AGGRESSION AND "AUTOAGGRESSION" IN SCHIZOPHRENIA

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The problem of aggression and "autoaggression" in schizophrenia is complex and rather comprehensive. It makes part of one of the basic social and medical problems in modern world — the problem of human aggression.

Presumably, under historical aspect, the initial steps in the study of mental patients' aggressive acts are related to the stage of scientific development of psychiatry — e. g. the first half of the 19th century. According to D. Vladoff (1911), Ph. Pinel was the first to study the heaviest aggressive act — homicide — committed by mental patients.

The differentiation of schizophrenia as a distinct nosological entity (at the end of 19th, and at the beginning of the 20th century), and the rapid development of forensic psychiatry have urged the undertaking of systematic researches into the problem of aggression "and autoaggression" in this, doubtlessly, most frequently met with psychosis.

Many authors have dedicated special researches into the various aspects of the problem outlined (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16,17, 18, 19, 20, 21, 22, 23, 24 etc).

Purpose, object and method of study

In this work we set out to outline some clinico-psychological characteristic features of schizophrenic patients accomplishing aggressive and "autoaggressive" acts, hardly detectable by the routine clinical examination. For the purpose we made use of a definite set of projective psychological methods (the PF test of Rosenzweig, Murry's TAT, and the stress-test of V. Ivanov) with a view to improve the prophylactical measures in this respect. The listed above methods were picked out since they have been already adopted by the psychological laboratory of the Chair of Psychiatry and Medical Psychology of the Medical Faculty — Varna, under the direct guidance of prof. L. Ivanova, and since they afford relatively good possibilities of projecting personality adjustments, tendencies, motives, experiences and the like, directly or indirectly related to the aggressive and "autoaggressive" acts.

A series of fifty patients with aggressive acts, and twelve with "autoaggression" were studied. The results were compared with a control group, consisting of analogical number of schizophreniacs without evidence of aggression or "autoaggression" in the background. Upon setting up the control group, an attempt was made at selecting the cases by basic indicators (sex, age, education level, clinical picture, developmental course, number of attacks, long-standing of the disease, and family history with inheritance), which were practically full analogues to the main group. Interpretation of the psychological study data was made from the standpoint of materialistic (cognitive) psychology, without resorting to in-depth psychological, symbolic interpretations.

Results

1. Clinical study data.

Classified by sex the individuals committing aggressive acts amount to 38 men and 12 women; by age they are distributed as follows: 18 to 30 years — 21 patients, 31 to 40 — fourteen, 41 to 50 — thirteen, and above 50 — two patients.

By form of development of the disease (we used the so-called pathokinetic classification suggested by A. V. Snejnevsky et al), the patients are distributed in the following fashion: with continuous forms — 15 cases, shift-like progressive forms — 21, and with periodical form — eight. In six patients it was impossible to determine the form of affection since it was a matter of first attack, lacking sufficiently typical symptomatology.

The paranoid and paranoid-hallucinatory syndrome was the leading one in thirty nine patients, the paraphrenic one — in three, and the so-called recurrent circle syndrome — in the remainder (8 patients).

The duration of the disease until aggressive act commitment was the following: up to one year — six patients; from 1 to 3 years — eleven patients, and 3 to 10 years — thirty three patients. Out of the perpetrators of heavy aggressions, only three were with duration of the affection less than three years. "Initial delinquency" (21) was discovered in one patient only.

A positive familial history for mental diseases (psychoses) was present in eighteen patients.

Most frequently, the aggressive acts were performed in the patient's home — 22 cases, followed by intrahospital aggressions — 15 cases. In 24 instances the victims were members of the patient's family (wife, parents, children, brothers and sisters), and in 23 instances — persons from close circles such as friends and acquaintances; in three cases it was a matter of aggression accomplished against casual individuals.

Regarding the motives of aggressive acts, in 29 instances they were due to insanity, and in three they were done under the direct influence of hallucinatory experiences with imperative character. In thirteen patients a peculiar interlacing and combination of psychopathological and normal psychological motives was present. In the remainder (5 cases) the aggression was situation related, and was conditioned by normal psychological motives. Premeditation was discovered in 16 cases, and meditation — in nineteen.

