

DELUSIONS IN FORENSIC EXAMINATIONS

Jerzy Pobocho

Polish Forensic Psychiatry Association, Individual Specialized Medical Practice, Szczecin, Poland

Key words: delusion, delusion-like idea, overvalued idea, fanaticism, over-diagnosis, forensic evaluation

tematic but only alive" (die weder logisch noch systematisch sondern nur lebendig sind) [26].

Summary

Different definitions of delusions and their history are critically examined. The analyzed definitions include DSM-III, DSM-IVR, ICD-10 and those found in textbooks of clinical/forensic psychiatry and in dictionaries. Examples of mistaken diagnoses in forensic psychiatric evaluations such as, for example, latent schizophrenia, paranoid hypochondria, and schizophrenia, such as incorrectly diagnosed in A.B. Breivik of Norway, are discussed. It is shown that mental processes, such as making judgments, are influenced by other mental factors such as anxiety and personality disorders, physical health, educational background, intellectual capacity, cultural background, political and religious views. It is thus concluded that delusions are false judgments which cannot be corrected or explained in a different way, that is, as beliefs, attitudes, prejudices, overvalued ideas, compulsive thoughts, phobias, simulation, etc. Incorrect diagnoses of delusion made by psychiatric experts result from their limited knowledge, insufficient clinical experience, not taking into consideration the impact of the aforementioned factors on thinking and behaviour of evaluated individuals, utilizing abbreviated, incomplete definition of delusion, and a tendency to over-diagnose.

There are many different points of view on the nature of delusions and many different definitions of what a delusion is. Mayer-Gross believes that "it is impossible to define a delusion without being involved in philosophical controversies unessential from a pragmatic point of view"[31]. The definition offered by Gruhle is that "a delusion is seeing relationship between things without any reason. Delusion is a mood without a reason"[18]. Kretschmer thought that delusion prevented one from getting a clear insight into things "which are neither logical nor sys-

Delusion is one of the most important psychopathological symptoms described by Kraepelin in *Dementia Praecox and Paraphrenia* [25] and in his monograph on delusional disorders [16]. Most authors, however, rely on the work of Karl Jaspers, who states: "delusion has been taken as the basic characteristic of madness. To be mad was to be deluded, and indeed what constitutes a delusion is one of the basic problems of psychopathology." It is "psychologically irreducible," a direct and intrusive form of new meaning [22, 24]. Jaspers wrote of "delusion proper" not in terms of "considered interpretations but direct experiences of meaning, while perception itself remains normal and unchanged" [22, 24]. Mojtabai states that "delusion is the morbid manifestation of knowledge and error in regard to empirical reality, as it is of faith and superstition in regard to metaphysical reality"[32]. Jaspers distinguishes four forms of belief, i.e. four distinct modes or ways in which beliefs can be presented to consciousness. These are normal belief, overvalued idea, delusion-like idea and primary delusion"[22, 34, 46]. Sims, in his book *Symptoms in the Mind*, appeals to Jaspers and gives the following criteria for delusion:

- (a) they are held with unusual conviction
- (b) they are not amenable to logic
- (c) the absurdity or erroneousness of their content is manifest to other people. [Sims, 1988, p. 84, cit. Walker – 46, p. 95]

A delusion, unlike an overvalued idea, "is not understandable" in terms of the patient's cultural and educational background although the secondary delusion (or delusion-like idea) is understandable with the addition of some other psychopathological event such as hallucination or abnormal mood [Sims, 1988, p. 85-86, cit. Walker – 46, p. 95]. Jaspers distinguishes "two large groups of delusions according to their origin (*Ursprung*), one group *emerges understandably* (*verständlich hervorgegangen*) from preceding affects, from shattering, mortifying, guilt provoking or ot-

her experiences, from false-perception or from the experience of derealisation in states of altered consciousness, etc. The other group is for us psychologically irreducible, but phenomenologically, it is something final. We put the term *delusion-like (wahnhaftige Ideen)* to the first group; the latter we term *delusions proper (echte Wahnideen)*” [22, 46].

