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Case Study

Institutional Setting - A Possible Risk for Psychopathy, Drug Use and Prostitution

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Abstract

"Loss of a loved person is one of the most intensely painful experiences any human being can suffer" [2] and for this reason many complications emerge in the life of the people exposed to this pain. In this case, upon referring to a child raised in an institutionalised setting, we can say that most children in public care experience feelings of confusion, frustration, despair and fear of abandonment. It is difficult or even impossible for them to understand why they cannot enjoy the warmth of a home like most children, being most of the times abandoned without any explanation [13]. Over time, the lack of parental affection leads to an increase in frustration and it makes the person more prone to developing a personality disorder. Once out of the institutional setting, upon reaching the age of 18, they are more likely to fall into the traps of society, like prostitution, drug use, even committing offences.

We feature the case of a young woman, aged 24, raised in a public care centre; a cannabis and cocaine user, admitted for the first time in a psychiatric unit. She came as a psychiatric emergency, accompanied by police officers, for a symptomatology manifested by psychomotor agitation and impulsive-explosive behaviour towards her colleagues and the personnel in the public care centre. She was diagnosed with emotionally unstable borderline personality disorder and antisocial personality disorder. The problematic behaviour of the young woman was based on an unhappy childhood. She never knew her family, being abandoned at birth in a public care centre.

Keywords: *Emotionally Unstable Personality Disorder; Family Abandonment; Public Care Centre; Antisocial Personality Disorder; Drugs; Aggressiveness*

Theoretical Background

Studies report that the loss of family in case of abandoned children has a stronger impact on mental state than in case of the children with one or both parents because in the first case, most of the times the cause of abandonment is not known, and those children feel unwanted and stripped of their identity. Although social work tries to substitute the lack of family, these children display educational deficit and they may develop mental conditions subsequently [3]. Family abandonment transforms the children in public care into fragile beings, far more vulnerable to the traps of society. Studies show that persons with an abandonment history live in a permanent state of anxiety and who are highly susceptible of developing personality disorders and posttraumatic stress disorder [1]. A cohort study that followed the institutionalised children in the UK for 30 years showed that they are more likely to develop various medico-legal issues and expressly more prone to illegal drug use, both sexes being twice more likely than general population to have a criminal conviction by the age of 30. Concerning the educational system, men with a history of public care were less likely to attain a higher degree and were seven times more

likely to be unemployed than the general population. However, this study rejected the idea that girls raised in the public care system are more likely to have an unwanted pregnancy or to become victims of human trafficking than general population [16].

The term personality refers to the stable behavioural qualities of an individual under a variety of circumstances [4]. Personality disorders maladaptive behavioural models, profoundly rooted, which may be identified during adolescence or even earlier and that continue throughout most of one's adult life, though they may become less obvious during middle age or old age. A personality may be abnormal in terms of the balance of its elements, their quality and their expression, or overall. Therefore, the patient suffers or makes others suffer, thus entailing an adverse effect on the individual or the society [5]. Personality disorders tend to emerge in late childhood or in adolescence and they continue to be present during adulthood. Thus, it is unlikely for a diagnosis of personality disorder to be correct for a patient younger than 16 or 17 [7].

