

## PSYCHIATRY DURING COVID-19 PANDEMIC: A CASE REPORT OF ATTEMPTED MERCY KILLING

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### INTRODUCTION

The rapid diffusion of Coronavirus or COVID-19 in the current century is creating concerns in the psychiatric services for the direct and indirect impact of the pandemic on the whole population and individuals with mental health conditions or vulnerable to high stress. In the complicated cases, the emotional load linked to severe and lethal illnesses like COVID-19 pandemic can affect vulnerable people beyond their point of resistance, leading to increased stress reactions, depression, suicide, homicide, and psychosis. A more extreme case of paranoia is that of the Italian male nurse who strangled to death his doctor girlfriend believing that she gave him Coronavirus (Tidman 2020). The current case report refers to the a middle-age man who was admitted for the first time to a psychiatric hospital after he disclosed planning to kill his family to save them from COVID-19 infection.

### AN ATTEMPTED MERCY KILLING

We describe the case of a 50-year-old man, currently employed, admitted for the first time to a psychiatric hospital under compulsory detention for 28 days. Before the admission, he was arrested by the police as he assaulted his partner the day before. According to the family, he was worried about COVID-19 in the last few weeks before admission. He was found with an axe under a pillow that he wanted to use as a means to kill family 'so they would not feel fear of the virus.' On one episode, he tried to assault his partner with an iron but was stopped by his neighbours. At the home assessment, this person did not show any remorse for the alleged actions. He said he was concerned about the state of the world such as overpopulation, finite resources, and other irrelevant matters. Recently his concerns intensified due to Coronavirus outbreak, and he became progressively worried about a 'Dystopian future.' He appeared to have encouraged wife and daughter his family to live together with him during the outbreak; this would have made it easier for him to kill them. He was ambivalent whether he would have also killed

himself. Regarding his thoughts, he produced the following narratives: becoming increasingly preoccupied with COVID-19 and the possibility of becoming himself and his family infected and dying; having progressive worries about the destiny of his family and the consequences of a deadly virus; planning to take the life of his family 'to reduce their suffering deriving from being infected with COVID-19'; believing that partner and daughter family members were substituted by impostors and brought to a place of safety by the government; discontinuing all electronic devices in his house as he thought they could be used by the government to control him; believing that Coronavirus infection was an extreme strategy that the government used to control society. At admission, his mood was euthymic or slightly anxious, he presented as coherent and appropriate, and there were no abnormal perceptions. He was fully oriented, and cognition was grossly intact. Psychiatric Tests at admission were: GAD-7 (Spitzer et al. 2006), (Generalized Anxiety Disorder – 7) = 15 (moderately severe anxiety,) PHQ-9 (Spitzer et al. 1999) (Physical Health Questionnaire – 9) = 11 (moderately severe depression); BDI-I (Beck 1961) (Beck Depression Inventory-I) = 12 (mild depression) and BDI-II (Beck et al. 1996) (Beck Depression Inventory-II) = 23 (moderate depression); PANSS (Kay et al. 1987) (Positive and Negative Symptoms of Schizophrenia) = 57 (scoring high on delusion, preoccupation about thoughts, anxiety and psychomotor agitation before admission). BPRS (Brief Psychiatric Rating Scale) (Overall & Gorham 1962) = 50 scorings high in anxiety, suspiciousness, unusual thought content and tension. CGI (Guy 1976) (Clinical Global Index of Severity) at admission: Severity = 7 (extremely ill); CGI-Improvement = 2 (much improved with some symptoms remaining). Brain CT scan performed at admission was negative. The biochemical assessment did not show abnormalities. ICD-10 diagnosis at admission was F23.0 Acute Paranoid Reaction and Reactive Psychosis, although differential with F 20.0 first presentation of Paranoid Schizophrenia. He responded to a brief course of antipsychotic medication and was discharged home one week after his admission.

## DISCUSSION

In the case discussed, COVID-19 worries have triggered a first clinical presentation of a paranoid psychosis. Research reports that either stress or substances that increase dopamine levels in the brain can cause psychosis hence postulating the role of psychological stress to trigger psychosis in vulnerable persons (Soliman et al. 2007). Other studies indicate the correlation between social deprivation and mania, depression, paranoia and hallucinations via the induction of stress which, then, triggers the psychiatric symptoms (Wickham et al. 2014). Predictably, other similar cases will present to psychiatric services.

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Abdul Nusair, Ahmed Shoka & Marco Rabottini: comments on the concept of article, literature searches, writing some parts of manuscript, approval of the final version.

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