Introduction: Previous studies showed, that reduced executive function can be associated with antisocial and aggressive behavior. For the measurement of executive functions numerous standardized neuropsychological tests are available.
Objectives: We thought to compare the results of an executive function examination with Wisconsin Card Sorting Test (WCST) of patients observed at the Semmelweis University's Department of Psychiatry and Psychotherapy to normative data from published database. We also performed a subgroup analysis between the violent and non-violent groups of the patients.
Methods: After data clearance our dataset consisted of 20 patients, who were divided into two groups based on whether the crime they committed before their admission was violent according to the Cornell scale.The analyzed parameters were the number of perseverative errors, the percentage of perseverative errors, and the number of completed categories. For comparison, the data bank from the 1993 edition of the WCST manual as normative data was used. The deviation from the healthy average for all three parameters was compared between the violent and non-violent groups using a two-sample T-test.
Results: There was significant difference between the patient and normal populations in all the 3 analyzed WCST parameters: the mean difference was 9,37±2,764, (p=0,0008) in the number of perseverative errors, 14,04±2,21 (p<0,0001) in the percentage of perseverative errors and -2,39±0,34 (p<0,0001) in the number of completed categories (Table 1).

Table 1: The difference between the average scores of healthy individuals grouped by age (from the 1993 WCST manual) and the scores of the patients.

Observed parameter	Average difference (Patient-normal)	SD	Confidence interval (95%)	P value
number of completed categories	-2,39	0,343	-3,064 — 1,716	<0,0001
number of perseverative errors	9,37	2,764	3,936 — 14,804	0,0008
percentage of perseverative errors	14,04	2,212	9,692—18,388	<0,0001

On the other hand, there were no significant differences between the violent and non-violent subgroups in the average deviations (from the normative data) of the number of perseverative errors, the percentage of perseverative errors and the number of completed categories (with p-values of 0.092, 0.34 and 0.59, respectively).
Conclusions: As a limitation, it is important to note that due to the low sample size, and our sample's heterogeneity in terms of psychiatric diagnosis, drawing reliable conclusions is not possible. However, our results were in line with previous similar research in the forensic psychiatric population (though not under forensic mental state observation) regarding the significant deviations in two examined WCST parameters when compared to normative data. Additionally our study did not find significant difference between the violent and non-violent subgroups of the patients.

Disclosure of Interest: None Declared

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Reaching the limits of antipsychotic treatment: the upper end of severe schizophrenia in forensic institutions - a case report

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Introduction: Severe schizophrenia is often closely related to delinquency resulting in relative overrepresentation of these manifestations of disease in forensic institutions.
Objectives: The aim of the present work is to report the therapeutic challenges in a case of severe schizophrenia in a forensic institution from a clinical viewpoint as a basis for discussion.
Methods: The case report is based on the available clinical documentation, exploratory interviews as well as a structured clinical interview (PANSS).
Results: Presenting a case of a 41-year-old, male Caucasian inpatient suffering from a catatonic schizophrenia, we report the challenges in treatment of chronic, major schizophrenic disease resistant to antipsychotic medication. Without any previous criminal convictions, he has been instutionalized in a forensic psychiatry after a bodily harm to a random stranger about three years ago. Regarding medical history, information is limited to a few inpatient admissions prior to detention documenting intravenous opioid and cocaine abuse. Initially, the patient presented sexual disinhibition and ongoing endangerment of others with frequent assaults to other patients and prison guards. From a psychopathological viewpoint several phenomenona such as delusional intuition, acoustic, tactile and coenaesthetic hallucinations, echolalia, mannerisms and thought diffusions reflect the severe course of the disease (PANSS: P 34/49, N 38/49, G 73/112; total 145/210). Therapeutic attempts with an antipsychotic combination of risperidone, olanzapine and quetiapine as well as valproic acid resulted in insufficient recovery with persistent physical assaults and florid psychosis. In reaction to that zuclopenthixol for impulse control was added. As from the beginning of this year a switch of medication by gradually replacing risperidone and zuclopenthixol with haloperidol and clozapine showed modest success. Under the current medication and therapeutic drug levels the patient does not pose endangerment to others. However, regular tonic-eye fits require supplementary treatment with biperiden, and the patient still presents frequent periods of self-harm punching himself, verbal lack of impulse control and the psychopathological phenomenona described before. In addition to pharmacological treatment the patient receives psychotherapeutic one-on-one conversations. Despite approaching all limits of the available antipsychotic repertoire, psychopathology is only insufficiently controlled leading considerations to electroconvulsive therapy as a treatment of last resort.
Conclusions: Certainly, the present case is exemplary for a severely ill population of patients reaching – after a long and untreated course of disease - a chronic stage that does not sufficiently respond to a multitude of treatment attempts despite proper compliance raising the urgent need for further treatment options.

Disclosure of Interest: None Declared