



Letter to the Editor

Comments on “Distinctive profiles of traits predisposing to violence in schizophrenia and in the general population”


Keywords:

Schizophrenia
Violence
Aggression
Risk factors

Proper recognition and management of violence in psychiatric populations is a topic of great importance. Accordingly, I read with great interest the article by Drs. Krakowski and Czobor (2018). The authors reported that violent schizophrenia patients, similarly as non-psychotic violent subjects, are characterized by more severe psychopathy, trait aggressiveness and impulsivity. The results are logical, expected and consistent with some previous studies. However, having in mind the complexity of the population surveyed, the results deserve a few comments.

In his recent invited commentary, professor Rund (2018) emphasized that the present literature about the relationship between violence and schizophrenia “showed mixed findings for almost all of the external and clinical factors”, and that the major problem is that “very broad terms have been used, particularly for violence and diagnostic categories”. A major issue here is that there is not one type, but at least three types of violence in schizophrenia: impulsive, psychopathic (predatory) and psychotically motivated violence (Quanbeck, 2006; Volavka and Citrome, 2008). In short, impulsive acts are unplanned and associated with anger. This type of aggressive act is often followed by remorse. Psychopathic acts are planned, goal-oriented and basically without emotions (Quanbeck, 2006). Psychotically motivated acts are also premeditated, but are self-defensive reactions motivated by delusions (and eventually hallucinations) (Junginger and McGuire, 2004). It is reasonable to believe that self-defensive acts are not associated (just) with anger, but rather with fear. Also, it would be logical to expect that there should be differences in psychopathology scores between patients who committed psychopathic and psychotically motivated acts. Further, impulsive and psychopathically motivated acts are associated with conditions such as personality disorders or substance misuse regardless of whether schizophrenia is present or not. In fact, proneness to impulsive violence, or impulsive behavior in general, is associated with specific temperamental traits rather than with a specific diagnosis (Cloninger et al., 1993). Accordingly, we may expect similar results for both schizophrenia patients and nonpsychotic violent persons if their violent acts are similarly motivated. On the other hand, the finding by Krakowski and Czobor that in “those without such problems (mentioned predisposing traits), the symptoms of the illness play a more

important role for the violent behavior” is also logical. This is because the main predisposing traits to violence would not exhibit a significant influence in most psychotically motivated violent acts. In other words, certain trait predispositions are associated with certain types of violence, rather than with the diagnosis of schizophrenia.

The authors did correctly mention the heterogeneity of violent behavior. The fact is that a single violent act may have “overlapping characteristics” of different types of violence, and that one patient may commit clearly different types of violent acts in different occasions. These facts may complicate the methodology of research. On the other hand, results of similar studies would depend on the predominant subtype of violence in the population studied. Similar studies about trait predispositions should improve our understanding, prevention and treatment of violence in schizophrenia. Can we expect that any preventive program or treatment will be equally effective in reducing so different subtypes of violence? An equally relevant question is what we can learn about violence in schizophrenia if there is evidence of substance misuse disorders and probably of antisocial personality disorder in the majority of participants.

In other words, I believe that differently motivated acts are distinctive phenomena and should be, at least sometimes, investigated separately in studies with establish diagnostic homogeneity. Otherwise, we should mainly talk about violence in schizophrenia patients with comorbid conditions and expect results that would depend on comorbid conditions.

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21 December 2018