Walker writes: “most of the primary delusions of Jaspers’ examples would be considered delusion-like ideas or secondary delusions because they clearly do not fulfill the Psychiatric Symptoms Examination (PSE) criteria of primary delusion. For Jaspers, however, they are all primary delusions because (a) they are direct experiences of new meaning, (b) they have no precedent in the patient’s previous experience or personality (i.e. they are not understandable), and (c) they produce a radically new view of seeing the world (i.e. a change in the totality of understandable connections which is personality). Their “sudden” origin is of no consequence. In contrast, a delusion-like idea is considered a judgement whose origin is understandable through other experiences and personality [46, p. 102].

Thus the final difference between the primary delusion and the other forms of belief is that the primary delusion entails a change in personality [46, p. 101]. The result is that many more beliefs are taken to be primary delusions and the crucial distinction is between normal belief, overvalued idea and delusion-like idea which are understandable (*verständlich*) and the primary delusion which is not understandable (*unverständlich*) [46, p. 102]. Cobb (1979) categorizes delusions into normal, neurotic and psychotic [7; 33, p. 827]. The same problem pertains to jealousy: how to differentiate what is “normal” and what is pathology. Mullen writes that normal or physiological jealousy appears as an understandable reaction to an actual threat to the relationship, while the hyperaesthetic jealousy is an excessive reaction, out of proportion to the actual or implied threat, and, on occasion may involve emergence of delusions of infidelity, which include (1) jealous monomania, which applied Esquirol’s (1976, first published 1838) concept of monomania to a group with delusions of infidelity emerging *de novo* without other major abnormalities of mental state; and (2) jealous insanity, where delusions of infidelity form part of a generalized psychotic state, often with hallucinations and affective disturbance [33, p. 827].

DSM-IV gives the following definition of delusion: “a false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary” [8, p. 756]. Clinical description of such a personality is found in the study by Shostakovich, M., et al.: “such a behaviour is

accompanied by selfishness, uncompromising nature, intransigence, and a desire to always act as one pleases, following one’s whims. Such people have stiff and judgmental opinions, which usually makes it difficult to maintain good relationships with family and other people. ... Lack of tolerance of others’ views is transformed in them into open hostility. Exaggerated attention to detail takes a form of ‘picking on others’ and turns into a meticulous pedantry ... ‘fighting for justice’ is their reaction to little things affecting their personal interests” [41]. A similar clinical picture can be found the works of R. Meyer, M.E. Seligman and al., D. P. Bernstein and al. [1, 30, 39].

Sometimes diagnoses made by forensic psychiatrist appear to be contradictory. This fact is often due to differences in assessments of thinking processes and disorders. The question is therefore where is the line that divides normal thinking from pathology. And thus whether any particular expression of the thinking process is still a fantasy and/or the manifestation of a delusion-like idea, or a pathological psychotic delusion. Difficulties in the proper diagnosis of delusions were one of the reasons in diagnosing schizophrenia for forensic psychiatric purposes in people who actually did not have [45].

Conflicting psychiatric forensic opinions are found in the famous case of a politically-motivated terrorist attack in Norway. On July 22, 2011 at 15:25, Anders Behring Breivik detonated a 950-kg fertilizer-based car bomb in the downtown government quarter, killing eight people and severely injuring nine. From the bombsite Breivik traveled directly to the small island of Uty, where he killed 69 people [29]. Prior to the attack, Anders Breivik had developed a 1515-page manifesto: *European Declaration of Dependence* [5].

After his arrest, Anders Breivik was subjected to a psychiatric examination. The first two of court-appointed psychiatrists, Torgeir Husby and Synne Sørheimadresse, who conducted with him 13 interviews covering a total of 36 hours, in addition to hearing or viewing all police interrogations and interviewing his mother. These evaluators combined unstructured talks with structured diagnostic interviews, including, the Mini-International Neuropsychiatric Interview, the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) and the Positive and Negative Syndrome Scale (PANSS). During the psychiatric examination Breivik said that “he believed there was an ongoing ethnic cleansing in Norway and that he feared for his life. He thought the events he was a part of could start a nuclear third world war ...[that] he worked with solutions to improve the Norwegian ethnic genetic pool, make illnesses extinct, and reduce the divorce rate. He thought about reservations for indigenous Norwegians, DNA testing, and

factories for mass deliveries of babies” [19, 29]. Breivik also thought that one could make DNA tests of the remains of King Olav the Saint (the Viking King who introduced Christianity to Norway) and then choose the one with best genetic likeness to be the new king. Breivik claimed he had exceptional personal abilities, for instance, knowing what other people think – including his evaluators – though he never explained to them how he did it [29].

