AGGRESSIVE BEHAVIOUR TOWARDS A CARE-GIVER: A CASE REPORT OF A PATIENT WITH PARANOID SCHIZOPHRENIA

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ABSTRACT

Background: *Aggressive behaviours are often found in paranoid schizophrenia, which could occur either at the acute or chronic phases of the disorder. Paranoid schizophrenic patients may show dysfunctional impulsive aggression which may be caused by several factors such as environmental frustration. These patients have poor insight, experience disorders of thought and have poor control of their aggressive impulses.*

Methods: *This is a case report of a 27 year old school dropout, who has been on treatment for paranoid schizophrenia for five years. He presented with acute symptoms of the disorder which includes delusion of reference, delusion of persecution, command hallucination and restlessness. Prior to the current presentation, patient had stopped taking his medication and refused to come for follow-up. Last follow-up from records was thirteen months prior to this current admission.*

Results: *Clinical features met the criteria for diagnosis of paranoid schizophrenia following a relapse due to poor compliance with medication and follow-up visits.*

Conclusions: *Elevated risk forviolent-offending in paranoid schizophrenia is not just as a result of active symptoms, but also associated social problems. Therefore managing these groups of patients should target such issues.*

Keywords: *Aggressive behaviour, Care-Giver, Paranoid, Schizophrenia*

INTRODUCTION

Schizophrenia is a disorder of thinking, behaviour, perception and social interaction. Common symptoms include hallucination, delusions, apathy, distorted thinking and disorganized behaviour (Kapur, 2009). Aggression among schizophrenic patients was not more than that found in other disorders (Rueve & Welton, 2008) as 92% were found not to be aggressive on their own. The risk of aggression in this major mental disorder is increased in the subtype paranoid schizophrenia. This is due to the following factors: paranoid entails hallucination and delusion in a person who fulfills criteria for schizophrenia, (ICD 10). The role of paranoid symptoms of schizophrenia in increasing risk of aggression has been overestimated, but that notwithstanding it still plays a role undoubtedly (Mullen, 2005).

CASE REPORT

Mr. W.S is a 27 year old secondary school drop-out. He dropped out of school due to his ill health in senior secondary two at the age of 20 years. He has been a patient of the department of psychiatry of a tertiary hospital in Nigeria for five years. Patient presented for the first time in July 2012 with complaints of hearing voices talking about him in third person, believed he was followed by his enemies whom he often reported to the police but no one has ever been apprehended, patient also reported that he was told to carry out certain function which he hears through his ears in clear consciousness and said to hear his action being reported as he was doing them. All above symptoms have been ongoing for

about 6 weeks before he presented. There was no history of substance or drug abuse or any form of physical illness prior to onset of symptoms.

At that time, patient was assessed and a diagnosis of paranoid schizophrenia was made based on ICD-10 diagnostic criteria. He was admitted and treated with antipsychotic medication. Patient was discharged after six weeks when symptoms resolved and patient had gained insight to his problem. He was followed up consecutively for two years after which his follow-up and medication compliance became erratic. He was last seen at follow-up thirteen months ago before his current presentation.

Patient reported to the psychiatry unit on the 29th/December/2016 with complains of command hallucination, delusion of reference, delusion of persecution and restlessness of two weeks duration. He was taken to the prayer house and for traditional medication all to no avail. His father insisted that he was brought to the hospital because his symptoms are similar to the previous symptoms he had which warranted his first admission. A lot of resistance ensued before patient came in for consultation. Mr. W.S was admitted in the male ward and commenced his treatment immediately. The management team was informed and took over management of the patient from the emergency team. Patient initially refused to take his medication which warranted depot medication.

A week into admission about 10:30pm, patient was reported to have stabbed another patient's care-giver with a kitchen knife on the abdominal wall. The eyewitness immediately held the patient and informed the nursing staff who collected the knife and hurriedly took the victim to a specialist hospital. The patient was restraint physically and the doctor on call was informed. When Mr. W.S was questioned about what happened, he reported that he acted in self defence because the victim was about to attack him physically and he was told by a voice to stab him with a knife. The patient believed that the victim was a threat and his persecutor; he was commanded by a voice to stab him because the victim was dangerous and will eventually kill him the patient.

The victim (care-giver) Mr. A.D is a 22 year old student, who is the son of another patient. He was a calm young man who took care of his mentally ill father. He had no problem with anyone including the patient. Mr. A.D was at the wrong place and at the wrong time, because it was a random event. He was rushed to the emergency unit of a specialist hospital where he was attended to immediately. Victim had a stab wound on his abdomen, bleeding was arrested and investigations were carried out for emergency laparotomy. His vital signs were all stable and investigations were within normal limit.He had emergency laparotomy done, no vital organ was damaged and no internal bleeding. He had antibiotic medication prescribed and was on admission for three weeks. The managing team wrote to the teaching hospital to pay the bills for the victim since the incident occurred within the hospital.

DISCUSSION

The relationship between schizophrenia and aggression is of long-standing importance with implication for treatment, research and public policy. Effectively preventing and managing aggression not only benefits patients and their families, but also provides a safer escalate to violent crimes such as manslaughter and murder.

Our patient had some peculiarities that are worthy of note. He had a relapsed schizophrenic illness due to non-compliance, active psychopathology and also perpetrated a violent act against an unrelated caregiver while on admission in a tertiary hospital at the hour of 10:30pm.

Clinically, we were able to establish the presence of active symptoms of paranoia in the patient which manifested from his abnormal belief and secondarily systematized through voices giving him a command to attack the victim. In the presence of hallucination particularly commanding auditory hallucination, risk of violence is increased due to compliance with the command the patient receives especially when the voice is familiar, (Junginger, 1990). Also in patients experiencing delusions of persecution believing someone is out to harm or attack patient, they may preemptively attack the victim in self defence (protecting themselves). Our patient in the case report heard a voice commanding him to attack the victim who he believed was out to harm him and he obeyed the command by attacking the victim in self-defence.

The event surrounding the act suggests he actually planned it and intended to kill considering his choice of weapon, the time and perceived belief that it's an act of self-defence. Moreover, it is a period when activities in the ward are usually at its lowest ebb. In another manner, it can also suggest that intensity of the hallucinatory experience was more at this hour of the night.Paranoid delusions with threats, in a

mentally disordered patients is more likely and has a two fold increase for aggression when compared with psychotic patients who are not paranoid, (Flannery et al, 2001). When a schizophrenic patient believes someone controls his thoughts or mind which is found in paranoid schizophrenia "control override" or passivity phenomenon, it heightens violent behaviours, (Link, Stueve, & Phelan, 1998).
This act confirms earlier studies which considered aggression to occur in response to psychotic experience, especially delusions and hallucinations and that the content of the psychotic symptom may be significant in relation to dangerous behavior (Witt et al 2013). Similarly, it was also reported that the type and degree of patient's psychopathology are important factors determining aggression in a study carried out in this hospital (Chukwujekwu & Stanley 2011).
More worrisome is the fact that the patient attacked a caregiver unrelated to him thereby making a case for protection of not only the family members but also unrelated caregivers in close proximity to schizophrenic inpatients.

We can comfortably extrapolate from this report that risk assessment is very important in schizophrenic patients with active positive symptoms such as command hallucination and persecutory delusion. They should also be managed in a special unit with adequate provisions for 24 hours surveillance and appropriate treatment measures for aggression.

Conclusion

Elevated risk forviolent-offending in paranoid schizophrenia is not just as a result of active symptoms, but also associated social problems. Therefore managing this group of patients should target such issues. For this to be achieved, service delivery system needs to be restructured and professionals in the care re-educated.

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