REVIEW ARTICLE

SET-UP MADNESS: A REVIEW

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Abstract

Objectives: **Psychosis can be defined as a mental disorder in which a person's thoughts, affective response, ability to recognize reality, and ability to communicate and relate to others are sufficiently impaired to grossly interfere with his or her capacity to deal with reality. The classical characteristics of psychosis are impaired reality testing, hallucinations, delusions, and illusions. While factitious disorder and malingering are usually acknowledged as contrived psychiatric conditions for acquisition of interior or exterior profits, respectively, another alternative, also, exists that though is not manufactured individually, is enforced peripherally. Such cases, which are usually referred by the judge's ruling, for evaluation and treatment, are more important than comparable simulated or genuine mental conditions, because incorrect diagnosis, or careless, cagily, and guarded validation of preliminary diagnosis that has been issued in the authorized or emergency department, can seriously endanger the individual's civil rights, while it should not be overlooked that incorrect diagnosis is a kind of malpractice that may harm an individual awfully. In the present article the clinical picture of the said situation, in addition to some case histories, and recommendable hints for differential diagnosis between different types of psychoses, has been discussed.** ***ASEAN Journal of Psychiatry, Vol. S1 (2): March- April 2021: 01-08.***

Keywords: Primary psychiatric disorder, Psychosis, Frame-up psychosis, Set-up psychosis, Forensic psychiatry, Clinical-legal issues in psychiatry, Malpractice.

Introduction

While factitious disorder and malingering are usually acknowledged as contrived psychiatric conditions for acquisition of interior (psychological) or exterior (social, legal or economical) profits, respectively, another alternative, also, exists that though is not manufactured individually, is enforced peripherally. The later condition can have root in a tempestuous or revengeful quarrel between disagreeing partners, intrigue by, such as, relatives or part owners, for illegitimate acquisition of wealth, or dishonest radical or felonious ways for ostracizing, defaming and deletion of opponents. Such cases, which are usually referred by the judge's ruling, for evaluation and treatment, are more important than comparable simulated or genuine mental conditions, because incorrect diagnosis, or careless, cagily, and guarded validation of preliminary diagnosis that has been issued in the authorized or emergency department, which is commonly shaped during an inadequate assessment and based on data that is decorated by the objectors, plotters or challengers, can seriously endanger the individual's civil rights. So, while it should not be overlooked that incorrect diagnosis is a kind of malpractice that may harm an individual awfully, maybe it is better to acknowledge that any diagnosis in the aforementioned sites often has an unspecified outline, due to expectable deficiency of time and information, and so can be excluded or included in the same way. In the present article, the

above problem has been surveyed under the label of 'frame-up psychosis', because it usually has the allegation of insanity or craziness by ordinary people, which so turns into psychosis by the professionals. Moreover, after description of psychosis, for better representation of the condition a few correlated case histories have been talk about.

Definition of Psychosis

Psychosis can be defined as a mental disorder in which a person's thoughts, affective response, ability to recognize reality, and ability to communicate and relate to others are sufficiently impaired to grossly interfere with his or her capacity to deal with reality [1]. the classical characteristics of psychosis are impaired reality testing, hallucinations, delusions, and illusions [2]. Delusions are fixed beliefs that are not amenable to change in light of conflicting evidence, and their content may include different themes [3]. While persecutory delusions and referential delusions are common, grandiose delusions, erotomanic delusions, nihilistic delusions, and somatic delusions are not rare, too [4]. Delusions are considered bizarre if they are clearly improbable and not understandable to same-culture peers and do not derive from regular life experiences, as like as thought withdrawal, thought insertion, and delusions of control [5]. The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear or sensible opposing evidence as regards its reliability. Hallucinations are perception-like experiences that occur without an external stimulus [6]. They are vivid and clear, with the full force and impact of normal perceptions, and not under intentional control. They may occur in any sensory modality, but auditory hallucinations are the most common in schizophrenia and related disorders. Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, which are perceived as distinct from the person's own thoughts [7]. The hallucinations must occur in the context of a clear sensorium; those that occur while falling asleep (hypnagogic) or waking up (hypnopompic) are considered to be within the range of normal experience. Hallucinations can be a normal part of religious experience in certain cultural milieus [8]. Disorganized thinking is typically inferred from the person's speech. The individual may switch from one topic to another. Answers to questions may be obliquely related or completely unrelated. Rarely, speech may be so severely disorganized that it is nearly incomprehensible and looks like receptive aphasia in its linguistic disorganization. Because mildly disorganized speech is common and nonspecific, the symptom must be severe enough to substantially impair effective communication. Grossly disorganized or abnormal motor behavior may show itself in many ways, ranging from childlike "silliness" to erratic agitation. Problems may be noted in any form of goal-directed behavior, leading to difficulties in performing activities of daily living [9]. Catatonic behavior is a marked decrease in reactivity to the environment. This ranges from resistance to instructions; to maintaining a rigid, inappropriate or bizarre posture; to a complete lack of verbal and motor responses. It can also include purposeless and excessive motor activity without obvious cause. Other features are repeated stereotyped movements, staring, grimacing, mutism, and the echoing of speech [10]. Finally, negative symptoms account for a substantial part of the illness linked with schizophrenia but are less noticeable in other psychotic ailments. They include: diminished emotional expression, avolition, alogia, anhedonia, and asociality [11,12].