The psychiatrists who evaluated him first saw all these as grandiose delusions with bizarre and paranoid qualities that went far beyond conspiracy notions about an Islamist take-over of Europe. Breivik had been taking anabolic steroids in several periods prior to July 22, combined with large doses of ephedrine, caffeine, and aspirin on the actual day of the attack. In this first evaluation, the diagnosis of schizophrenia was based on the presence of bizarre delusions. In accordance with ICD-10 definition (persistent delusions of other kinds that are culturally inappropriate and completely impossible, e.g. being able to control the weather, or being in communication with aliens from another world) [29].

On November 29, 2011, the psychiatrists who issued the first opinion reported to the court that Breivik was psychotic (paranoid schizophrenia) while planning and implementing his acts and during the evaluation, but psychologist Erik Johannessen, who testified in the Oslo District Court on 11 June, 2012, stated that: “Breivik does not have paranoid schizophrenia and Asperger’s Syndrome, ... he is not suffering from a psychotic disorder, and his extreme views should be attributed to political extremism, not to a mental illness” [23]. Clinical Psychologist Svern Torgensen also suspected that “...Breivik is actually suffering from a narcissistic personality disorder. To this he attributed Breivik’s delusions of grandeur and his belief that he was singled out to be a knight in a crusade against Islam.

The second evaluation was done by forensic psychiatrists Agnar Aspaas and Terje Tørrissen, who were appointed to examine Breivik for the second time. They examined him between February - March 2013. In their evaluation they used an inpatient observation which was done in prison by trained psychiatric personnel. They found no signs of gross disorganization or outward signs of auditory hallucinations. In their opinion the results of the MMPI-2 test and repeated examinations lasting up to five and half hours indicated that dissimulation of a mental illness was not possible. However, they stated that “pathological self-aggrandizement and ideas of heightened self-esteem, power and knowledge may be reminiscent of what is observed in cases of delusional disorders.” But they interpreted his negative symptoms, such as social withdrawal, as a natural consequ-

ence of planning a terrorist attack, and so they assumed political motivation of his violence [29, 44]. They assumed that Breivik’s symptoms were due to narcissistic personality disorder combined with pseudologia fantastica (pathological lying), he was not psychotic during the interviews nor at the time of his crimes, thus being legally accountable for his deeds. His “delusions involved phenomena which lie outside the realm of natural science,” Breivik’s absurd grandiose notions are not bizarre. His claim that he knew what other people were thinking could likely be based on his experience as a telephone salesman. His withdrawal and suspiciousness could be a consequence of his terrorist plans.

What is most important here is that “Breivik does not meet (ICD-10) criteria for schizophrenia, but would meet the DSM-IV criteria” [29, 44]. Breivik’s case shows how important it is to take into account the context in which psychiatric evaluations are made. “The source of confusion may lie in some subtle, but relevant, differences between the ICD-10 and the DSM-IV classifications” [29].

The prosecution appointed to the case Einar Kringlen, a Norwegian professor of psychiatry, related to Vinderen Psychiatric Clinic in Oslo, and one of Norway’s leading psychiatrists. For the most part, he rejected the previous diagnosis of Breivik’s insanity: “Mental illness cannot explain all evil such as the Holocaust.” On 24 August, 2012, Anders Breivik was sentenced to 21 years in prison because he was not declared legally insane. Ingrid Melle, a Norwegian psychiatrist whose assessments was quoted above, rightly observes that Breivik’s case should be a lesson for psychiatrists [29].

This case also demonstrated how important it is to have good knowledge and understanding of fanaticism, and to be able to look at this from the perspectives of various disciplines. Breivik’s extreme views and opinion call for a remainder what fanaticism in fact is. The etymology of the word fanaticism comes from the Latin word *fanaticus*, which means “inspired” [10]. Fanaticism is defined as excessive, irrational enthusiasm or uncritical belief in the absolute validity or truth of some cause, idea or way of conduct, which makes a person’s behaviour highly emotional, often aggressive; their attitude showing little tolerance, concessions while proclaiming some and combating other ideas, often religious or political. Thus the psychology fanaticism should take into account the following [10]:

- environmental and cultural influences
- group pressure
- isolation
- manipulation
- influence on the subconsciousness (indoctrination)

- compensation for one’s shortcomings
- personality such: paranoid, epileptoid, Machiavelian-manipulative, hysterical, for example: e.g. Calvin, Robespierre, Frederick the Great, A. Hitler, J. Stalin

At two conferences in Szczecin in 2003 and 2004, I suggested a multidisciplinary approach to fanaticism, which involves disciplines such as philosophy, psychology, ethics, history, sociology, political science, etc. It is also important to take into account social aspects of fanaticism and its effects such on development of fundamentalism, sects, intolerance, national chauvinism, terrorism, totalitarianism, Nazism and revolutions.

