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# HOMICIDE AND SUICIDE ASSOCIATED WITH AKATHISIA AND HALOPERIDOL

**Jerome L. Schulte, M.D.**
*Director of Medical Education*
*Atascadero State Hospital*

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Keckich reported a single case of violence, as a manifestation of akathisia, in which a man assaulted his dog with an intent to kill following treatment with low dose haloperidol in combination with impramine.[1] Most clinicians have observed adverse CNS effects, of a mild to severe degree, to often occur in the first few days of treatment with high potency, low dose neuroleptic medications. Parkinsonian or extrapyramidal side effects, in patients under regular treatment with currently popular neuroleptics, generally are found to be reduced and become less severe with reduction of dose or addition of antiparkinsonian agents. Neuromuscular reactions such as motor restlessness, dystonia, akathisia, hyperreflexia, opisthotonos and oculogyric crisis have been reported as occurring less frequently, but often being very severe requiring discontinuation of the drug at times and, occasionally, emergency room treatment. These agents (especially haloperidol) are increasingly being used in emergency rooms, hospital wards, and other settings for the rapid control of agitated and violent psychotic symptoms and behavior.

## RECENT CASE HISTORIES

The following five cases are reported to bring attention to the potential for severe violence, as a result of akathisia, following such administration of a neuroleptic for acute psychiatric symptoms. Particular emphasis is directed to an experience of sensory dissociation associated with the uncomfortable physical reactions, resulting in extreme acts of physical violence.

## CASE NO. 1

A 23-year-old married, Salvadorian-born male, with a four-day history of progressive paranoia and disorganized behavior, had been taken by the police department to a hospital at the request of his parents. The physician insisted he receive an injection of haloperidol in the emergency room while awaiting admission

to the psychiatric unit where he had previously been a patient on a number of occasions.

He tried to resist but felt he had no option with the staff and police surrounding him. He felt he was being unnecessarily delayed in being admitted to the inpatient unit. In addition, he felt he had been lied to, in that apparently he had been told he was going to see his wife who had deserted him approximately 48 hours earlier. He then escaped from the emergency room and the authorities, ran several miles to a park, tried to get a policeman to help him, escaped again and totally disrobed. Within the next 45-minute period of time, he assaulted one woman who was walking her dog and attempted to rape her. When pulled off by the husband, he proceeded down the street, broke down the front door of a house where an 81-year-old lady was sleeping. He severly beat her with his fists, "to a pulp," by his own description, following which he found knives and stabbed her repeatedly, resulting in her death. Then, after being confronted in the street by a policeman who sprayed him with Mace, he returned through the house, exiting the back door where he ran into another woman with her child. He repeatedly stabbed the woman in front of the child, whereupon he moved on to the next person he encountered, a woman whom he severely assaulted and stabbed to the extent that an eye was lost and an opening into the anus was created resulting in major surgery and serious residual problems, including a colostomy. He was then finally captured and subdued by eight policemen and hospitalized.

He had ten previous psychiatric hospitalizations between 1975 and the present. All of these hospitalizations have been only a matter of hours to several days. He would always be placed on medication and released, following which he would stop taking the medication and go along until another upheaval would occur.

He had a history of problems with anger and acute paranoid beliefs leading to hyperactive behavior and one incident in which it was reported he tried to choke one of his brothers.

His description of his mental status at the time of his offense is quite striking. He describes himself as feeling almost like a spectator in a movie. He makes a point of describing how he had lost all sense of caring about anything or anyone in life. Additionally, he describes a feeling of loss of physical sensation, including feeling nothing when maced by the police. He felt enormous energy with a feeling of needing to rid himself of it.

He gives the history of having been picked up by the police on a traffic violation in 1979 and placed in jail for the first time in his life. He became angry and was given a series of haloperidol injections, becoming progressively more agitated and unmanageable to the point he was rolled up in a mattress and handcuffed in order to be transported to a psychiatric inpatient unit. In 1980, during another hospitalization, he was, despite his protests, changed from chlorpromazine to haloperidol and within hours became totally unmanageable, requiring six individuals to subdue him and place him in seclusion and restraint.

## CASE NO. 2

A 30-year-old man with a history of mental illness dating back seven years, with hospitalizations in three other states, was admitted to the hospital on six counts of burglary. His diagnosis was paranoid schizophrenia, and he had been found not guilty by reason of insanity by the courts. The admission note by the psychiatrist stated, "He is somewhat paranoid, but says he has side effects from most tranquilizers." On the third day of hospitalization, he was referred to the psychiatrist by nurses because of difficulty getting to sleep. No evidence of aggressiveness or self-injurious behavior was charted that day in the nurses' notes. The psychiatrist prescribed haloperidol, 5mg. three times a day, which was begun the next day, with three doses administered with Cogentin, 2mg. twice a day. Nurses' notes that day stated, "He was very anxious about being in the hospital and threatened to kill himself if he gets up the nerve." At 10:45 p.m., notes stated, "He has regressed during this shift in all assessment areas. His hygiene is poor, and he is irresponsible, e.g., lying on the floor without shoes or socks." He refused medication initially at 5 p.m., and stated that phenothiazines, "fuck me up." He finally took the medication but then stated angrily, "Now I'll really get crazy." He ranted loudly and profanely for 30 minutes. He took his 9 p.m. medication and started his haranguing again, only louder and more threatening. "I'll kill all of you mother-fuckers before I leave here." He was found in his room at 6:50 a.m., having hung himself with a bed sheet. A letter from his attorney to the hospital had stated that "medications caused him problems (I should perhaps state that by medications I mean psychotropic drugs)."

## CASE NO. 3

A 52-year-old male first came to psychiatric attention eleven years earlier following an assault on his wife. He had delusions of cancer, a belief he would die and felt sexually inadequate.