The concept of abnormal personality in psychiatry was coined in early 20th century, when the French psychiatrist *Pinel* described the "*manie sans délire*". Pinel applied this term to the patients who were more prone to experiencing unmotivated furious and violent outbursts, but without delirium [11]. In 1835, J. C. Prichard, a primary physician in Bristol published a *Treatise on insanity and other disorders of mind.* After referring to the *manie sans délire* of Pinel, he proposed the term *moral insanity* that he defines as a "morbid perversion of natural feelings, affects, inclinations, temperament, habits, moral dispositions and natural impulses, without a remarkable disturbance or defect of the intellect, of knowledge or of judgment, particularly without delirium or hallucinations". Towards the end of the 19th century, specialists began to understand that mental conditions may also occur without delirium and that mood disorders and schizophrenia are separate entities. Nonetheless, the concept of moral insanity was preserved, though with a much more limited meaning. Thus, it was applied by Henry Maudsley to the persons incapable of a real moral feeling, thus considering that all the impulses and wishes of the person in question are selfish, the behaviour being governed by immoral motives that are felt without any obvious wish of resisting them. The next step towards modern ideas was made when the German physicist Robert Koch coined the term *psychopathic inferiority*, which indicated a group of individuals with abnormal behavioural notes, in the absence of mental impairment or intellectual deterioration [8]. Subsequently, the word *inferiority* was replaced by the term *personality* to avoid excessive judgments. The German psychiatrist *Emil Kraepelin* adopted the term *psychopathic personality* and described seven distinct types: excitable, unstable, eccentric, liar, swindler, antisocial and quarrelsome [9]. Another German psychiatrist, *Kurt Schneider*, took a step further. He extended the concept, by including those causing pain for themselves and not necessarily for the others. He included, for instance, individuals with marked depressive or uncertainty characters. In *Schneider*'s opinion, psychopathic personality occupies the entire field of abnormal personality, not only antisocial personality. The confusion over the term of psychopathic personality does not end with the more extended definition provided by *Schneider*. To other uses of the term draw attention. The first one was used in the work of the Scottish psychiatrist *Sir David Henderson*, who in 1939 published a highly acclaimed and extremely important book titled "*The Psychopathic States*". In this book, he starts by defining psychopaths as people who - though abnormal from a mental point of view - throughout their life or from an early age manifested antisocial or asocial behavioural disturbances, usually of a recurrent or episodic type and that proved in many cases difficult to influence using social work, criminal or medical methods, or because there are no adequate preventive or curative methods. The psychiatrist *David Henderson* refers to three groups of psychopaths: predominantly aggressive, predominantly passive or inadequate and creative psychopaths. The predominantly aggressive group does not include only those who are repeatedly aggressive, but also those prone to suicide and to alcohol and drug abuse. The group of passive or inadequate personalities includes unstable, hypochondriac and sensitive individuals, pathological liars and persons with a schizoid nature. The group of creative psychopaths is so vast, that such a criterion has a limited value; thus, the examples provided by *Henderson* also included *T.E. Lawrence* and *Joan of Arc*, both creative in different ways, with few common traits. Another variation to the meaning of the term psychopathy was introduced by the Mental Health Act for England and Wales in 1959. In this act, the psychopathic disorder was defined in Section 4 as a persistent mental disorder, (irrespective of the presence or absence of subnormal intelligence) resulting in an abnormally aggressive or severely irresponsible behaviour from the part of the patient, and which is susceptible of medical treatment [5].

The prevalence of antisocial personality disorder is 0.2 - 0.3%. The highest prevalence of this disorder (over 70%) was identified within male samples that also associated an alcohol use disorder or who came from substance abuse clinics, prisons or correction facilities [6]. Borderline personality disorder is commonly investigated in the chapters within psychopathology treatises or medical psychiatry treatises. The prevalence of this disorder is estimated at 10% among patients treated in specialised community outpatient care, 15 - 20% among patients assisted in psychiatry clinics, 30 - 60% among patients with a personality disorder and approximately 1 - 2% among general population. Generally, clinical trials suggest that borderline personality disorder is more common among women than among men [11].

Dissociative identity disorder is a personality disorder often in the spotlight of medical attention due to the dissonance between the patient's behaviour and the social norms, characterised by a cruel indifference for the feelings of the others, a persistent attitude of defiance for the social norms, rues and conventions and by failure to maintain long-term relationships. Furthermore, they have low tolerance to frustrations; they are prone to aggressiveness and even extreme violence. The incapability of feeling guilt and the tendency to always blame others or to offer plausible explanations for their behaviour complete the picture of disharmony. In addition, an associated trait may be irritability. Behavioural disorder during childhood or adolescence - though not invariably present - may consolidate the diagnosis.

Emotionally unstable personality disorder is a personality disorder where there is a marked tendency of acting impulsively, without considering the consequences, along with mood instability. Planning capacity can be quite basic and the intense outrages may often lead to violence or to "behavioural blowouts"; they can occur easily when the impulsive acts are criticised or prevented by other persons. The emotionally unstable borderline personality disorder includes characteristics of emotional instability. Furthermore, the patient's self-image, his inner aims and preferences (sexual ones included) are often troubled. There is usually a chronic feeling of inner void. A tendency to get involved in intense and unstable relationships may cause repeated emotional crises and it can be associated with excessive efforts to prevent abandonment and a series of suicidal or self-harming acts; though they may emerge without any obvious triggers [7].

Concerning the treatable character of personality disorders, we have unfortunately pointed out the lack of well-controlled clinical trails with positive outcomes, as it occurs for other mental disorders such as schizophrenia or depressive disorder [15]. The Practical Guide of the American Psychiatric Association recommends psychotherapy as first line treatment, accompanied by pharmacotherapy as adjuvant therapy in personality disorders. The treatment for these two personality disorders is mainly represented by psychotherapy, and as adjuvant therapy the pharmacological treatment is recommended. If we refer to antisocial personality disorder, treatment is often difficult, even impossible. Usually, the effective psychotherapeutic treatment is the behavioural one (for instance, behaviour may be modified by the threat of legal sanctions or by the fear of punishment). Success has also been reported in case of group therapy, including self-help groups. The treatment for the emotionally unstable personality disorder usually involves mixed psychotherapy, supportive and exploratory. The management of transfer psychosis, of counter-transfer, of passing to the act and of threats and suicidal wishes raises problems. The therapist functions as an auxiliary ego; he sets limits and provides structure. Behavioural therapy may be useful to control the impulses and rage bursts and to reduce the sensitivity to criticism and rejections; it is also used for training social skills, dialective therapy may also be useful [14].

