpretations: "I know I can make my penis 666 million km long, because 666 came up on my calculator"

- delusional ideas of denial, accompanied by macromanic feelings of grandeur and omnipotence (Hettema, Prescott, Myers, Neale, & Kendler, 2005): "I had my heart cut off with a sword, but it reproduced back"; "I got a guillotine to the face and big tubes to my head but I still hold on"; "My whole throat was

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cut, but it regenerates", "They cut my right hand, but I found it" "My mother has no soul, the soul is a component of the other world, the soul is divided into a thousand parts, this is what Christ did and that is why he became the Devil's Lawyer"

- megalomaniac delusions of grandeur: "I produced the tsunami in Japan." "I buried all of them alive, I did not fight with people, I fought demons." "I destroyed the Ceausescu family house, I used acid."

- delusional ideas with a rich sexual theme: "A girl left her white orgasm because I have a 666-million-kilometer-long penis, not to mention the pushing force." "I was supposed to have children because I had sex at the same time with that girl, but I have sealed hormones, but instead, a part of my head tells me to rape a little girl"; "There are violet, ultraviolet orgasms, I practiced them, I was with all women."" I was in a relationship with Cleopatra and everyone is jealous of me, 5 ovaries jumped from her. "" Satan no longer has penis, only I have one, and the demon with whom I had sex was screaming with pleasure in Japan."," They all made love to each other, men and women (non-differentiation experience), "I took the first girl's virginity at age 7"

- Parasitic delusion: "Through my body have passed billions of cestodes per second, I barely managed to keep them in my body"

- Delirium of fantasy and magic, encompassing the cosmogonic idea, along with pseudo-remembrance and cryptomnesia: "There have been dragons, hyenas, demons across the apartment building, it was a luminous apartment building, we made 80 hearts with clover," "The brain was on fire from a light, ""I produced the tsunami that destroyed Japan, "; "A tsunami will hit the earth, another earth will be made and 800 billion planets too";"A priest and a little toad made love, I caught the little toad and that's why two intersonic trains have deviated. "

- Delusional mystical idea (Trifu, Marica, Braileanu, Carp, & Gutt, 2016): "I was exorcised, the Alien bit me, it wanted to get rid of me and decapitate me."

- Ideas of xenopathic control: "When the Police comes to take me, I do not yell, someone else screams through my mouth, the devil was coming"

CAUTION!

The theme of the delusional idea is one dominated by aggression and violence (swords, seams, cut hearts and throats, concrete slabs that crush, torpedoes, dragons, hyenas, demons).

Arguments in favour of Cotard syndrome: immortality (reproduced cut heart, cut and regenerated throat, "I was pouring concrete on myself and nothing was happening") + enormity (the 9 billion tons plate, the 666 million-kilometre penis, the plate of 1 million tons, 80 hearts, a soul divided into 1,000 parts, a 5000-meter Arnold Schwarzenegger, symphony of 100,000 towers) + death concerns ("Satan is dead before being the tomb").

Arguments against the Cotard syndrome: the affective experiences that accompany the macroman delirant idea are from the spectrum of grandeur and omnipotence and are not of depression-micromanic nature (Hodges, Myers, & Michael, 2007).

5.6. Language:

- Neologisms, presented in the form neoformation, starting from meaningful roots, expressing particular spiritual experiences, for which the patient does not find a correspondent in the usual language:

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"bionical women" - women without meat and bones, 10 times bigger, who had sex for 7 hours and exploded; "lit apartment building"

- Associations by contiguity: "I was annoyed when I had sex and I made this noise ... The noise comes from the Predator ... That means I was a predator in the house." - the use of diminutives: "Father's little hat", discordant to the aggressiveness of the patient's speech.

5.7. Emotionality:

The mood is hypertimic, hostile-aggressive, with potential of being irritable and low frustration tolerance (Kay & Tasman, 2006).

5.8. Activity:

Psychotically motivated odd behavior can be easily observed, going as far as psychomotor agitation (present at admission). The behavior is unpredictable, with potential of aggressiveness and instability tendencies (Nevid, Rathus, & Greene, 2014).

5.9. Sleeping pattern:

The patient talks of mixed insomnia (of sleep and waking up). Sleep is currently induced by medical drugs.

5.10. Instinctual life:

Food behavior is preserved. The patient, on the other hand, has increased concerns about erotic life and alcohol consumption. In his personal history: occasional substance use (prior to the age of 24).

