Dangerous Episodes occurring around the Time of Discharge of Four Chronic Schizophrenics

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Summary: Four patients with severe drug resistant chronic schizophrenia all committed a dangerous act around the time of their discharge from hospital. Discharge from a long stay ward may be an important life event and might therefore be expected to be associated with some depression. Detection of depression among vulnerable schizophrenics may be important if suicide or other dangers are to be prevented.

Schizophrenics are known to have a high suicide rate (Markowe and Heyworth Davies, 1967; Tsuang et al., 1980) and sometimes commit dangerous acts against others. These actions are usually thought to be unpredictable (Barraclough et al., 1974) as they occur with little or no warning and also because remarkably little is known about the patient’s mental state, treatment status or triggering events occurring at the time. Since the term ‘institutional neurosis’ was coined by Barton (1959), and Goffman (1961) has described the impoverished monotonous life in mental hospitals, it has been generally assumed that schizophrenic deterioration was partially caused by institutionalization rather than by the illness itself, although this view has recently been challenged (Johnstone et al., 1981). Thus, whenever possible, to avoid institutional effects, patients with even severe chronic schizophrenia are discharged into the community, usually with success. In this report I wish to describe four cases where discharge was quite unsuccessful and may have resulted in a dangerous episode. All four cases were under my personal care and were collected during a six-year training period, suggesting that these episodes though uncommon may not be rare either.

Case B.C.

He had an 11 year schizophrenic illness, which started at age 25 when he presented to the Maudsley Hospital complaining of smells and feeling depersonalized. He was admitted six times, usually for between three and six months between 1965 and 1974 although his final admission was for two years. He was sometimes deluded, believing missile rods had been placed in his back by a firm called Nuclear Enterprises, which he thought was a front for prostitution; at other times he was paranoid. He often got depressed and the possibility of a schizoaffective disorder was once also considered. He was a shy intelligent man who disliked taking his medication, a mixture of phenothiazines and antidepressants neither of which helped him greatly.

In 1974, in response to a delusion that God would guide him to heaven, he made a fairly serious suicidal attempt by deliberately crashing his car into a wall. By 1976, after a two year admission, it was thought that he was becoming increasingly institutionalized and he was therefore transferred to a behaviour therapy ward for rehabilitation where he took part in an intensive social skills training programme. A pre-condition to his participation in the programme was that he would be discharged when it finished.

He did well and left hospital on pimozide, amitriptyline and diazepam. He attended the day hospital rather sporadically and probably stopped his medication. Six weeks later he went out with his girlfriend who was alarmed by the severity of his depression. She advised him to return to hospital, but he replied “hospital wasn’t the right place for him”.

Later that night he committed suicide by jumping off a high building. Although he had been admitted and discharged several times previously with comparative ease, his contract stipulating discharge may have prevented his doctors from readmitting him when he began to deteriorate and inhibited him from seeking help at the critical moment. Firm contracts insisting on discharge may not be helpful in patients with severe chronic schizophrenia.

Case W.T.

She had a severe florid schizophrenic illness from the age of 31 and was an inpatient in the Maudsley...
Hospital between 1971 and 1978. Both her grandmother and brother also had chronic schizophrenia. She had continuous auditory hallucinations, which she referred to as 'conferring'. She claimed she could hear God talking to Mr Brezhnev and could hear the voices of Mr Wilson and Satan, and she often laughed in response to jokes that her voices told her. She sometimes wore dark glasses to protect herself from people who were plotting to kill her. When her psychosis was particularly florid she cut all her hair off and had to be nursed in the locked ward, as her symptoms were untouched by any medication.

She occasionally took overdoses, often in the context of her strained relationship with her boyfriend, but usually forewarned nursing staff of her intentions. However, aged 34, in response to a hallucination she jumped off a second floor balcony and broke her back.

In 1977, after a six year admission, during which time her illness had if anything worsened, she was transferred to a hostel within the hospital grounds with a view to possible discharge. After nine months there she formed a relationship with another male inmate. His mother had been chronically mentally ill and he was orphaned at an early age and brought up in a variety of London County Council homes. He

Case J.H.

He had a 35 year history of schizophrenia and was an inpatient throughout. The illness started in 1947 when, at the age of 18, he attacked another Borstal inmate. His mother had been chronically mentally ill and he was orphaned at an early age and brought up in a variety of London County Council homes. He was hallucinated and deluded, particularly in respect to homosexuality, was manneristic, used neologisms and often spoke and gesticulated in response to imaginary voices. Phenothiazines had little effect, but three paranoid phases during which he believed the food was poisoned responded well to ECT. He stole frequently, eventually forging the master key of Cane Hill Hospital and stole from all its departments. Because of this he could no longer be contained in an open hospital and was transferred to Broadmoor where he remained from 1958 to 1971.

