Aggressive potential in psychotic disorders and the evolution of schizoaffective disorders in conditions of imprisonment

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Abstract- The purpose of this case study is to display and present the life of a 28-year-old man sentenced for imprisonment, as a result of the act of murder, being able to classify the case as a symptomatic of the schizoaffective depressive disorder. Genetic baggage, early family stress and the consumption of cannabis built the vulnerability of the patient and predisposed him to the development of the disorder, as a result of the accumulation of stressful life events. Furthermore, physical abuse and imprisonment maintained the evolution of the disease. The patient presents an important damage to his social functions, marked by lack of interest when it comes to his wellbeing, dysphoric mood and inadequate emotions. On top of that, we can notice a disturbance of his alimentary behavior, and impaired motor skills; he is reluctant regarding personal aspects and talking about them, giving short answers.
Keywords – schizophrenia, imprisonment, dangers, hetero-aggressivity

I. INTRODUCTION

Schizoaffective disorder has a prevalence that is 3 times lower than schizophrenia, and it affects 0,3% people among the world population. Regarding gender differences, schizoaffective disorder affects more women than it affects men, and this fact can be explained because the depressive type is more present in women than it is in men. The age of onset is around the young adult age, but it can start at any given time, starting from adolescence and up to old age.

1.1. Relevant anamnestic data

1.1.1. Identification Data

A.D., gender masculine, 28 years old, comes from an urban environment, unmarried, higher education.

1.1.2. The reason why he is executing prison sentence, private of freedom

A.D. was convicted to 20 years to life for torture murder – he stabbed his grandmother with a kitchen kinfe in the cervical area and her skull, following her death (he was 24 years old at the time of the crime).

1.1.3. Life Story

He is coming from a two-parent family, with 2 children (both of them were boys), the patient being the oldest from the two. He was raised by his maternal grandparents who he had a good relationship with, until he reached the age of 10, when he was taken by his parents to live together. After a couple of years, his grandfather died of natural causes. The relationship between him and his parents was harmonious, looking at the documents found saying that he was very close to his parents and liked to show his affection through hugs. He had a conflict of rivalry with his brother, wanting to win his parents' attention. His younger brother says he had an extremely manipulative attitude, following only his personal interest. He had a close relationship with his aunt, his mother's sister, who was leaving in another county. There was no information given about his father.

Initially, he enrolled in Business Administration courses, and after his first year he dropped out and got into Journalism. After his final exam, he went to The Netherlands, and he got a job in IT. Furthermore, he enrolled into a school with this domain, but he never actually finished it. He started using cannabis in The Netherlands and he also started a relationship with his partner. On the background of a conflict with his partner, the patient came back in Romania, refused to return his calls or meet him, and after a few days he committed the horrible crime.

During the arrest period, the patient suffered physical and emotional abuse from the other inmates. After the establishment of his execution regime and him moving to a single room, his condition stabilized – he didn't suffer any abuse.

1.1.4. The storyline of the disease

A.D. didn't report any admission in the mental ward prior to his crime, as reported by his parents. After his deed, the crime author was subjected to a forensic expertise to find out if in the moment of his crime he had discernment. The

psychiatric expertise declares that he in fact had discernment, however he was diagnosed with narcissistic personality disorder with notes of impulsiveness. Throughout his detention, A.D. was hospitalized in Psychiatry many times, and got his diagnosis changed to dissociative identity disorder with depressive episodes, for which he got medication. In the present, he is receiving treatment for depressive disorder, but he is noncompliant to the treatment.

1.1.5. Hereditary-collateral antecedents

After meeting the patient's parents, we have come to these conclusions: mom shows schizoid personality type, while the father is completely functional socially and professionally wise. The maternal grandfather died of cardiac causes. There weren't given any information about the father's parents, arguing that they're „sick in the head".

1.1.6. Tests that were applied

He was hesitant about doing tests that were proposed to him, motivating that it is too hard for him.

1.1.7. The reason behind meeting a psychologist

The notification came from the prison's supervisor, declaring the following symptoms: he is quiet, reserved, he doesn't talk to anybody, he eats very little, he refuses to take his treatment and the big worry is that he can get „worse", like he used to be before.

II. PSYCHOLOGICAL EXAMINATION

2.1. General Appearance

He presents a sloppy appearance, briefly dressed, inconsistently with the outside temperatures - he is wearing a slong sleeved shirt with baggy pants, he is wearing socks with slippers. He had been wearing this outfit while going outside at negative temperatures.