The sex distribution of patients committing "autoaggressive" acts is as follows: nine women and three men. Most of them were in the age group 18—30 years (8), three were 31 to 40, and one — above 40 years. With duration of the condition up to 1 year were eight of the patients; 1—3 years — one, and above 3 years — three patients. Mental disorders (psychoses) in the family history were discovered in three cases.

In seven patients the basic syndrome was the paranoid-depressive one, and in the remainder — paranoid and paranoid-hallucinatory. "Autoaggression" was done in domiciliary conditions in six instances, while intrahospital "autoaggression" was recorded three times.

2. Psychological study data.

The PF test of Rosenzweig in patients committing aggressive acts shows high extrapunitivity ($E=8$, $1<0_3$) of a self-defence nature, and high values of the so-called "pure aggression" ($E—\mathbf{E}=27$, $5\% <O_3$). The obtained values

of extrapunitivity, and of the so-called "pure aggression" compared to the control group, are statistically significant ($p<0.001$).

Regarding intropunitivity, the values in those performing aggressive acts are lower that the control ones, this holding true for the so-called "pure selfaccusation" too (I—**I**).

In the group of patients realizing "autoaggressive" acts, the picture is dominated by the low values of extrapunitivity ($E=3$, $6<0_1$) and the so-called "pure aggression" (E—**E**$=10$, $8\%<0_1$), at high values of intropunitivity ($I=4$, $2>0_3$) and the so-called "pure selfaccusation" (I—**I**$=13$, $8\%>0_3$).

The study of patients committing aggressive acts using the stress test, shows elevated values of the H scale (enhanced distrust and paranoidity) — 1.08, as compared to the control group — 0.75, and the values accepted for normal ($p<0.01$). As regards SES (social efficacy scale) and SVS (social value scale of the personality), the individuals committing aggressive acts disclose lower values (4.4 points for SES, controls — 5.52 points at $p<0.05$; 1.3 points for SVS, controls — 2.12 points at $p<0.05$, but on the whole within normal limits for either scale). In those performing autoaggressive acts the SES and SVS values are lower (SES$=2.25$ points, and SVS$=1$ point), while the H scale values are higher (1.7 points), both as compared to controls (0.75 points) and norm, at $p<0.05$; the above values prove higher than the respective ones for the group realizing aggressive acts.

The thematic apperception test (TAT) shows that patients who have committed aggressive acts project more frequently than controls fear (1.2 against 0.44), family conflicts (1.9 against 1.0) and aggressiveness (2.48 against 0.84), at $p<0.001$. In the other projections traced, such as suspiciousness, mistrust, paranoid insanities, infidelity, conflicts outside the family circle and verbal aggression, the subjects performing aggressive acts display higher projection values.

Suspiciousness and mistrust, disloyalty, depressive experiences, thoughts of futurelessness and "autoaggressive" tendencies are more frequently projected in "autoaggressions".

If we compare the "projection of aggression" in the three basic groups (aggresions, "autoaggressions" and controls), it will be seen that aggression has the highest projection values in the group of persons committing aggressive acts, and accordingly, the lowest values in the group of those committing "autoaggressive" acts.

Discussion

The clinical studies show that aggressive acts in schizophrenic patients are encountered much more frequently among men, mostly in the age limit 18—40 years; in two instances only the acts were done by patients aged above 50 years.

It is of interest to note the correlation existing between primary chinical syndrome and performance of aggressive acts by schizophreniacs. Our results definitely corroborate the high incidence of paranoid and paranoid-hallucinatory syndromes in the clinical picture of the affection in individuals committing aggressive acts. Certainly, it should be beared in mind that among the overall population of schizophrenic patients this particular category predominates. In our case, the above syndromes give rise to psychotic motives

against the background of entirely psychotically conditioned aggressive acts, as well as to a psychotic component, if we are allowed the expression, in the queer combination of psychotic and normal psychological motives in performing the aggressive offenses. The more detailed study of the insane motives, recorded in 29 patients of our series, warrants the assumption that the so-called "self defence" motive is not only the most frequently encountered (in 27 of 29 cases), but also virtually pathognomonic for the paranoid and paranoid-hallucinatory syndromes, and lacking the imperative nature of hallucinations in the latter. Aggressive acts performed under the influence of imperative hallucinations and pseudohallucinations are recorded in a few patients (3), and at that, following considerable "resistance" against the voices "instigating" them towards aggression. The participation of psychotic and normal psychological motives (simultaneously or consecutively) in the motivation of aggressive acts is observed in 13 patients. The group where psychotic motives did not play a role in the aggressive act realization is very limited (5 cases).