In Poland we also had a case of extreme fanaticism. In 2012 A political fanatic and terrorist, Brunon K. was arrested as he attempted to blow up the Polish parliament, kill the president and prime minister. Psychiatric evaluation determined that was not mentally ill, and so he received a prison sentence [6].

It is sometimes difficult to differentiate between delusions, delusion-like ideas, and fanaticism. The difficulty that many psychiatrist have when assessing such case is reflected in their often conflicting opinions. Below I describe two examples of conflicting opinions, (summarized on tables 1, 2) which can illustrate difficulties in differentiating paranoid personality disorder from delusional disorder.

The first is the case of a 50 year-old man who was diagnosed with and treated for paranoid personality for 12 ye-

ars. Without a serious reason, he frequently engaged in conflicts with his neighbors, health care professionals, shops assistants, etc. This escalated to the point when he actually murdered a women who was his next door neighbor because she approached him about his untidiness and disturbing of peace. Two forensic opinions were passed in this case. In the first evaluation he was diagnosed with a delusional disorder with delusions of persecution and was declared legally insane. However, the diagnosis from the second evaluation was different: paranoid and narcissistic personality disorder, radiculopathy with pain syndrome. Excessive sensitivity to failure, inability to forgive insults, suspicion, delusion-like fantasies, emotional conflict situation, reduced sanity.

The second case involved a 55 year-old who man who suffered a bout of rheumatic disease, which resulted in endocarditis, mitral valve damage, and embolism of the eye accompanied by amblyopia. He was treated by an ENT specialist for chronic tonsillitis, by a rheumatologist for rheumatic disease, and also by an ophthalmologist and a cardiologist. He was diagnosed with paranoid hypochondria with paranoid schizophrenia on the basis of his exaggerated opinions related to his diseases and delusion-like fantasies and anxieties. However, the sort of opinions he held are very typical of people living in the countryside from which he came from. He was treated for schizophrenia for 15 years. Four times involuntarily hospitalized. The

Table 1. Case 1. Conflicting opinions: Delusional disorders or paranoid/narcissistic personality disorders?

Murder, First Opinion	Murder, Second Opinion
Diagnosis: Delusional disorders F22	Diagnosis: Paranoid and narcissistic personality disorders F60.0, F60.8 Radiculopatía pain syndrome M54.1
Persecutory delusion Insanity defense	Excessive sensitivity to setbacks, unforgiveness of insults; suspiciousness; delusion-like fantasies; emotional conflict situation, diminished responsibility?

Table 2. Case 2. Conflicting opinions: Hypochondriac paranoia or anxiety nosophobia? Treatment: 15 years with a diagnosis of schizophrenia

Specialist	Diagnosis	Opinion I	Opinion II & III
ENT specialist	Pharyngitis, tonsillitis	7 years of observation Diagnosis I: anxiety disorders; nosophobia - F40.2; no treatment, no civil commitment	Based on one hour examinations: Diagnosis II: paranoid schizophrenia – F20.0; treatment: neuroleptics, civil commitment Diagnosis III: delusional disorders -- hypochondriac paranoia F22; treatment: neuroleptics
Rheumatologist	Rheumatic disease with endocarditis		
Ophthalmologist	Eye embolism		
Cardiologist	Mitral valve insufficiency after endocarditis		

first diagnosis was made based on seven-year follow-up, including a three-month clinical observation, a two-month hospitalization, neurological tests: anxiety disorder, nosophobia, patient does not require involuntary hospitalization or any psychiatric treatment even despite the discontinuation of any psychotropic drugs. The second diagnosis: paranoid schizophrenia, requires involuntary treatment. Third opinion: delusional disorder, paranoid hypochondriac, requires neuroleptic treatment. The third opinion did not take into account the fact that the patient actually suffered from somatic diseases, which was confirmed by an otolaryngologist, a rheumatologist, a ophthalmologist, and a cardiologist. The court rejected the claim for compensation for the patient unnecessary treatment, loss of ability to work as a result of drug-induced Parkinson disease, based on the opinion of experts, who have accepted that the patient was and is a person with schizophrenia.