Case vignette

1) A middle-age, low-educated man had been referred and hospitalized in a public psychiatric hospital, by the judge's ruling, for psychiatric evaluation and treatment. He was accused of aggressive and threatening behavior against neighbors, and so, based on the testimony of plaintiffs about his abnormal behavior, from one hand, and defiant and bellicose conduct of the charged in the police department, forensic unit and law court, on the other hand, has been hospitalized with diagnosis of Bipolar Disorder. This happened in spite of the kin's severe objection and testament in support of the health of the indicted. Singleness, unemployment, a bit of nervousness, sporadic fierceness, occasional sleeplessness, and some pompously attitude was the basis of the said primary diagnosis. After admission and first interview and Mental Status Examination (MSE), due to normal vegetative functions and absence of DSM-5's

diagnostic criteria for bipolar disorder the said diagnosis was rather destabilized, but due to the aforesaid petition an absolute dismiss demanded more certainty. So, as well as inclusion of daily records by nurses, psychologist, and occupational therapist, the caseworker was appointed to probe his social behavior in indigenous setting, which was in remote distance from the hospital. In the first expedition, which was in a workday, no worthwhile data was attainable, except than meeting with a local shop-owner, who was himself among the petitioners, and so had repeated again the aforesaid accusations. But in the second trip, which was in a holiday, more meetings and interviews with a number of neighbors were possible. The fresh data could endorse kin's announcements regarding the normal behavior of the accused before admission and the context in which the conflicts had happened, which was in harmony with the findings of day-to-day MSE and personnel's accounts during one week incessant monitoring in the hospital. So, due to lack of evidence on behalf of any known as a political dissident and so she was the 'person of interest' for secret intelligent services, and could feel their hidden presence, she could not prove their undercover doings; an allegation that was neither provable nor refutable. Nevertheless, whatever seemed to be as like as a delusional mood, was not in harmony with her students' testimonies and level of educational or professional function in the last weeks, months or years. On the other hand, her ideal dissidence, which was an inactive disposition integrated with her business, was definitely demonstrable. So the milieu was ready for reciprocal dubiousness. In such a situation, paranoid ideas can turn into understandable systematized secondary non-bizarre delusions, accompanied sometimes by some elementary or context-related hallucinations. Anyhow, after a few days and thanks to her kin's perseverance she was released without any final conclusion or methodical rejection of the said primary diagnosis.

3) A young educated man was refereed and ordered to be hospitalized in a public psychiatric hospital, by the judge's ruling, intended for psychiatric evaluation and treatment. The problem had begun when he started a political debate with the driver of a taxicab and another passenger in the same cab that ended soon into an altercation and strong swearword, which caused an indictment against him by the aforesaid complainers. Aggressive behavior, yelling, confrontation with police officer, and encounter with the judge in the law court, as well, triggered the magistrate to advocate referral of the charged to a psychiatric hospital. So, in line with the available reports, he had been hospitalized with the primary diagnosis of Bipolar Disorder. After initial interview and MSE, he stated that probably he was not anonymous for the cabdriver, who purposefully and unexpectedly started an argument against his political thoughts and used the other traveler (maybe his friend or accomplice) as testifier. Absence of classic criteria of bipolar disorder and lack of affirmative facts in history and MSE, plus insistence of his relatives regarding his good mental health, necessitated a mission by the caseworker for examining his social function, which validated, once more, satisfactory relations and businesses during the months or days before admission. So, after one week incessant monitoring and day-to-day MSE and staffs' reports, and due to lack of proof in support of any serious mental problem, he was released without any psychiatric diagnosis.

4) Two sisters were refereed and hospitalized in an academic psychiatric hospital according to the ruling serious mental problem he was released with no diagnosis.