5.11. Consciousness of the disease:

The patient has no criticism of the disease.

5.12. Psychological examination:

The last psychological examination was performed on 09.01.2019 at a previous admission.

It has been concluded that the patient has a hyperthimic mood with angry, irritable, with a memory mild prosexic deficiency, a polymorphic delusion with delirious interpretation, accelerated ideological and verbal rhythm. The personality is psychotically influenced, with socially and capabile efficiency diminished. (Tandon, 2008)

GAFS = 38/100

6. Findings

6.1. Syndromes

Starting from the psychiatric description above, we can systematize the present symptoms in the following syndromes:

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- Psychomotor agitation syndrome: abnormal behavior, disturbed (instinctive / affective) motor disorder and disorganized pulsations reaching out of voluntary control through a particular affective state, a delusional hallucinatory state with destruction of consciousness (Trifu, 2014).

- Paranoid syndrome: delirium without systematization, with persecutory content / suspicion + hallucinations, especially of auditory, imperative ones.

- Clérambault's mental automatism syndrome: The syndrome consists of the patient's conviction that his thinking is no longer his own + pseudohallucinations + delirium of influence (xenopathy) (Kaplan & Sadock, 2001).

6.2. Diagnosis

Taking into account the previously exposed symptoms, we claim that the diagnosis of Axis I is paranoid schizophrenia. From the DSM-V criteria, the following are met:

Criterion A – presents for a significant period of time in one-month delusions, hallucinations, disorganised behavior (3 out of 5 are present, 2 are sufficient for diagnosis or even 1 if the delusion is bizarre or the voices are commenting.);

Criterion B – for a significant part of time, work, interpersonal relationships and self-care are affected;

Criterion C – Signs of disturbance are present continuously for a period of at least 6 months, when those included in criterion A have been present for at least 1 month even under treatment;

Criterion D – To exclude mood disorders (schizo-affective disorder, depressive and bipolar disorder with psychotic elements);

Criterion E – Excludes conditions associated with use of substances and medicines;

Criterion F – A pervasive developmental disorder is excluded.

Axis II: Personality traits in the antisocial spectrum

Diagnostic Criteria of DSM IV Antisocial Disorder:

A. There is a pervasive pattern of disregard and violation of the rights of others from the age of 15 years, indicated by 3 (or more) of the following:

1. Incapacity to comply with social norms related to legal behaviors, indicated by the repeated committing of acts that are grounds for arrest

2. Incorrectness, indicated by repeated acts of lying, use of alibi, manipulation of others for profit or personal pleasure

3. Impulsiveness or inability to plan ahead

4. Irritability and aggression, indicated by repeated attacks and fights

5. Recklessness for one’s own safety

6. Considerable irresponsibility, indicated by repeated incapacity to have a consistent attitude towards work or towards honouring financial obligations

7. Lack of remorse, indicated by being indifferent or justifying whe they have caused suffering or have stolen from someone

B. Antisocial behavior does not occur exclusively during schizophrenia or a manic episode.

C. The individual is at least 18 years of age.

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D. There is evidence of an onset of behavioral disorder before the age of 15.

The subject fulfils criterion A of the diagnosis, supported through verbal and mental hetero aggressiveness, along with conflicts with society, forensic history of theft, violence, imprisonment. According to the patient's report, there is also the possibility of onset in the form of a Conduct Disorder in his adolescence around the age of 12-13 years old, with possible episodes of early violence. The uncertainty of the conduct disorder and the overlapping of the diagnosis of schizophrenia (even if it started after the violent acts) do not allow clear diagnosis in the second axis of the antisocial personality disorder, allowing us to take into discussion only antisocial personality traits.

Axis III: absence of somatic diseases

Axis IV: alcohol pathology, forensic conflicts, lack of social network.

Axis V: GAFS = 35 point

6.3. Differential diagnostic with axis I (Paranoid Schizophrenia):

6.3.1. Schizo-affective disorder – expansive episode: an argument for, is the expansive nature of the speech through its grandeur and omnipotence, which affects the process of thinking rather than the emotionality (mood), which advocates for the diagnosis of schizophrenia. Also, during the counter – transference, the patient does not contaminate his presumptive expansiveness.

6.3.2. Paraphrenia: It is characterized by a chronic, hallucinatory systemic delusion, of magical character, whose imaginative abilities go as far as the creation of an imagined world (“I went to sleep in one room and woke up in another place”).

