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Forensic Psychological Evaluation of an Incarcerated Client with Schizophrenia: A Case Report on Psychosis-Driven Arson

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Abstract

The psychiatric evaluation of N, a 33-year-old Zimbabwean man detained at Chikurubi Maximum Prison Psychiatric Hospital after being charged with arson and attempted homicide during a psychotic episode, is presented in this forensic case report. N was diagnosed with schizophrenia (DSM-5-TR F20.0) following a thorough evaluation that included psychometric testing, a mental status assessment, collateral interviews, and risk assessment. The results showed auditory hallucinations, persistent persecutory delusions, diminished insight, and a high risk of violence or harm to others if left unattended. The client's history, clinical presentation, evaluation findings, and formulation are all covered in depth in the report, which ends with suggestions for ongoing inpatient mental health treatment, organised supervision, and medication compliance. The case emphasises how crucial forensic psychological evaluations are to striking a balance between public safety concerns and professional treatment.

Key words: Schizophrenia, Psychosis, Arson, Risk Assessment, Delusions, Incarceration

Client demographic information

Name	N (Pseudonym)
Date of Assessment	02/06/2025
Date of Birth	28/02/1992
Chronological Age	33 years 3 months 5 days
Nationality	Zimbabwean
Gender	Male
Marital Status	Single
Profession	Former shop assistant
Academic Level	ZIMSEC Ordinary Level

Client history

Referral Source: Referred by the Harare Magistrate's Court in conjunction with the Chikurubi Psychiatric Forensic Unit.

Developmental History: Normal developmental milestones with no perinatal complications.

Family Background: Youngest of four, raised by mother. Paternal absence noted. Maternal uncle has history suggestive of psychosis.

Social History: Became socially isolated two years before arrest, developed mistrust and persecutory beliefs.

Educational and Occupational: Completed Form Four. He worked intermittently due to behavioural issues and unreliability.

Substance Use: Occasional cannabis user, denies other substances.

Forensic History: No prior offences.

Medical and Psychiatric: Diagnosed with schizophrenia in 2025. Symptoms began in 2022 but were untreated until incarceration.

Dsm-5-tr diagnostic impression

Primary Diagnosis: Schizophrenia – F20.0

Differential Diagnosis Considered:

Delusional Disorder: ruled out due to hallucinations and functional decline

Substance-Induced Psychotic Disorder: excluded due to absence of current use and persistent symptoms

Case management and treatment plan

Case formulation

Predisposing Factors

N's predisposition to schizophrenia is influenced by his family's history of psychosis, especially the history of his maternal uncle. Furthermore, his frequent cannabis usage has made him more susceptible to psychotic symptoms including persecutory delusions and auditory hallucinations.

Precipitating Factors

N's increasing paranoia, disorganised behaviour, and the emergence of persecutory ideas were significantly triggered by unemployment and social isolation. His idea that he needed to "drive out demons" by setting fire to the neighbouring property was exacerbated by the tensions connected to his apparent mental conflict with malevolent spirits.

Perpetuating Factors

N's psychotic symptoms persisted and his understanding of the nature of his condition was hampered by his noncompliance with treatment, which was demonstrated by the delay in starting antipsychotic medication until his incarceration. His ongoing delusions and lack of remorse for his conduct highlight the continuous difficulties in treating his psychosis and lowering the likelihood of violent behaviour in the future.

Protective Factors

In N's instance, inpatient supervision and family support proved to be critical protective factors. A framework for tracking his development, guaranteeing medication adherence, and reducing the risk of harm to himself and others upon possible community reintegration is provided by the organised behavioural supervision within the correctional facility and the continuous mental health support.

Follow up sessions

This session's main objectives were orientation and rapport-building. At first, the client came across as distrustful and defensive. He constantly questioned whether the interviewer was "part of the system" and was hesitant to respond to personal queries. He claimed to have been "sent to deliver people from darkness" and made nebulous references to a spiritual conflict. The session gave important first impressions of his disordered thinking and religious hallucinations, despite little participation.