He had been unsuccessfully treated with Lithium and antidepressants, as well as various tranquilizers. He had continually been an inpatient or in board and care facilities, and three and one-half months earlier, he had his medications changed to 10mg. of Haloperidol in the a.m. and 40mg. of Haloperidol at hour of sleep, with 2mg. of Artane twice daily. Each month he stated he complained to his psychiatrist of severe restlessness. He stated he had to roll over and over in bed at night and usually would be unable to get to sleep until 3 or 4 a.m. During the day, he would try to lie down but couldn't because of his severe uncomfortableness. He described after being turned down again by the psychiatrist, he became despondent and angry, lost hope and decided if he could not ever even sleep like the rest of his boarding home mates that life wasn't worthwhile. He secured a knife and repeatedly stabbed himself in the abdomen, was rushed to the hospital and barely survived. He remarked he could never even feel the knife when stabbing himself.

## CASE NO. 4

A 39-year-old Caucasian male with a diagnosis of chronic paranoid schizophrenia, with alcohol abuse, and history of mental illness since his father's death 20 years earlier and having six prior hospitalizations, would discontinue neuroleptic medications after short periods as an outpatient. In acute episodes, he would have paranoid and grandiose delusions. He had two suicidal episodes ten years earlier by ingestion of aspirin and attempting to jump off the Golden Gate Bridge and shooting himself in the groin. He had hit his mother in 1976 because she refused to help him commit suicide. On another occasion, he struck a cab driver who he felt was evil.

In early 1982, he became delusional, went to several hospitals seeking aid, and eventually was sent on an involuntary hold to a psychiatric hospital where he had been an inpatient on five prior occasions. He received two doses of haloperidol, "25mg." and was allowed to leave the hospital for an outpatient psychiatrist appointment 12 hours after admission.

One court-appointed evaluator's report described his developing symptoms of neck rigidity, arms twisting, legs being unsteady, needing to walk and being confused. Another court-appointed psychiatrist's report described the man had feelings that "his body was falling apart, that it was like all the bones in his body were broken, and that he was retarded, spastic and had a minor stroke." He had been unable to sleep and stated he felt a need to get out of the approximate seventh or eighth episode of these symptoms. It was then within 36 hours that he got a hammer from the basement and walked up behind his mother, striking her repeatedly, leading to her death that day.

The patient, over prolonged study, has described a feeling of incomprehensibility of his having been able to commit the murder and confusion and disorientation and being lost in his own home during the incident with uncomfortableness to a point he felt his behavior was beyond anything he had experienced during previous psychotic episodes. Repeatedly, he describes his skeletal framework being out of kilter, with neck twisted and difficulty walking. A period of loss of control, like jumping off a fence and being in mid-air was another of his descriptions.

He had received doses of 10mg. of haloperidol in the past without problems, but never a dosage at the level of 25mg. He had never required antiparkinsonian drugs in the past.

## CASE NO. 5

A 35-year-old white male was transferred from the correction to the mental health system. He had been diagnosed as developmentally disabled, with mild mental retardation. He had numerous psychiatric hospitalizations from childhood up to the present. He had prior arrests for malicious mischief, vandalism and currently was under sentence for assault with a deadly weapon. He had been receiving haloperidol

as an outpatient for approximately four months and described how progressively his head was rushing, that he felt speeded up, that he was in great pain in his head and had an impulse to stab someone to try to get rid of the pain. He went to the nearby grocery store he frequented on a regular basis and impulsively and repeatedly stabbed the grocer whom he had known for some time. The patient stated he was told he stabbed the man in front and in back but has a loss of memory for a number of the stabbings. His statement was, "The only reason I knifed the guy was Haldol had me messed up," "Prolixin makes me want to kill, too," and, "I put a knife to someone's stomach one time four to five years ago in the hospital after a Prolixin shot messed me up," "Mellaril works good for me and keeps me smooth."

## PATIENT SAFETY

Untoward reactions may occur up to as late as 24 hours after administration of haloperidol due to its half-life of 24 hours. Serious question must be raised as to the safety to the patient and to others in the emergency room use of these agents, where patients are typically released in a brief period after administration with no followup often taking place within the next 24 to 48 hours. Additionally, consideration must be given to the need for concomitant treatment with antiparkinsonian agents when treatment with these neuroleptics is indicated in emergency settings. As Case No. 2 illustrates, however, we know that, clinically, antiparkinsonian agents are not always effective.

These patients all had a history of varying degrees of potential for violence, and their responses may indicate a severe exaggeration of basic personality traits as is often seen in acute organic brain syndromes. Therefore, careful history taken to elicit a history of potential for violence should also be taken prior to use of these agents in emergency rooms.

## AKATHISIA

It has been this clinician's experience working with large numbers of physicians, nurses and psychiatric technicians that the syndrome of akathisia is perhaps the least understood and appreciated side-effect of neuroleptic therapy. Because it is primarily an internal sensation, which may not present with any externally visible manifestation, the clinician must be certain to question the patient before ruling out its presence.

Each of these four living patients describe *feelings of sensory dissociation* during the height of their violent behavior. Three of the four described *feelings of loss of sensation to pain*, and the fourth, *a loss of orientation in his most known environment*. The four patients currently show no overt signs of psychosis. Case No. 1 is currently on no medication. Case No. 3 is on Impramine and Perphenazene. Case No. 4 is on Thiothixene, and Case No. 5 is on Thioridazine.

## REFERENCE

1. Keckich, Walter A., M.D., "Violence as a Manifestation of Akathisia," *Journal of American Medical Association (JAMA)*, Vol. 24, 1978, p. 2185.