On his return he settled well, working with the hospital tailor, and in 1980 a decision was made to try and discharge him to a hostel. As he had previously been in Broadmoor a forensic psychiatrist also assessed him and concurred with the plan. The patient also appeared to be in agreement. However, as he was very shy and mumbled into his beard, his speech tended to be incomprehensible and his true feelings may not have been properly assessed.

Ten days later he picked up a heavy metal ashtray and viciously attacked two old ladies on the head. They would probably have been killed without the intervention of the nursing staff. Later he said, 'They pressed jelly on my head and the voices said they would burn me in hell if I did not attack the old ladies'. Some months later he confided to a ward domestic that he had been unhappy at the prospect of leaving hospital. For him the mere thought of discharge was sufficient to reactivate violence not apparent since the onset of his illness some 33 years previously.

Case F.V.

In 1980, aged 31, the patient had a ten month admission to St Giles Hospital during which time he was both deluded and hallucinated. He claimed he had seen a devil who meant to harm him by taking liberties with his soul and expressed the delusion that his arse was in his head. He was diagnosed as having schizophrenia. While on weekend leave he often made highly threatening remarks to his mother, that he would poke her eyes out with a red hot poker, and once absconded in a paranoid deluded state. Because of this he was placed on a compulsory treatment order (Section 26). He was a shy man whose illness showed little response to either chlorpromazine or fluphenazine injections.

After ten months, during which time there had been no real change, his order was lifted and he was discharged. The following day he jumped from a fifth floor balcony, but sustained only minor back injuries. Initially he said he did not want to commit suicide and therefore had jumped on to the grass, but later told a friend that he had wanted to kill himself because he was 'tired of psychiatry'.

Three months later he was observed to be rather lethargic and showed a remarkable improvement after being placed on imipramine, suggesting he may have been quite depressed as well as deluded at the time of his suicidal attempt. He is still an inpatient and is no longer depressed, but refuses to eat as he believes that he is a spiritual being requiring no food.

Discussion

All four patients committed a dangerous act around the time of their discharge, two completed suicide, one
made a serious attempt which failed, while a fourth made a violent attack. In two of the three schizophrenic suicides described by Wilkinson (1982) discharge may have been relevant, as one killed herself one day after her discharge and the other some two months later. The role of rehabilitation is difficult to assess but an exacerbation of schizophrenic symptoms during rehabilitation is well recognized (Stone and Eldred, 1959; Wing et al, 1964). Fernandez (1973) reported that four out of 56 patients who took part in a token economy rehabilitation programme committed suicide, two during the programme, but two around two months after their discharge.

Depression may have been a significant factor in the present cases but for quite diverse reasons their depression was overlooked. Thus both W.T. and B.C. failed to make contact with their doctors at the critical time. J.H.'s speech was incomprehensible and so his mood was rarely assessed, and in FV depressive psychomotor retardation may have been confused with schizophrenic flatness of affect. Depression is a frequent accompaniment of chronic schizophrenia and its relationship to the illness has recently been reviewed by Hirsch (1982). He cites several recent studies which have all consistently found a high incidence of depression among chronic schizophrenics (Knights et al, 1979; Johnson, 1981). He considers depression to be an integral component of the schizophrenic process, only revealed once the more florid symptoms have abated.

How can this possible association between discharge from hospital and dangerous episodes be explained? In particular, why should there be an episode of depression at around the time of discharge or shortly afterwards? Recent life events research may provide some partial insights. Discharge is by definition an 'exit event' and exit events are associated with a sixfold increase in the incidence of depression (Paykel, 1974). Life events may have a more potent depression-inducing effect among those with some pre-existing vulnerabilities, and chronic schizophrenics would be a highly vulnerable group (Brown and Harris, 1978). Furthermore, an accumulation of several recent life events can result in an acute episode of schizophrenia (Brown et al, 1972). Encompassed within the single act of discharge may be a host of other important life events such as the loss of a job, a fall in real income, change of housing, as well as the loss of other supportive and caring relationships. Discharge could therefore result in a relapse of both schizophrenia, as it includes many life events, and depression, as it is an exit event. Against this explanation, Johnson (1981) failed to find any link between depression and recent life events among a small group of chronic schizophrenic outpatients.

Alternatively, it could be argued that all four patients reported here were too ill to have been discharged at all. Against this, Johnstone et al (1981) reported that the severity of symptoms among a group of chronic schizophrenic inpatients was similar to that found in an age-matched control group who had been discharged from hospital some years previously. Further delineation of the clinical features of such vulnerable patients may be helpful in preventing such episodes. These four patients all had a severe drug resistant schizophrenic illness, and in personality all were shy non-complaining individuals who made rather poor and erratic contact with their doctors. Their depression was not of a classical endogenous type and was missed. Among such patients it may be especially important to keep a watchful eye for even mild degrees of depression at the time of discharge or in the subsequent few months.

References


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