Analysis of the course run by the psychosis shows that aggressive acts were most frequent in the shift-like progressive (21) and continuous (15) forms, and much rarer in the recurrent (periodic) forms of the course (8). Certainly, it is logical to accept that in the recurrent form, both in connection with the primary syndromes and favourable remissions, typical of this particular form of the morbid course, aggressive acts, at least on psychotic motives, would be more rarely committed.

The duration of the disease is a factor of essential importance, and analysis of our case material demonstrates that aggressive acts are performed mainly by patients with a history of the disorder exceeding three years. This points to an essential dependence of aggressive acts upon the longstanding of schizophrenic psychosis. The "victim" of aggression are mainly persons making part of the family circle or close environment, a fact related to their much more frequent "inclusion" in psychotic experiences of the patients, on the one hand, and to the greater "likelihood" that such persons participate in conflict situations, solved by way of aggression on behalf of the patients, on the other. To create "cool" relations and conflict situations within the family and close circle of relatives, a definite role is attributed both to the morbidly modified personality of the patient, and to the "incomprehension" manifested by relatives and friends in terms of the patient and his own problems.

The male sex shows a marked predomination among patients committing aggressive acts, whereas subjects performing "autoaggression" are mostly females. One is impressed equally by the young age and short duration of the disease, which can easily lead to the inference that "autoaggressive" acts are resorted to much more frequently by patients whose personality is relatively less involved or modified by the morbid process. Analysis of the results of the psychological investigation on the basis of the three tests described above, enabled us to outline in a summed-up pattern the following psychological peculiarities of schizophrenic patients performing aggressive and "autoaggressive" acts, namely: aggressive act committers are characterized by high values of extrapunitivity, and by the so-called "pure" aggression in frustrating situations, high projection values of aggression, dread and paranoid insanities in the stress-test and TAT; persons performing "autoaggressive" acts are characterized by high values of intropunitivity, and by the

so-called "pure self-accusation" in frustrating situations, more frequent projection of paranoid experiences and "autoaggressive" tendencies in the stress test and TAT.

Conclusions

1. Aggressive acts are committed first and foremost by patients affected with paranoid form of the disease, with the paranoid or paranoid-hallucinatory syndrome being the primary one.
2. In the case material reviewed the most frequently encountered form of the morbid course (according to the pathokinetic classification of Snejnevsky et al) is that with shift-like progressive form, followed by the continuous form.
3. Aggressive acts are usually committed against the background of a considerable duration of the disease (exceeding 3 years).
4. Approximatively half of the aggressive acts are done in the home of patients, and members of the family are among the most frequently involved.
5. The motives of committing aggressive acts are psychotic in the highest percentage (32 patients), with the "self-defence" motive being virtually pathognomonic (27 patients). Normal psychological motives could be accepted with certainty in a comparatively small number of cases (5 patients). In thirteen patients it is a matter of combination between psychotic and normal psychological motives.
6. "Autoaggressive" acts are committed mainly by patients in the young age (18—30 years), with duration of the disease up to one year (in 8 of 12 patients)
7. Making use of the psychological projective methods (Rosenzweig's test, V. Ivanov's stress test, and TAT) proved particularly helpful in outlining the "psychological image" of the schizophrenic patient performing aggressive or "autoaggressive" acts.

The comparatively easy detection of psychological variations contributes somewhat to the prognostication of the acts in similar patients — a fact of essential practical bearing on the choice and organization of the most appropriate prophylactical measures for combating aggressive and "autoaggressive" acts in schizophrenia.

