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Violent Behaviors Associated with the Antichrist Delusion

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ABSTRACT: Delusions involving the antichrist concept have been occasionally reported. Some cases of the antichrist delusion have been associated with violent behavior. In this article we describe the case of a man who suffered from a chronic antichrist delusion and who also displayed repeated and serious violent behaviors. We also discuss the role of the antichrist delusion as well as other psychotic symptoms in the genesis of violence in the present case.

KEYWORDS: forensic science, antichrist delusion, delusional misidentification, psychosis, violence, aggression, forensic psychiatry

Religion occupies a central and generally positive force in the development of human civilization. Nonetheless, religious thought may also have negative consequences, such as a not infrequent association with aggressive ideas and behaviors. In fact, the historical record presents us with chronicles of numerous wars many of which were fought in the name of religious causes (1–5).

The well-known relationships between violence born of war and religion also finds a strange but unmistakable parallel in civilian based cults that demand unconditional acceptance of religious tenets with violent punishment to the transgressors. In recent years these cults have risen in a myriad of forms and some of these have led to dramatic episodes of serious aggression, including violent homicidal behaviors both to their own members as well as to others. One of the best known cults in recent history led to over 900 deaths and occurred in Jonestown, Guyana in 1978, when the leader of the People's Temple, Jim Jones, ordered his followers to poison themselves with cyanide as a "revolutionary act" that was intertwined with Jones' apocalyptic religious ideas (6). In 1993 David Koresh, the leader of the branch davidians, was alleged to have ordered what amounted to the burning and killing of his followers. Seventy-four cult members died in the process, including 21 children. David Koresh expressed the view that he was a messiah. His sexual behavior involving many minors of his cult and his apocalyptic views that led to the Waco massacre were based on Koresh's highly idiosyncratic religious views regarding his understanding of the Biblical book of Revelations (7,8).

In 1995 five two-man teams from the doomsday cult Aum Shinrikyo, allegedly under orders of their leader Shoko Asahara, released a nerve gas in the Tokyo subway system that killed 11 and sent over 5000 to the hospital. Shoko Asahara had built a cult that eventually incorporated religious apocalyptic notions that led to the nerve gas attack. Several other unsolved homicides are also thought to be linked to Asahara and his cult (9–11).

Because of the potential association of religious ideas with aggression, this issue has received great attention in order to better safeguard society. One potentially fruitful area of intervention is the association between aggression, religiosity, and major mental disorders. Some major mental disorders such as psychoses and manic states have been linked to aggressive behaviors (12). In regard to psychotic disorders, the presence of delusions has received special attention as a factor that increases the risk of physical violence in the affected person (13,14).

The co-occurrence of dangerous religious delusions could heighten the potential for aggression. One particular delusion of a religious nature that has been associated in some cases with aggression is the antichrist delusion (15). The antichrist is a biblical religious figure that is generally thought of as evil in nature (16). In this article we present the case of a man who suffered from a delusion in which he believed himself to be the antichrist. The association between his antichrist delusion and aggressive behavior are explored. The role that different delusional components as well as other symptoms and factors had in the development of this individual's aggression is also discussed.

Case History

Mr. D was a 32-year-old single male who suffered from the delusion that he was the Antichrist. He was raised in a traditional Protestant home where regular church attendance was the norm and religious holidays were celebrated. Available information indicated that he became psychotic at age 17 and about a year later he developed the delusion of being the Antichrist. He believed that it had taken him about eight years to become the Antichrist. Two years later he kidnapped and raped two women while delusional and intoxicated with phencyclidine. He described the instant offenses as being acceptable activities because as the Antichrist he had managed to "influence" them into participating in sexual intercourse. Objectively he was able to rape his victims because he threatened them with death at gun point. He also stated that as the Antichrist he was able to perpetrate activities such as forceful sexual intercourse because he was evil. He called himself the Antichrist and Lucifer, adding that the two names referred to the same evil entity. Mr. D was found not guilty by reason of insanity on both counts of rape.