2) A highly educated young woman, was refereed and hospitalized in a community psychiatric hospital according to the ruling issued by the judge, due to complaint of neighbors and accusation of aggressive behavior, irrational mistrustfulness, frequent bickering, and attributing misconduct like overhearing, espionage, sneaking, and stalking to other neighbors, in the last few months. So she was hospitalized, in spite of her and her kin's severe resistance in the police department and courtyard, with the primary diagnosis of Schizophreniform Disorder (in the list of Schizophrenia Spectrum and Other Psychotic Disorders). After admission and first interview and MSE, while the persecutory ideas were a bit retrievable, no bizarre delusion, whether complete or partial, or organized auditory hallucination or other comparable illusions were detectable. As said by her, though she was an academician, she was

while she

issued by the judge, due to complaint of some of the blood relatives and allegation of aggressive conduct, unreasonable distrustfulness, repeated quarreling, crazy altercations, and blame of fraud (against accusers and the current government, as their accomplice) for embezzling their shared father's inheritance. Their disobedience against trooper and civil officer, and combative conduct in the forensic department and law court, as well, reinforced the said accusations, which finally ended in arraignment against them and hospitalization with the primary diagnosis of Shared Psychotic Disorder (Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, in DSM-5). Reports showed that while no observable problem was evident regarding their sleep and appetite, their daily activities before admission, as well, was completely regular, which was provable, over again, by their proper manner in the ward and in the occupational therapy sessions. MSE could not show any remarkable finding except than preoccupation with familial discord over inheritance, which was confirmed later according to the social worker's investigation. Also, their assertion against the government had occurred because the main petitioner was a high-ranking government functionary, who, on the word of them, perhaps, but not certainly, could be supported administratively. Justice in distribution of inheritance was their only request. So, the said primary diagnosis had been cancelled and they released without any diagnosis.

Discussion

Among the medical specialties, psychiatry plays a particularly distinct role within the province of the law, given its potential application across a wide range of legal issues. Contained at the core of most legal principles is the general presumption that adults of sound mind possess the capacity to understand, appreciate, reason, and choose throughout a boundless range of life activities. When those mental capacities are called into question at the behest of a legal quandary, psychiatry may be summoned to assist with reaching an equitable resolution. The presence or absence of a mental health or cognitive disorder may significantly impact the manner that a legal issue, whether civil or criminal, is perceived and ultimately managed [13]. The enduring relationship between the law and psychiatry has evolved over the centuries as a necessary element of humankind's aspiration toward just resolution of legal disputes. In no other place is this more evident than with the historical development of the legal concept of insanity in criminal law. Two traditional legal justifications, 'parens patriae' and 'police power', provide state jurisdictions with the authority to involuntarily hospitalize, or civilly commit, mentally ill people for the purpose of treatment. 'Parens patriae' refers to governmental power to care for individuals who are unable to care for themselves. The 'police power' principle refers to the societal interest of permitting governmental authority to protect the general public from potential harm. Jurisdictional statutes regarding involuntary psychiatric hospitalization generally require the presence of a mental disorder and a degree of risk of harm to the patient or to others due to the patient's symptoms of mental ailment [14]. Typically, the clinical determination for the necessity of civil commitment weighs a patient's current symptoms, relevant historical information, and collateral information sources (e.g., family members, friends, etc.) in the setting of a patient's inability or unwillingness to cooperate with the examination. Usually, these civil commitment assessments involve emergency situations in which family members, ambulance personnel, or police bring the patient to the emergency department because of concerns that the patient will imminently engage in suicidal, self-injurious, or violent behaviors. So, during these assessments, the critical issue that must be addressed is whether patients' current psychiatric symptoms place them at risk of harming themselves or others. Additionally, some jurisdictions specifically require that involuntary treatment be implemented via the least restrictive alternatives available. However, clinical efforts to preserve patient dignity and foster a therapeutic alliance with the patient remain paramount [15]. In converse to factitious disorder and malingering that exhibits ill mental health due to internal or external incentives, while there is really no primary psychiatric disorder, person with frame-up psychosis denies from the start existence of any psychiatric disorder in himself or herself, which is very similar to denial of illness in real psychotic patients with impaired judgment, who have lost absolutely the insight about the real state of affairs (Table 1). The later situation along with testimony of other people, whether blood relatives or unfamiliar