The Brief Psychiatric Rating Scale and Mental Status Examination were given during the second session. N's thought process was incoherent, and he repeated persecution and divine missions. He said he thought his neighbours had brought demons into his house. Observations of auditory hallucinations were supported by his periodic pauses in midsentence and his apparent response to internal

General observations

Appearance	Poor grooming, unshaven, mild body odor
Posture	Slumped
Eye contact	Intermittent
Speech Thought content	Mostly coherent but circumstantial, vague Persecutory delusions, conspiracy beliefs, religious preoccupation
Mood	Flat affect with inappropriate smiling
Insight	Absent
Behavior	Cooperative but irritable when discussing offense
Motor activity	Slightly slowed, stable
Hallucinations	Likely auditory (responding to internal stimuli)
Attitude	Polite, religious references, insisted actions were divinely guided

History of presenting problems

N's offense involved setting fire to a neighbor's house while shouting that he was 'driving out demons'. He believed the family next to their house was bewitching his mother and that the house was occupied by malevolent spirits. He attempted to prevent the family from escaping. Neighbors intervened before police arrival. His family reported a gradual decline since 2022, marked by paranoia, disorganized behavior, and insomnia. African Traditional interventions failed. By 2025, delusions culminated in violent behavior. Post-arrest, antipsychotic medication was initiated, with some improvement but persistent delusions.

Assessment of the client

This forensic psychological evaluation was done by combining psychometric testing, a thorough mental status examination, collateral interviews, and structured risk assessment tools, the evaluation aimed to ascertain his present mental condition. Clarifying the severity of his psychotic symptoms, auditory hallucinations, persistent persecutory delusions, and limited insight as well as assessing his risk for future aggression if treatment is not received were given special attention.

Mental Status Examination (MSE)	Disorganized thoughts, delusions, flat affect, impaired
Brief Psychiatric Rating Scale (BPRS)	Score: 49 – Moderate to severe psychotic symptoms
Positive and Negative Syndrome Scale (PANSS)	P: 23, N: 18, G: 38 – Consistent with chronic schizophrenia
Beck Depression Inventory-II (BDI-II)	Score: 15 – Mild depression (worthlessness, guilt, fatigue)
HCR-20	High risk markers: psychosis, violent behavior, poor impulse
Collateral Interviews	Confirmed deterioration, delusional behavior, aggression,

inputs. He maintained his physical composure during the discussion, despite the presence of hostile themes.

The PANSS and BDI-II were administered during the third session. N used structured tools with greater ease. He maintained his stated denial of depression while endorsing cognitive symptoms including fatigue, diminished concentration, and a sense of being "drained by evil forces." Significant delusions, conceptual disarray, and suspicion were shown by the PANSS results. Negative symptoms including flattened affect were consistent with the patient's lack of emotional sensitivity and nuanced reactions.

The HCR-20 was used for risk assessment. The offence and previous behaviours were discussed in the session. "God's instruction to cleanse evil" is how N characterised the arson incident. He showed no contrition and denied any guilt. During the past year, there was a trend of untreated psychosis and increasing aggressiveness, according to collateral interviews with family members and jail authorities. He still lacked knowledge into sickness.

A psychoeducation session was held using simplified explanations of mental illness and illustrations. N framed his experiences as spiritual combat, rejecting the terms used in psychiatry. "They're trying to silence me, but I know my mission," he said in response to a question concerning medication. Despite his resistance to clinical interpretation, he paid close attention the entire time. His ignorance brought his erroneous framework's depth to light. The last session went over the results and talked about possible outcomes. For a portion of the program, correctional unit staff participated. N showed no further understanding or introspection, but he stayed courteous and docile. Because of the ongoing pharmacological medication, his speech was more structured than in previous sessions. The care team was reminded of the importance of secure accommodation, frequent supervision, and continuous mental health support.