The algorithms of pharmacotherapy are focused on the symptomatology specific to the three following clusters: cognition (with neuroleptics), affectivity (with selective serotonin reuptake inhibitors), impulsive-explosive behaviour (with selective serotonin reuptake inhibitors and small doses of neuroleptics). Studies show that the efficiency of pharmacotherapy for the treatment of personality disorders varies. For instance, two studies have found good results in the case of treatment with Olanzapine. Concerning the efficiency of thymostabilisers, Carbamazepine did not have better results than the placebo, but valproic acid had good results on psychoemotional instability and o impulsiveness. There was an attempt to conduct a small clinical trial, on 30 patients with borderline personality disorder, which were given Omega 3, with satisfying results. Antidepressants such as Amitriptyline and Imipramine had good results for depressive syndrome, but not for the other symptoms associated; Fenalazine mitigated hostility, but not also depression, while Fluoxetine reduced irascibility and aggressiveness. Concerning the efficiency of Haloperidol, results vary from one clinical trial to the other. Some trials have demonstrated au high efficiency on hostility and schizoid symptoms, while others have shows a higher efficiency of Fenalazine, as the last also has beneficial effects on depression and anxiety, respectively [10].

General Case Presentation

This case concerns an urban female patient aged 24, unemployed, with Romanian citizenship, with a college degree, not married, admitted for the first time at the "Socola" Psychiatric Institute of Iaşi. the patients was brought in as a psychiatric emergency by the police, from the care centre where she lived, for the following symptomatology: psychomotor agitation, irritability, irascibility, low tolerance to minor frustrations, psychoemotional lability, insufficiently censored impulsiveness expressed by physical and mental aggressiveness towards the beneficiaries and employees the Centre for Protection of Human Trafficking Victims.

Concerning her family medical history, there are no available data, because the patient never knew her family, and her own medical history (physiological and pathological) is irrelevant.

Data concerning and living standards and work conditions show that she was abandoned by her parents at birth in a public care centre; over time, due to her aggressive behaviour, she was transferred to various care units, but she did manage to graduate, with many difficulties, from the Faculty of Economics. Later, she worked in a palliation centre in England for two months, but she was fired because she failed to observe her job description. "I would go out for a smoke whenever I felt like it; some other times, patients could not find their jewellery and I got blamed for it". Subsequently, she worked for a short period in a warehouse, and then she returned to Romania, to the public care centre. Because she had no money and because she felt more and more the need to use drugs, she decided to practice prostitution. "At the shop near the care centre, there were some guys who approached me one day, asking me if I want any cocaine. I said yes, of course, and then they told me that if I agreed to sleep with the persons they were sending over to me, they would give me as much cocaine as I want and, more, they would give me some of the profit. I told them I only wanted cocaine and cigarettes and we shook hands. They would call me to various apartments, where I would sleep with six-seven men a day. After a couple of months, I realised that was not ok and I decided to run. Am left the phone, the clothes and I went out in the streets. The police found me and they brought me to this protection centre for human trafficking victims". The patient has been a smoker since the age of 14, while from 22 she began taking cannabis and cocaine: "I started drugs when I was in depression, after finishing college, when I realised I had no future. Drugs made me feel energetic, full of life, they were my only joy".

The clinical examination by systems did not show any pathological modifications, and concerning the paraclinical examinations, we recommended a gynaecological consult and a pregnancy test, implicitly, the result thereof being negative; the gynaecological examination pointed out chronic cervicitis, for which specific treatment was started.

Concerning the psychiatric examination, the expression psychodiagnosis showed a partially cooperative attitude, the patient made eye contact, but she had a hard time maintaining it; she did respect the mutual character of the dialogue with the examiner. Her attire was clean, specific to the hospital setting, she had good personal hygiene, mobile gestures, expressive facies, pantomimic with normal range, but with episodes of unmotivated laughter throughout the psychiatric interview, hypermobile look, a voice with average tone and intensity, with slight affective modulation.

The knowledge functions show marked hyperesthesia; at the moment of the examination, the patient denies the presence of delirious-hallucinatory psychoproductive phenomena. The prosexic and mnesic functions are within normal limits. Thought is coherent, with average rhythm and flow of ideas but with bizarre contents at times. "I am a lesbian, but I decided to have a relationship with a gay man, because we both thought that this way we would be considered normal by society. I felt no love for him, but I did become attached to him somehow, so when he left me, I want to kill myself". She is highly suspicious, interpretative and hostile; she has negative expectations for the future. "I don't think about starting a family. I would not be able to be a good mother; I have no role models because I was not raised in a family". She displays self-harming ruminations. "I don't have a job; I don't know my past; I have never seen my parents; I don't know my real name; I spend my present in a psychiatric clinic; my future is hopeless, I feel there is nothing to live for"; suicidal thoughts in her history: "I tried to slash my wrists with a blade several time, but somebody would find me every time".