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Mr. D's Antichrist delusion was chronic and he continued to be confined in a hospital for the criminally insane. He was last evaluated during his ninth year of confinement. At that time he stated that he was the Antichrist and that he was going to bring Armageddon upon the human race. Specifically he explained that a great portion of the human race could perish as a result of his activities as the Antichrist. He also complained that several members of the hospital staff had attempted to take his mind and powers in order to deprive him of the powers of the Antichrist, but added that they would only succeed at times. He also believed that Mr. E, a member of the hospital staff, had studied Mr. D's body chemistry and thought, and with the aid of special machines had succeeded in making physical replicas of Mr. D. He believed that these replicas were controlled by spirits that were positioned in the bodily replicas by Mr. E. Mr. D also believed that the bodies of many members of the hospital staff no longer exhibited their personalities, but added that Mr. E had placed spirit minds in their bodies substituting the original minds in the process and would thus be able to control the staff. Mr. D also believed that the hospital where he resided was not a real hospital, adding that only initially was he deceived into believing that he was in a real hospital. He did not, however, believe that there were several replicas of the hospital.

Because Mr. D believed that he was being harmed by hospital staff and by patients, and because he believed he was destined to destroy the human race, he engaged in numerous physical fights with both patients and hospital staff. He also expressed fears that others would like to perform anal intercourse with him, because they believed that he was a homosexual. He suffered from insomnia claiming that he needed to stay awake because he feared physical, including sexual, attacks from others. He also stated at times that he needed to hit people in order not to lose his abilities and powers as the Antichrist. Mr. D. displayed a labile mood. His insight was impaired in that he was delusional and also did not believe that he was mentally ill. His thought processes were consistent with loose associations. His thinking also was very concrete. At times he would report experiencing auditory and visual hallucinations. He was oriented to place and time. In the hospital Mr. D. also experienced difficulties with impulse control independent of his hostility. He would experience great difficulties in managing his money and would frequently overspend his money in the local canteen. He was unable to complete chores assigned to him because he would suddenly abandon what he was doing. He would also fail to stay in therapy groups because he would often leave to start other activities. His attention span was consistently low.

Mr. D's physical, including neurological, examination was unremarkable. His complete blood count, urinalysis, serum chemistries, and EEG were within normal limits. He had a history of regular alcohol and cannabis use of several years duration prior to his present confinement. He had no history of major medical problems.

Mr. D met DSM-IV diagnostic criteria for paranoid schizophrenia, alcohol abuse, and cannabis abuse (17). He had been treated with multiple trials of antipsychotic medication for his psychosis, and carbamazepine as well as lithium to control his poor impulse control and aggression. In spite of continuous psychopharmacologic treatment in a high security psychiatric unit, he has only demonstrated little improvement regarding his impulsivity and aggression and his delusions have remained unchanged.

Discussion

In 1996 Silva and colleagues noted that some delusions involving antichrist content could be categorized as a function of delusional misidentification content (15). In delusions of misidentification the affected individual delusionally believes that radical changes in bodily and/or mental make-up occur in the self and/or others terminating in different identities from the originals (18). From the viewpoint of delusional misidentification it has been proposed that an antichrist delusion may be of two types. First, the affected individual believes that he or she is the Antichrist. Second, the affected individual may only delusionally misidentify others as the Antichrist. However, it should also be stressed that non-misidentification delusions involving antichrist content also exist. An example would be an individual who delusionally believes that the Antichrist is pursuing him or her but makes no claims that the Antichrist is identifiable. In this example, the Antichrist delusion is part of the picture of a broader generalized paranoia. Mr. D's antichrist delusions apply only to his own personal identity and are more consistent with the first type (15). Specifically, Mr. D. suffered from a syndrome of delusional misidentification of the self because he believed that he was mentally someone else other than his objective identity, namely the Antichrist. This delusion of personal identity is consistent with reverse Capgras syndrome, in which the individual believes that he or she have a different mind or is in the process of becoming mentally someone else (18–20).

Delusions of misidentification of the self are also well known to co-occur with delusions of misidentification of others (20,21). Mr. D also believed that numerous members of the hospital staff no longer had their minds, but instead harbored the minds of spirits, or else they were controlled by the mind of another hospital staff member. Furthermore, no changes in bodily makeup were postulated. This presentation is consistent with a Capgras-spectrum delusion in which the misidentified object is conceptualized as harboring a different mind without changes in physical appearance (18). Mr. D also believed that physical replicas of him existed with personalities different than that of the patient. This presentation is consistent with a delusion of subjective misidentification (18,22).