Course of the therapy

Phase 1: Stabilization

During this stage, the main goals were to address N's spiritual beliefs within a forensic psychology framework and stabilise his symptoms through medication adherence. Conducting individualised psychoeducation sessions that incorporate N's spiritual framework with the reasoning for antipsychotic medication was a crucial component of the treatment approach. Medication was increased, adherence and treatment participation by acknowledging and honouring his beliefs. Motivational interviewing techniques were also be used to investigate how N perceived his spiritual experiences. Building trust with N and provided him the tools he needed to actively manage his mental health by encouraging a cooperative and non-confrontational approach.

Phase 2: Insight Building

The goal was to help N gain understanding of the distress brought on by his persecutory delusions and conspiracy theories, the treatment plan included Cognitive Behavioural Therapy for Psychosis (CBTP) principles during this phase. CBTP was adapted to explore the cognitive distortions that were underling N's delusions while acknowledging his distinct views.

N's comprehension of how his thoughts affected his feelings and actions was enhanced, reality check was encouraged, and false convictions gently challenged. We effectively navigated the fine line between examining N's ideas and preserving a therapeutic relationship that relied on empathy and validation by applying forensic psychological approaches.

Phase 3: Risk Management

The implementation of a thorough relapse prevention strategy that incorporated forensic risk management techniques was incorporated in the treatment plan. Early warning indicators unique to N, such heightened religiosity and irregular sleep habits, were recognised and actively watched through continuous risk assessments. This conducted by regular and comprehensive risk assess

ments using validated tools such as the HCR-20 to evaluate N's level of risk for violence and harm to others.

Correctional employees such as prison officers, mental health specialists, and family members were integrated to develop a crisis intervention plan that offered prompt assistance during times of increased risk. We guaranteed a coordinated reaction to possible crises and reduce the risk of harm to N and others within the forensic context by developing a structured crisis plan. By implementing these elaborate and case management and treatment techniques based on psychological approaches, we intended to offer comprehensive care that attended to N's special requirements, facilitating rehabilitation, and creating a secure and encouraging environment that supported his recovery and well-being.

Concluding evaluation and outcome

N demonstrated partial improvement under treatment but remained at high risk if unsupervised. His offense was directly linked to psychotic symptoms, with impaired judgment and absent insight. Forensic psychiatric intervention and strict monitoring remained essential in reducing risk and supporting rehabilitation.

Ethical considerations

The ethical guidelines for forensic psychology were followed in this evaluation. Only authorised professionals were given access to the findings, confidentiality was preserved, and informed consent was requested in the client's capacity.

Recommendations

Structured Daily Supervision

Implement a structured behavioural supervision schedule that included; aily routines with fixed wake-up times, hygiene checks, medication administration, and scheduled activities

Medication Adherence Monitoring by conduct weekly psychiatric reviews for the first 3 months of treatment to evaluate symptom response and side effects.

Regular Structured Risk Assessments

Reintegration & Long-Term Planning throughe reintegration planning six months prior to potential community transfer and Re-assessing violence and relapse risk every 3 months using the HCR-20 V3 to monitor dynamic risk factors.

Family Therapy by Scheduling family review meetings via in-person and ensuring consent is obtained.

Staff Training in Managing Psychosis in Correctional Settings to recognizing psychotic symptoms and behavioral concerns and de-escalation techniques suitable for psychotic agitation.

Conclusion

This case illustrated the grave implications of untreated severe mental illness as well as the ethical dilemmas that arise when the forensic and psychiatric areas intersect. This case provide insights on the risks associated with untreated psychosis and the difficulties in striking a balance between qualified treatment and public safety. Zimbabwe's cultural background, which include unsuccessful traditional healing procedures, offers this narrative a unique depth and emphasises the significance of culturally sensitive methods in forensic psychology. The distinctive characteristics of the arson motivated by psychosis highlight the complex relationship between mental health issues and criminal activity. We may gain more understanding of the complexities involved in forensic psychiatric evaluations and interventions, particularly in varied cultural settings, by emphasising these key concepts in the debate or conclusion.

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