2.2. Orientation

The patient is space-oriented, he presents difficulties when it comes to temporal orientation, but they are not major and can be explained as a cause of his detention; he knows the year and the month we are in. He is oriented psychically, but he does not remember all the people he gets in contact with (because he doesn't manifest any kind of interest to do so).

2.3. Memory and concentrated attention processes

The patient presents hypomnesia (according to the MMSE task), associated with hypoprosexia (according to the Kraeplin task) – the patient didn't manage to give any correct answer, counting in descending order from 100 to 1 by intervals of 7, he gave up very easily to this task („Let's say I don't like math that much."). His difficulties in concentrating his attention are also revealed by the answer he gives to certain questions, he has a 4-5 second delayed response, followed by short, vague answers. For example „Depends" and „You know how it is…". He refused to complete the BDI task, motivating it is too hard for him.

2.4. Motor performance

We can identify catatonic stupor, illustrated by a resistance to commands and by maintaining o rigid posture: he refuses to sit on a chair as he sits with head down and his hands behind his back. We can also notice the decrease of his motor performance, associated with the delay of cognitive processes.

2. 5. Perception

Declaratory, the patient has not suffered from hallucinations in the past and still doesn't. We don't notice any delusional ideas.

2.6. Thinking

At the level of thought we can distinguish some elements that can allow the stand of delirious ideation:

• He refused to sign the informed consent, motivating that, we can talk just like this, without me signing anything".

• He stopped using extasy, saying that he doesn't like the idea of putting chemical stuff in his body.

• When he was asked about the medication that the doctor prescribed, and if he would take it, he gave the same answer, refusing to consume, chemical stuff".

• He only eats food that is brought from home, and if he doesn't have that anymore, he only eats bread and drinks water.
• He gives elusive answer, he doesn't give any real answer, saying that „I don't know you very well."
Regarding the moment of the crime, the delirious ideas were present, according to the witnesses, („Bitches, you killed my father!", „You're a bitch!"), as well as auditory hallucinations(he put his hands to his ears, trying not to hear the voices anymore). Also, before the crime happened, he only stayed in his room, and his mom said that he had a blank look that scared his mother.

2.7. Language and communication
We can remark the decrease of ideoverbal rhythm along with the absence of communicating information about the crime and about his life in prison - „I think you know the answer.", „Everything is different here in prison compared to the free life.''. He wants to talk about his life before getting into prison, but he doesn't give many details.

2.8. Emotionality
He presents inadequate emotions, for example, he laughs when he talks about something unpleasant. These things are associated with emotional blunting and dysphoria. When he is smiling and talking about a lot of things, he is trying to get back to his blank expression, and to stop talking.

2.9. Instinctive behavior
From the information that we have from the documents, we can identify sexual instincts disorder (homosexuality). The patient does not want to talk about this aspect, and he doesn't want to admit.

III. PRESUMPTIVE DIAGNOSIS

Schizoaffective disorder, depressive type with catatonic syndrome, multiple episode, but in partial remission [1]. The following criteria are met:

- Persecutory delusions.
- Negative symptoms (reduced affect display, avolition, alogia, and anhedonia).
- Catatonic stupor (rigid, uncomfortable posture).
- Social and academic functions are seriously affected (he doesn't talk to anyone in the room and he doesn't participate in any educational activity).
- Delirious ideas have been present in the past two weeks, with the absence of any major depressive episode.
- The symptoms that meet the criteria of a major depressive episode are present in both active and residual periods of the disorder.
- The symptoms cannot be attributed to any kind of medication or other medical conditions.

IV. DIFFERENTIAL DIAGNOSIS

The research that was conducted in the field of psychotic disorders helps identifying the subtle differences when it comes to the manner of occurrence and their thorough examination offer the certainty of diagnosis and treatment. For example, the similarities and differences between disorders that are a part of the psychotic spectrum can be explained through these 5 dimensions: mania, negative symptoms, depression, positive symptoms, and cognitions [2]. Moreover, unlike the patients that are diagnosed with schizophrenia, those diagnosed with schizoaffective disorder reported more delusional ideas, more depressive episodes, mania and positive symptoms, rather than negative symptoms. Furthermore, in contrast to those diagnosed with bipolar disorder, those with schizoaffective disorder are reportedly younger, with more delusional ideas and less manic episodes, but they have more psychotic related hallucinations [3]. Regarding catatonic behavior, the prevalence of the behavior is almost equal in both schizophrenia patients and patients with schizoaffective disorder [4].
Considering everything that was stated above, we can create a differential diagnosis overview, with the following pieces of information:
• The psychotic disorder secondary to any medical condition – there is no medical condition that can explain better said symptoms.
• Schizophrenia – delusional ideas of persecution are present most of the time during the active and residual state of the disease
• Bipolar disorder or depressive disorder – the symptoms (delusions and hallucinations) are present even in the absence of an affective episode, for at least 2 weeks.