As we saw in the material and cases presented in this paper, it is sometimes difficult to determine whether some expression of thinking process, beliefs or/and ideas is normal, oscillates on the border of normality, or is abnormal and pathological. The proper assessment depends on many different factors. Good psychiatric skills alone cannot guaranty that a diagnosis is correct, because the knowledge and boarder understand of cultural context is also necessary here. Psychiatrist and authors influenced by different background often present slightly different views.

The Oxford University psychiatry textbook defines delusion as a pathological conviction/belief has the following characteristics [40]:

- The patient believes in it with absolute subjective certainty and it is not possible to dissuade them from it.
- It requires no proof or evidence and can be maintained even in the presence of evidence to the contrary.
- It is highly personal and important to the person experiencing it. Such a conviction/belief cannot be considered part of some subculture or religious system.

It should be emphasized here that although the content of delusions is usually clearly erroneous and strange in its nature, this very fact of being strange or erroneous does not make something a delusion [40].

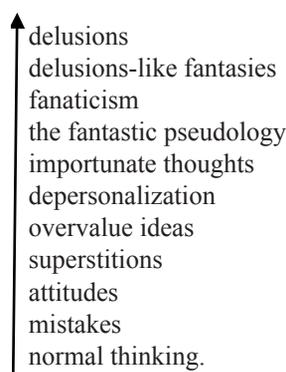
The authors of this textbook give a description of the overvalued ideas. “An overvalued idea is non-delusive and non-obsessive abnormal belief or conviction. It is a belief that a patient has, and, that in itself is acceptable and understandable, but which completely occupies the patient and dominates his of her thinking and behaviour. Such beliefs are not perceived as “external” or “extrasensory” but are usually extremely important to the patient. Overvalued ideas can have different contents in different disorders (e.g.

concern about one’s physical appearance in dysmorphophobia, concern about weight and body shape in anorexia, concern about personal rights in a paranoid personality disorder)” [40].

According to American authors delusions constitute false beliefs based on incorrect inference about external reality, not consistent with the patient’s intelligence and cultural background. They cannot be corrected by reasoning: “...a false personal belief [falsity] based on incorrect inference about external reality and firmly sustained [conviction] despite of what almost everyone else believes and despite of what constitutes incontrovertible and obvious proof or evidence to the contrary [incorrigibility]. The belief is not one ordinarily accepted by other members of the person’s culture or sub-culture” [8, 39, 42, 47].

DSM-IV indicates that it is often difficult to distinguish between a delusion and an overvalued idea, in which case an individual has an unreasonable belief or idea but does not hold it as firmly as is the case of a delusion [8, p. 765]. It can be considered a disorder in a person’s ability to pass sound judgment on the surrounding reality, to evaluate it in a rational way. The process can thus be illustrated on the gradual continuum starting with normal thinking and ending with proper delusion (Figure 1).

Figure 1. Graduation of thought disorders



Controversial diagnostic criteria may have various political implications. For example in the Soviet Union there existed a diagnosis of latent schizophrenia known as *вялотекущая шизофрения*. In fact, it was Eugen Bleuler, who introduced the term into psychiatry [2]. Thus diagnosing mental disorders was used against dissidents in the Soviet Union. An example of which can be the case of General Piotr Grigorenko who questioned the policy of the Communist Party [3, 4, 12, 17, 28, 37, 38, 39]. Three opinions were issued in his case:

- 1st opinion – paranoid personality developing refor-

matory ideas, psychopathy, arteriosclerosis

- 2nd opinion – normal, energetic
- 3rd opinion – the conclusions of the second opinion were incorrect.

The diagnostic paradigm in the Soviet Union assumed that communism was the best system the human kind could possibly create, a paradise on earth. The official ideology did not tolerate any diversion from the official line. Thus anyone who would oppose this seemingly “wonderful and natural” world must have been psychotic. Perhaps a similar method to assess the mental state of involuntarily hospitalized were used in the case of Ezra Pound in the U.S. [37, 43].