What supports the diagnosis of schizophrenia is that the delirium is incoherent, associated with the destruction of personality, while the paraphrenic patient often retains a mechanism of adaptation to reality.

It is said that in the case of a paraphrenic patient, the more the imaginative delirium gains in fiction, the more is lost from its dangerous side, which cannot be said about the I.A. patient, where the forensic risk is substantial.

6.3.3. Organic personality disorder:

Denying the violent acts (“I did not slap, nor did I curse at my neighbour” “I did not fight people, I fought demons”) brought into discussion the epileptoid raptus, the markers of organic cerebral measured on EEG deny this hypothesis.

The reason for the patient’s speech is the collapse of the concrete slab on his head, which alongise of the clear delimitation of the “demons” on the left brain hemisphere raised the suspicion of a possible TCC in APP, for which CT was requested – it denied intracerebral posttraumatic lesions.

6.3.4. Histrionic personality disorder:

Fascination, seductiveness, impulsivity and manipulation are classic histological features that we can highlight in the I.A. Patient, which could mislead an uninformed eye. However, specialized literature mentions that antisocial, when in contact with psychiatric medical staff, put on a histrionic mask in order to receive special care and attention.

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6.4. Particularities

Schizophrenia, which had a debut based on the background of an antisocial personality with a criminal record of theft and violence, resistant to standard antipsychotic treatment, for which Clozapine (Leponex) treatment is brought into discussion in order to avoid forensic risks.

6.5. Evolution and prognosis:

Positive prognosis factors:

- Acute, late onset
- Significant precipitating factors (detention)
- Premorbid personality at risk
- Positive symptoms

Negative prognosis factors:

- Male
- Multiple admissions over a short period of time (approximately 30 in 5 years)
- Heredo – collateral history (his brother has a diagnosis of paranoid schizophrenia)
- Resistance to treatment
- Lack of insight
- GAFS 38/100

Evolving risks are:

- Forensic complications (acting out, risk of homicide and rape) on antisocial personality disorder under xenopathic control (ruptus on the epileptoid model). Additionally, the patient appears to have paedophilic concerns (Vaillant, 1977).
- Risk of continuous disorganization in thinking and behavior affecting social functioning
- Negative phenomenology risk
- Risk of secondary parkinsonism
- Chronic treatment with neuroleptics
- Risk of non-compliance with treatment
- We do not foresee depression or suicide

7. Conclusion

It is necessary to assess the degree of danger, ie the necessity of prolonged admission in the absence of family support and social support network, in the context of non-compliance with the treatment (Davison, & Neale, 1998).

The semi-permanent continuation of Clozapine treatment, along with an antipsychotic deposit, and the advantages and disadvantages of electroconvulsive therapy are under discussion.

Currently, the patient had an indication of hospitalization, considering heterogression, severe symptoms and non-compliance to the treatment.

Currently, he is treated with the neuroleptic Clozapine (Leponex) 100 mg, 2 + 0 + 2, along with Amisulprid 200 mg and Fluanxol 20 mg i.m. one capsule every three weeks. An argument for therapy with

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Clozapine is the impossibility of achieving complete remission, the patient having multiple admissions for short periods of time, the last hospitalization having happened of several weeks before. The decision was made taking into account the fact that there was no response to the previous 3 attempts with 3 different antipsychotics, recommended over a minimum of 6 weeks, to which non-compliance to therapy also contributed. Previously tested antipsychotics to which the subject did not respond were: Quetiapine 800 mg, Risperidone 8 mg, Amisulpride 800 mg. The forensic risk also militates for "reserve" neuroleptic treatment. It is also important to note that high doses of antipsychotics and rapid neuroleptics do not increase efficacy, only secondary reactions.

Considering non-compliance to the treatment due to the lack of insight and social and family support, the family does not cooperate in recognizing the signs of relapse, we have tried long-acting injectable antipsychotics - 20 mg of Fluanxol every three weeks.

Psychomotor agitation is treated with one tablet of Diazepam in the evening, along with Depakine, 500 mg, 1 + 1 + 1. Electroconvulsive therapy may be considered as a promising alternative to refractory symptoms, and its effectiveness may be considered synergistic with antipsychotic medication. We recall the indications of electro-shock therapy in patients with schizophrenia:

- Catatonia
- Psychomotor agitation
- For treatment-resistant are required 6-12 sessions
- Some forms of onset of the disease:
• Simple schizophrenia
• Hebephrenic schizophrenia
• Schizophrenia with increased depressive traits
• Schizophrenia with perplexity

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