V. STRESS – DIATHESIS MODEL

The development of psychotic disorders is associated with the following risk factors: early life trauma, negative life events and emotional dysfunctions [5]. Relating to the patient's life, we can emphasize a genetic vulnerability when it comes to the development of schizophrenia (the mother presents a set of characteristics from the schizoid spectrum and says that the parental grandparents are crazy). For example, scientific research highlights the predictive potential of family history, the decrease of socially professional functioning and the potential to experiment low intensity psychotic symptoms [6].

More than that, early life trauma, according to scientific research, has extremely harmful effects to the functioning of a patient with schizophrenia [7]. The fact that the patient was raised by his grandparents until the age of 10, and then suddenly taken away from them can represent one of his childhood traumas. Tienari et al., 2004 are talking about how social and familial stress can have a huge impact on one's mental health. Thus, according to the data they collected after the research, they discovered that the way a child with schizophrenic genetic predisposition is a significant predictor for the debut of psychotic disorders [8].

In addition, the patient admits to smoking cannabis occasionally (but does not mention a certain frequency), and, from this point of view, research from the area of psychotic disorders proves that cannabis consumption can trigger psychosis [9].

Epidemiological studies have shown that the risk is major even when it comes to recreational consumption, but it increases once the doses become bigger [10].

Starting from the statements that the patient made at the moment of the crime, we can assume that the disorder debuted in the form of a short psychotic episode, with a delusion of persecution. The patient denies the presence of any kind of hallucinations in that moment, he refuses to talk about himself after the crime happened, and also regarding this, in the indictment it is mentioned that he would have said „I don't know what happened".

Scientific research emphasizes that exposure to stress plays a very important role in triggering and relapsing schizophrenia [11]. Regarding the situation of the patient, the event with a huge stressful contribution might have been the argument that he had with his partner. The gravity of the misunderstandings can be understood through the patient's subsequent acts: he didn't answer his partner's calls and didn't want to meet him, and also the fight led to cancelling a trip they had been planned beforehand, to Asia.

More than that, it is possible that the patient's emotional stability might have been marked by admitting his real sexuality to his mother – after admitting it to her, he asked „Does God still love me now?", according to the indictment. Looking forward, on the account of the inherent privations of the prison life and the loss of his freedom, the patient was susceptible to the development of depressive episodes that followed the already existing symptoms.

Following those written above, the stress-diathesis model analysis reveals the following aspects:

- The elements that loaded the patient's vulnerability are:
  - The premorbid state of his mother and grandparents;
  - Early family stress;
  - Cannabis consumption;
- The elements that triggered and maintained the disease:
  - The fights with his partner;
  - Admitting the truth about his sexuality;
  - Inherent privations of the prison life;
  - The physical and mental abused he was put through;

VI. WORKING HYPOTHESIS

On the background of genetic predisposition, early family stress, the fight with his partner, and admitting to his real sexuality, all of this led to the increase of his stress levels, creating in the end a short psychotic episode that led to the crime. This interpretation is based on scientific research. For example, Large and Nielssen [12] offer significant data to support the fact that a huge proportion of people that go through a psychotic episode commit acts of violence before being hospitalized and getting the right treatment. Furthermore, Lamsma and Harte [13] conceptualize violence as being a phenomenon that appears at the intersection of more correlated risk factors: social factors, delirious ideas of persecution, hallucinations, comorbid antisocial pathology, substance use, inadequate insight, lack of compliance to the treatment and physiological factors.

VII. CONCLUSION

A significant proportion of violent acts are committed by people that can be diagnosed with mental disorders. The presented case illustrates this kind of situation, where antisocial acts are acted out on the basis of mental difficulties.

In this case, from the available data, the patient committed the crime on the background of auditory hallucinations and delirious ideas, and because of the incarceration the patient suffered from depressive episodes. [14]

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