The authors of *Psychopathology* [37, p. 257-261] present a list of symptoms often observed in dissident-patients who did not believe that the communist system was perfect, and so their sanity was questioned:

- suffering
- maladjustment
- irrationality
- unpredictability and lack of control
- unique and unconventional behaviour
- exaggerated display of discomfort
- flagrant violation of norm

Since diagnostic criteria for disorders described in the ICD-10 [47], as well as DSM-IV-TR [8] do not include the term *delusion-like idea* is one of the reasons why psychiatrists, when diagnosing delusions, do not used the complete definition and do not take into account Jaspers’ views on the subject: “Delusion-like ideas ... emerge understandably (*verständlich*) from other psychic events and can be traced back psychologically to certain affects, drives, desires and fears” [22; 46, p. 98]. “The primary delusion is a direct, immediate or unmediated (*unmittelbar*) phenomenon while the other three forms of belief are all mediated by thought (*gedanklich vermitteltes*). That is, normal beliefs, overvalued ideas and delusion-like ideas are all reflective, considered interpretations. In fact, the primary delusion is essentially not a belief or judgement (*Urteil*) at all, but rather an experience (*Erlebnis*)” [46, p. 98] While “normal people can give reasons, can engage in a dialogue, can engage in the possibilities of doubt, etc., especially if we engage in a dialogue with them”. [42, p. 257].

The following can be considered causes of incorrectly assessing some statements as delusions:

1. Relying mainly on the criterion of their falsity.
2. Superficial analysis of such statement without trying to determine how their source and genesis are anchored in the experience and personal history of the person.
3. Insufficient consideration given to personal determi-

nants in the peculiarities of thinking that occur in: paranoid, narcissistic and antisocial personalities, and which may affect the content and variability of expression of overvalued and delusion-like ideas.

4. Failing to analyze the level of self-consciousness and its role in the formation of abnormal cognitive patterns, over-interpretation, and delusion-like fantasies.

5. Not taking into account the role of egocentric beliefs in the formation of over-interpretation [11, 27, 36].

6. Not using measurement scales for delusions and disorders of judging, which include works by the following authors: Peters E. et al.: Peters Delusions Inventory (PDI) [35], Garety P [13,14, 15], Fenigstein A. et al. [11], Ellett et al. [9].

As the IDC-10 and DSM-IV-TR classifications do not use concepts such as over-interpretation, delusion-like statements or expressions and delusion-like fantasies, some psychiatrists think that in practice there are only two possibilities for the evaluation:

1. Correct – normal.
2. Incorrect – delusional.

Whereas the term delusion-like statements can be found in abundance in psychiatric literature [9, 11, 15, 21, 22, 32, 40, 42, 46]. In Poland, the term was used, inter alia, by prof. Jan Jaroszyński [20, 21]. In 1972, I witnessed an evaluation of a women who was hospitalized for forensic psychiatric observation and diagnosed with paranoia. Whereas the aforementioned psychiatrist demonstrated that her statements were merely delusion-like based on a personal examination.

In the final analysis, the reason why psychiatric experts sometimes incorrectly diagnose delusions is their narrow general knowledge and limited clinical experience. Using shortened and incomplete definitions of delusions and having a tendency for over-diagnosing, they often fail to take into consideration different factors that can dramatically influence thinking and behaviour of the examined patient.

References

1. Bernstein DP, Useda D, Siever LJ. Paranoid personality disorder: review of the literature and recommendations for DSM-IV. *Jornal of Personality Disorders*, 1993;7(4):53-62.
2. Bleuler E. *Affektivität, Suggestibilität, Paranoia*. Halle, 1906.
3. Bloch S, Reddaway P. *Psychiatric Terror. How Soviet Psychiatry In Used to Suppress Dissent*. 1977.
4. Brązkiewicz B. *Psychiatria radziecka jako instrument walki z opozycją polityczną w latach 1918-1984*. 2005.
5. Brewick A. *A European Declaration of Independence*. London, 2011.
6. *Chciał zwerbować 12 osób i razem z nimi wysadzić Sejm*. Jak