people, about exhibition of irrational behavior or strange warning signs by the person, in emergency department or lawful settings, can persuade initially every clinical examiner that maybe he is facing with a real psychosis, in the range of Schizophrenia Spectrum and Other Psychotic Disorders**,** Bipolar and Related Disorders**,** Substance-Induced Disorders, or at least an Unspecified Mental Disorder, which demands further probe and data. While usually medical and laboratory checkups can dismiss substance-related or medical causes, the other exclusions customarily depend on mental state examinations, staff's observations, or data of other relatives, colleagues, neighbors, or friends, if accessible. Therefore, the assessor is often and submissively dependent on exterior information and inferences, which is always a major problem in modern psychiatry that lacks any clear-cut organic diagnostic standard, up to now. Quarrelsome partners, confrontational part-owners, resentful competitor, envious opponent, or an ordered conspirator may misrepresent the situation one-dimensional or unidirectional enough to cause wrongful diagnosis, even by an experienced psychiatrist. Creating a quarrelsome scene to deceive people, through provoking or irritating people, and setting up testimonial evidence by means of filming, voice recording or testament of spectators, are among the typical tricks of rivals or antagonists for devastation or dishonoring the victimized subject. Accusing or libeling psychosis, too, may instigate from the similar process. Moreover, initial and emotional defense and defiance of victimized individual reinforce the aforesaid deceitful blaming, because it is very similar to usual resistance and denial of known outrageous and crazy (psychotic) people. On the other hand, it is understandable that why the inference or explanation of common people as regards abnormal or lunatic behavior should be naturally different with the professional principles of qualified mental health workers, like psychiatrists, clinical psychologists, psychiatric nurses, psychiatric occupational therapists, or social workers. Experience and knowledge are the two important foundations concerning discriminating between understandable fierceness and un-understandable or morbid violence, which is a common problem solving strategy, too, for many of illiterate or bully persons, if we see aggressiveness, sometimes, as an occasional strategy for attainment of profits. The same gap is the keystone for insincere individuals to manipulate or misuse unaware common people against the 'person of interest'. Above and beyond, devious accomplices may help the aforesaid set-up process more effectually than the ignorant and meddlesome masses. Mindful Machiavellian collaborators can arrange the scenes and facts so expertly that deludes an inexpert clinician with no trouble. Finding signs and symptoms of schizophrenia or mania through newspapers or internet and attributing them, partly or completely, to their victim is not a difficult job for decisive conspirators. But as like as allegation of poisoning, which is not confirmable without laboratory finding of poisonous bits and pieces, verification of abnormal behavior or psychosis, too, is not possible without well-founded clues and detects during objective mental state examination, day-to-day staff's records, 24-hourly checking, vegetative functions, and analysis of milieu within which the events have happened, disregard to noisy assertions of current complainers. An exact history reported by the subject, his or her relatives, friends, colleagues, employer, employee, neighbors, local shop-owners, about remote or recent occasions, and especially the immediate period before denunciation and authorized referral to psychiatric service, can help the clinician to check methodically the situation by a phenomenological and descriptive approach, based on integration of contradictory and matching features. While there is no guarantee that the required information and accounts are achievable or retrievable, without them, also, no reliable diagnosis is imaginable, especially in a field that has no clear-cut organic indicative measure. At this point, the subjective aspect of psychiatric examination, including past, present, personal, familial, drug and medical history, is as good as the objective aspect of MSE, or sometimes even more significant, because while the items of MSE are changeable in different sessions due to various reasons, the history is usually unchanging if has been narrated by honest people and has been probed professionally and intelligently. A multidimensional history including personal, familial, and functional aspects of subject's life, can discern between accused symptoms and true warning signs. At this juncture, probing of daily doings by qualified personnel, like social workers, and mission teams, in