REFERENCES

1. Аменицкий, Д. А. Шизофрения. В кн.: Судебная психиатрия, М., 1938. — 2. Бруханский, Н. П. Судебная психиатрия. М., 1928. — 3. Данаджиев, Ст. Невменяемсстта в нашия наказателен закон, С., 1922. — 4. Дончев, П. Криминогенно значение на шизсфренията в съдебнопсихиатричната експертиза. *Бюлетин на НИИНП,* 1967, 11, 2, 104—109. — 5. Дончев, П. Механизми на обществено опасните действия и медицински мерки за социална защита при шизофренията. Канд. дисертация, С., 1970, 497. — 6. Калашник, Я. М. Судебная психиатрия. М., 1961. — 7. Липанов, Р. Г. *Ж. Невроп. и психиатр.* М., 1970, 70, 9, 1365—1368. — 8. Литвинцева, М. С. В кн.: Практика судебнспсихиатрической экспертизы (сб. научных работ № 24). М., 1973, 42—47. — 9. Мартиненко, В. П. Автореферат дисертации на соискание ученой степени канд. медицинских наук. М., 1974. — 10. Мизрухин, И. А. В кн.: Научные труды инст. судебн. психиатрия им. Сербского (вып. XVII). М., 1966. — 11. Морозов, Г. В. В кн.: Судебная психиатрия. М., Медицина, 1965, 131—156. — 12. Халецкий, А. М. В кн.: Судебная психиатрия. М., 1950. — 13. Шипковенски, Н. Прсблеми на шизсфренията «престъпност». Сб. Доклади и съобщ. на I конгрес на бълг. невролсзи, психиатри и неврохирурзи, 4—6 окт. 1967, С., Мед. и физк., 1969, 86—96. — 14. Шипковенски, Н.

Основни проблеми на съдебната психиатрия. С., Мед. и физк., 1973. — 15. Шумаков, В. М. Дисс. на соиск. учен. степени д-ра мед. наук., М., 1975. — 16. Achte, K. *Scand. J. Clin. invest.*, 1966, 23, Suppl., 108, 83. — 17. Aschaffenburg, G. *Zeitschr. ges. Neurol., Psychiat.*, Bd. 28, 1922. — 18. Baruk, H. et coll. *Soc. méd. psychol.*, 1952, 2, 273—277. — 19. Miles, C. P. *J. nerv. ment. Dis.*, 1977, 164, No 4, 231—246. — 20. Schipkowenski, N. Schizophrenie und Mord. Berlin, Springer, 1938.— 21. Stransky, Er. *Arch. Psychiat. Nervenkr.*, 1950, 185, 4, 395—413. — 22. Virkkunen, M. *Acta psychiat. Scand.*, 1974, 50, 2, 145—151. — 23. Vladoff, D. L'homicide en pathologie mentale. Paris, Maloine, 1911. — 24. Wanner, O. *Mschr. Kriminalstrafrechtsref.*, 1954, 37, 1.

АГРЕССИЯ И «АВТОАГРЕССИЯ» ПРИ ШИЗОФРЕНИИ

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РЕЗЮМЕ

Автор поставил перед собой цель очертить некоторые характерные клинико-психологические различия шизофренно больных, реализовавших агрессивные и «автоагрессивные» действия, недоступные для обычного клинического осмотра, при использовании определенного набора проективных психологических методик (теста Розенцвейга, стресс-теста Вл. Иванова и тематическо-аперцептивного теста Марея) в целях улучшения профилактических мер в этом направлении.

Исследованы 50 больных с агрессивными действиями и 12 больных с «автоагрессивными» такими. Эти исследования сравнены с контрольной группой, состоящей из такого же числа шизофренно больных, без проведенной агрессии или «автоагрессии». При определении контрольной группы она подобрана по основным показателям (пол, возраст, образование, клиническая картина, течение, число приступов и давность заболевания, которые являются полными аналогами основной группы. Толкование данных психологических исследований проводится с позиций материалистической (понятной) психологии, не прибегая к глубинно-психологическим и символическим толкованиям.

Результаты в обобщенном виде показывают, что комплексное клинико-психологическое исследование (при помощи указанных проективных методик) в состоянии раскрыть ряд особенностей больных с агрессивными, соотв. «автоагрессивными» действиями, в сравнении с контрольной группой шизофренно больных (которые не предпринимали таких действий). Эти особености касаются прежде всего степени экстра- и интропунитивности, так называемой «чистой агрессии», «агрессивных тенденций», проекции параноидных переживаний, стенических аффектов, «примиренческого» поведения, депрессивных переживаний и др. Таким образом дается возможность для известного прогнозирования агрессивных и «автоагрессивных» действий шизофренно больных, что имеет существенное значение для выбора и организации соответствующих профилактических мер в борьбе с ними.