- Brunon K. przygotowywał swój zamach? www.wyborcza.pl
7. Cobb JP, Marks IM. Morbid jealousy featuring as obsessive-compulsive neurosis: treatment by behavioural psychotherapy. *Br. J. Psychiatry.* 1979;134:301-305.
 8. Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV). Washington, DC: American Psychiatric Association; 1994:756.
 9. Ellett L, Lopes B, Chadwick P. Paranoia in a nonclinical population of college students. *Journal of Nervous & Mental Disease.* 2003;191(7):425-430.
 10. Fanatyzm. W: Wielka Encyklopedia Powszechna PWN. Tom III:579.
 11. Fenigstein A, Vanable PA. Paranoia and Self-Consciousness. *Journal of Personality and Social Psychology.* 1992;62(1):129-138.
 12. Fireside H. Soviet Psychoprisons. 1982.
 13. Garety P. Reasoning and Delusions. *British Journal of Psychiatry.* 1991;159(supl. 14):14-18.
 14. Garety PA, Freeman D, Jolley S, et al. Reasoning, emotions and delusional conviction in psychosis *Journal of Abnormal Psychology.* 2005;114:373-384.
 15. Garety PA, Freeman D. Cognitive approaches to delusions: A critical review of theories and evidence. *British Journal of Clinical Psychology.* 1999;38:113-154.
 16. Garlipp P, Haltenhof H. Seltene wahnstörungen. 2010.
 17. Gluzman S. On soviet totalitarian psychiatry. 1989.
 18. Gruhle HW. Die Psychologie des Abnormen. In: Kafka G (Hrsg.). *Handbuch der Vergleichenden Psychologie.* 1922.
 19. Husby T, Sørheimadresse S. 29.11.11 Rettspsykiatrisk Erklæring. Observanden: Breivik, Anders Behring. <http://www.document.no/rettspsykiatrisk-erklæring-anders-behring-breivik/>
 20. Jaroszyński J. Urojenia. W: Puzyński S (red.). *Leksykon Psychiatrii, Warszawa, PZWL.* 1993:404-506.
 21. Jaroszyński J.: Zespoły zaburzeń psychicznych. Warszawa: Instytut Psychiatrii i Neurologii. 1993.
 22. Jaspers K: *General Psychopathology*, (1923), 7thed. 1962.
 23. Johannessen E. <http://www.tv2.no/nyheter/innenriks/22-juli-terror-oslo-og-utoya/breiviks-psykolog-det-var-som-aa-treffehannibal-3803685.html>.
 24. Jones E. The Phenomenology of Abnormal Belief: A Philosophical and Psychiatric Inquiry. *Philosophy, Psychiatry & Psychology.* 1999;6(1):1-16.
 25. Kraepelin E: *Dementia praecox and Paraphrenia.* W: "Text-Book of Psychiatry", Robertson GM. 1919; 32.
 26. Kretschmer E. *Medizinische Psychologie.* Leipzig: Thieme. 1922.
 27. Martin JA, Penn DL. Brief report social cognition and subclinical paranoid ideation. *Br. Journal of Clinical Psychology.* 2001;40:261-263.
 28. Medvedev Z, Medvedev R. A Question of Madness. How a Russian Scientist Was Put in a Soviet Mental Hospital and How He Got Out. 1971.
 29. Melle I: The Breivik case and what psychiatrists can learn from it. *World Psychiatry.* 2013;12:16-21.
 30. Meyer R: *Psychopatologia. Jeden przypadek – wiele teorii. Studia przypadków.* Gdańskie Wydawnictwo Psychologiczne. 2003;137.
 31. Meyer-Gross W, Slater E, Roth M. *Clinical psychiatry.* Slater E, Roth M (eds.). 1960.
 32. Mojtabai R. Delusion as Error: The History of a Metaphor. *History of Psychiatry.* 2000;11(41):3-14.
 33. Mullen P. Morbid Jealousy and the delusion of infidelity. Bluglass R, Bowden P, Walker N. *Principles and practice of forensic psychiatry.* Melbourne. 1990; 823-834.
 34. Owen G, Harland R, Antonowa E, Broome M. Jaspers' concept of primary delusion. *BJP.* 2004;185:77-78.
 35. Peters E, Joseph S, Day S, Garety P. Measuring Delusional Ideation: The 21-Item Peters et al Delusions Inventory (PDI). *Schizophrenia Bulletin.* 2004; 30(4):1005-1022.
 36. Rassin E, Muris P. Abnormal and normal obsessions: A reconsideration. *Behaviour Research and Therapy.* 2006;45:1065-1070.
 37. Rosenhan DL, Seligman ME. *Psychopatologia. Tom drugi.* 1994:257-261.
 38. Savienko J. (Савенко, Юрий): "20-летие НПА России". *Nezavisimiy Psikhiatricheskiiy Zhurnal,* 2009;1:5-18.
 39. Seligman MEP, Walker EF, Rosenhan DL. *Psychopatologia.* 35:724-726.
 40. Semple D, Synth R, Burns J, Darjee R, McIntosh A. *Oksfordzki podręcznik Psychiatrii.* A Grzywa (red.). 2007; 59.
 41. Shostakovic PW et al. (Шостакович РВ), ВФ Матвеев: психопатия. *Справочник по психиатрии, Морозов, ГВ (ред.).* 1988;2:301.
 42. Spitzer M. The phenomenology of delusions. *Psychiatric Annals.* 1992; 22(5):252-259.
 43. Torrey EF. *The roots of treason: Ezra Pound and the secret of St. Elizabeth's.* New York, 1983.
 44. Tørrissen T, Aspaas A: 2012-04-10 Psykiatriske Rapport om Anders Behring Breivik. Rettspsykiatrisk erklæring til Oslo tingret. Avgitt 10.04.12 i henhold til oppnevning den av 13.01.12. <https://sites.google.com/site/breivikarkiv/dokumenter/anders-behring-breivik-rettspsykiatrisk-erklæring-2012-04-10#19.0>
 45. Uszkiewiczowa L. Orzecznictwo sądowo-psychiatryczne w świetle 4200 ekspertyz szpitalnych. 1960;1: 1, 297-359, Summ.: 395-400.
 46. Walker C. Delusion: What did Jaspers Really Say? *British Journal of Psychiatry.* 1991;159(supl. 14): 94-103.
 47. World Health Organization: *The ICD-10 Classification of Mental and Behavioural Disorders. Clinical Descriptions and Diagnostic Guidelines Geneva,* 1992.