The analysis of the affective function showed dysthymic mood, psychoemotional lability, irritability, irascibility, low tolerance to minor frustrations, insufficiently censored impulsiveness expressed by physical and mental aggressiveness towards the beneficiaries and employees of the Centre; affective indifference: "Life has taught me not to become attached to anyone, everybody in my past has disappointed me, and then I don't even know what love is. Nobody has ever loved me; I had no parents to show me unconditional love"; unmotivated laughter, fondness for cigarettes, drugs and alcohol. Appetite was big; she was sexually disinherited, both according to her and according to the medical staff. "I feel a great urge to have sex. I have sexually abused women several times; I either forcibly kissed them or I touched them in the intimate areas without their consent; I forced a little girl to perform oral sex on me, I had professional sex with an older woman, with a vibrator and a harness and penis"; exacerbated instinct of survival recently. "I can't stand anyone anymore. And yes, I admit I threw the first punch and I wanted to take the manager of the centre prisoner in the office, and she called 911 like a coward but that's who I am, there's nothing I can do! On the other hand, she provoked me with her indifference".

The effector function revealed psychomotor agitation in case of the patient; she is claiming, she states that she does not belong in a psychiatric clinic; she has behavioural bizarreness (she hits on her roommates, she avoids the dialogue with the medical staff). Throughout the psychiatric interview, we noticed she had an introvert personality, caused by both the lack of her parents and by the most recent traumatising event in her life. At the moment of the psychiatric examination, the patient has self-orientation, spatial and temporal orientation and she is consciously aware of the others, but she does not seem to be aware of her disorder.

Positive diagnosis

The psychiatric examination corroborated with the psychological examination has led us to set the diagnoses of Dissociative personality disorder and Borderline emotionally unstable personality disorder.

The diagnosis of Dissociative personality disorder is supported by the patient's indifferent attitude and by her lack of observance for the social norms and for the punishments received, her inability to maintain long-term relationships, because she did not manage to have friends or a stable job. The young woman is incapable of feeling guilt and she accounts the difficult aspects of her life as if it were funny. Other important characteristics support this diagnosis are irritability, low tolerance to minor frustrations, insufficiently censored impulsiveness often manifested by verbal and physical hetero-aggressiveness. In addition, when asked about the future plans, she had a tendency to blame the persons within her entourage and the family that had abandoned her for her behaviour that was in conflict with society.

The diagnosis of Borderline emotionally unstable personality disorder is supported by the following characteristics: marked tendency to act on impulse, without thinking about the consequence, associated with mood instability; distorted self-image of the patient, of her personal aims and preferences (sexual), as she has no plans for the future and no desire to succeed in life. In addition, her sexual preferences are uncertain; she claims to be a lesbian, but she did have a relationship with a homosexual man. The psychiatric interview has shows that the patient experiences the feeling of inner void, reason for which she tends to get involved in intense relationships, but which she cannot keep. "I have no close friends; they have all disappointed me and betrayed my trust over time. They all seem very ok in the beginning; I trust them and then I realise they either talk behind my back or they don't help me when I am in need". She made excessive efforts to prevent abandonment by attempting suicide several times (the psychologist within the public care centre states that the patient requested psychological counselling several times a day and that she became upset if she did not have undivided attention, thus attempting suicide and reproaching that she felt neglected).

Therapeutic conduct and evolution

In our clinic, the patient benefits from psychological counselling and medication, namely a mood stabiliser (Carbamazepine 600 mg/ day, 2), targeted Benzodiazepine for psychomotor agitation (Lorazepam 2 mg/ day) and a hypnotic (Clonazepam 0.5 mg/ day). During the two weeks of hospital stay, the patient's evolution was slowly favourable. Upon discharge, she returned to the Centre for human trafficking victims, where she will continue psychological counselling and the psychiatric treatment.

Conclusions

Considering the above case study, on which we focused on a fostered child- now an adult, and whose mental fragility is more enhanced than that of the general population, we can now admit that the social services in Romania has made important progresses in supporting and protecting children raised by the system.

Given this young woman's high psycho-emotional instability caused by family abandonment, we could associate the idea that such people are more prone to developing personality disorders, post-traumatic stress disorders and addiction to diverse drugs.

In conclusion, even though the road to recovery is difficult and requires a lot of time, patience and support, we can consider that the association between psychotherapy and psychiatric medication can and will have a positive impact for this young woman's quality of life.

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