the surrounding area, can have an influential help, which is not often replaceable by just telephonically tools for gathering information. While, socially, many people do not like to have contact with the psychiatric facilities or legal services, they cooperate without difficulty with mental health workers in their own milieu. Furthermore, even though diagnostic evaluation in outpatient settings can be considered as a thinkable alternative, serious and doubtful cases have to be hospitalized and observed 24-hourly for enough period, up to attainment of enough data for excluding or including a serious condition, which may impact the individual's civil rights for the rest of his or her life. Though medical malpractice law is that segment of tort law that addresses harm caused by health care professionals, it does not expect psychiatrists to cure all their patients. Nor does it expect that any psychiatrist need perform at an above-average level. Rather, medical malpractice law expects only that psychiatrists will not intentionally (*i.e.,* purposefully) or negligently (*i.e.,* unreasonably) harm their patients. As reflected in the claims made against the liability insurer for American Psychiatric Association (APA) members, 8% percent of errors claimed to have caused harm included incorrect diagnosis. So, as has been advised in DSM-5's code 298.9 (F29), maybe it is better to assume any conceivable diagnosis of psychosis in the emergency room settings as 'Unspecified Schizophrenia Spectrum and Other Psychotic Disorder' or 'Unspecified Bipolar and Related Disorder', or even 'Unspecified Mental Disorder', when there is insufficient information to make a more specific diagnosis, or, perhaps as a better tactic, to preface with 'ruling out' (R/O) of ……. , as an alert phrase, and avoid a definite diagnosis in uncertain or doubtful situations. On the other hand, maybe, frame-up psychosis should be included, by some means, in the section II. Diagnostic criteria and codes of DSM-5, in the chapter of "Other Conditions That May Be a Focus of Clinical Attention", which covers other conditions and problems that may be a focus of clinical attention or that may otherwise affect the diagnosis, course, prognosis, or treatment of a patient's mental disorder. A condition or problem in the said chapter may be coded if it is a reason for the current visit or helps to explain the need for a test, procedure, or treatment. So, the conditions and problems listed in the aforesaid chapter are not mental disorders. Their inclusion in DSM-5 is meant to draw attention to the scope of additional issues that may be encountered in routine clinical practice and to provide a systematic listing that may be useful to clinicians in documenting these issues. Adult Maltreatment and Neglect Problems, whether by Spouse or Partner, or Non-spouse or Non-partner, particularly Adult Psychological Abuse, Other Problems Related to the Social Environment, like Social Exclusion or Rejection, Target of (Perceived) Adverse Discrimination or Persecution, Problems Related to Crime or Interaction With the Legal System, or Problems Related to Other Psychosocial, Personal, and Environmental Circumstances, like Victim of Terrorism or Torture, or Exposure to Disaster, War, or Other Hostilities, can be mentioned as the related subdivisions, incidentally [16].

Conclusion

Among different types of accusations, psychosis that is framed up by adversaries demands extra care and patience by psychiatrist, because there can be a number of confounding elements, like scarcity of time, source, and information, which may make an improper diagnosis more possible than a right one, especially by an inexpert clinician in an awkward atmosphere. This may happen in spite of clinician's subjective and professional trustworthiness. So, an all-inclusive in-ward analysis by taking into account the staff's reports, plus regional probes or extra professional consultations, if necessary, during an enough period of time, can prevent, in total, an incorrect diagnosis of psychosis.

Variables	Factitious disorder	Malingering	Primary psychiatric disorders	Frame-up psychosis
Positive premorbid history	Possible	Possible	Very probable	Possible
Positive familial history	Possible	Possible	Very probable	Possible
Duration	Usually chronic	Usually acute	Chronic or Acute	Usually acute
Delusion	Bizarre/non-bizarre (partial)	Bizarre/non-bizarre (partial)	Bizarre/non-bizarre (complete)	Non-bizarre (partial)

Hallucination ; Pseudo-hallucination	Very probable	Very probable	Usually	Very unlikely
Illusion	Unlikely	Unlikely	Possible	Very probable
Disorganized speech and behavior	Possible	Possible	Very probable	Very unlikely
Vegetative functions	Usually normal	Usually normal	Usually abnormal	Usually normal
Nervousness	Unlikely	Unlikely	Usually	Probable
Observable aggressiveness	Unlikely	Unlikely	Usually	Unlikely
Resistance against admission	Unlikely	Unlikely	Usually	Usually
Resistance against treatment	Unlikely	Unlikely	Usually	Usually
Attitude to interview	Cooperative	Cooperative	Semi-cooperative ; Non-cooperative ; Guarded; Evasive	Cooperative
Vanishing of reported symptoms instantly after hospitalization	Unchanged	Unchanged	Sluggish	Abrupt
Detecting of reported symptoms in the first MSE	Easy	Easy	Easy/Difficult	Difficult
Mood	Euthymic	Euthymic	Euthymic; Euphoric; Dysphoric; Depressive; Labile; Anxious	Euthymic; Anxious
Affect	Appropriate	Appropriate	Appropriate; Inappropriate; Blunted; Restricted; Flat	Appropriate
Speech	Normal	Normal	Normal; Retarded; Pressure of speech; Volubility	Normal / Talkative
Cognitive functions	Normal	Normal	Commonly Impaired	Normal
Acceptance of mental condition	Absolutely	Affirmative	Nope	Not at all
likelihood of Understandability of condition	Low - Medium	Medium - High	Un-understandable	High
Subjective explanation of state of affairs	Mixed up	Upside down	Disorganized	Systematic
Finding social, political or economical causes	Unlikely	Likely	Not ever	Definitely

Table 1: Differentiating hints concerning various psychoses.

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