KLIEDĖJIMAI EKSPERTINĖSE IŠVADOSE**Jerzy Pobocho**

Raktažodžiai: klieđėjimai, paranojinės idėjos, viršvertės idėja, fanatizmas, hiperdiagnostika, ekspertinė išvada

Santrauka

Aptariama klieđėjimo definicijų įvairovė ir prieštarngumas klasikiniuose tekstuose, klinikiuose bei teismo psichiatrijos vadovėliuose bei ankstesnėse ir dabar galiojančiose klasifikacijose DSM ir ICD, taip pat įvairios diagnozių formuluotės, kaip latentinė šizofrenija, paranoidinė hipochondrija ir garsios diagnostinės teismo psichiatrų klaidos, tokios kaip A. B. Breiviko byloje. Parodyta, kad mąstymo procesams, sprendimams įtaką daro kiti psichikos procesai, kaip nerimas, ekspertizės situacija, asmenybės sutrikimai, fizinė sveikata, išsilavinimo lygis, intelekto pajėgumas, kultūrinis fonas, politinės ir religinės pažiūros, gyvenimo būdas, taip pat ir pačios nusikalstamos veikos aplinkybės. Siūlomas atsargesnis klieđėjimo apibrėžimas – tai klaidingi sprendimai,

kurių neįmanoma koreguoti arba aiškinti kitaip – kaip įsitikinimus, nuostatas, prietarus, viršvertės idėjas, įkyrias mintis, fobijas, simuliaciją ir t.t. Ekspertai suklysta dėl savo žinių ribotumo, klinikinės patirties stokos, neatsižvelgimą į aukščiau minėtų veiksmų poveikį tiriamųjų mąstymui ir elgesiui, rėmimosi vienpusiškais klieđėjimo apibrėžimais ir polinkio (tendencijos) hiperdiagnozuoti arba skubėti diagnozuoti neturint išsamios informacijos apie inkriminuojamą veiką. Klieđėjimai priklauso nuo smegenų pusrutulių funkcinės lateralizacijos (kontrasto) ir anatominės abipusio ryšio stokos. Ją atspindi abu terminai - schizo-phrenia ir dementia praecox – ją sąlygoja ne pažinimo nepakankamumas, o paties mąstymo padrikumas.

Adresas susirašinėti: jpobocha@ifg.pl

2014-01-20