Misidentification delusions have been studied from a forensic psychiatric point of view and it is known that these delusions may lead to serious aggressive behaviors (21), although this impression must be tempered with information indicating that many cases of delusional misidentification do not present with aggressive ideas or behaviors. Misidentification delusions of the self involving the Antichrist identity have not been frequently reported, however they can be of forensic psychiatric significance because they may be associated with serious aggression. In 1991 Driscoll and colleagues reported the case of a 48 year-old male who believed he was the Antichrist. This individual attempted to strangle his 83 year-old mother. He also had struck her in the head and shoulders with an 110 pound bar (23). In 1992 Silva and associates mentioned the case of a man who reported sexually molesting a child because the man believed himself to be the Antichrist (21). In 1996 Silva and colleagues reported the case of a 24 year-old man who delusionally believed he was the Antichrist and as a result had wanted to shoot people with a gun. He was known to harbor homicidal ideas when he believed he was the Antichrist (15). In Mr. D's case it is clear that at least part of his aggressive behavior was due to his antichrist delusion. More specifically, the case of Mr. D was consistent with an antichrist delusion of the self that brought about violent behavior toward others. In his case there was clear evidence that he physically harmed numerous people because he believed that it was his destiny as the Antichrist to harm and even kill people.

Mr. D did not reveal any delusions in which he believed that others were the Antichrist. Such delusions involving aggressive ideas and violent behaviors have been documented. In one case,

for example, a man who angrily and delusionally believed that President Reagan was the Antichrist, was able to enter the President's residence before he was apprehended by the secret service (21). In another case a 25 year-old man suffering from schizophrenia stabbed and killed a social worker, believing in the process that he was killing the Antichrist (24). Although there is mounting evidence that antichrist delusions may be implicated in aggressive behaviors, we also emphasize that antichrist delusions without any association to dangerous behavior have also been documented (25). Moreover no epidemiologic evidence exists to indicate that antichrist delusions are more dangerous than other delusions.

Antichrist delusions often are part of a more elaborate multi-delusion system. In the present case, the antichrist delusion was accompanied by a significant component of grandiosity to the point that Mr. D's antichrist delusion can also be conceptualized as a grandiose delusion. Mr. D's belief that as the Antichrist he was a powerful figure destined to change the course of humanity, further encouraged him to harm others. His grandiosity also further encouraged his belief that he could not be controlled by human beings. Mr. D also experienced paranoid delusions that others were trying to limit his antichrist powers and that in general they wanted to hurt him. This paranoid belief caused Mr. D to become fearful as well as angry toward those he believed wanted to harm him. This paranoid process led Mr. D to frequently attack others.

Mr. D also suffered from somatic delusions during which he believed that others would steal several parts from his body. These delusions contributed to his dangerousness because he blamed several patients for the alleged stealing of his body parts and then has proceeded to physically attack the putative thieves.

The dangerousness of these individuals may be not only due to the misidentification delusion itself, but also to the mood lability (26). Mr. D appeared to have significant difficulties with poor impulse control that found expression in areas besides hostility. For example, he would initially attend but would impulsively leave group therapy in order to engage in other activities that suddenly came to his mind. Prior to his hospitalization he was also known for spending money frivolously and to impulsively abuse drugs. Therefore, impulse control may be a factor independent of hostile delusional cognition that needs to be taken into account when evaluating aggressive behavior associated with delusional thinking. Moreover, Mr. D. suffered from serious abnormalities in attention and also evidenced thought disorder associated with loose associations. These symptoms would have likely precluded him from being able to reflect on his thoughts and emotions.

Delusional cognition like non-psychotic thinking may also be significantly influenced by the contemporaneous psychosociocultural milieu of the affected individual (27–30). This is especially true of religious delusions that depend in large part on the social and cultural milieu that spawns a specific religion. Thus for example, psychotic individuals raised in western countries with a Judeo-Christian tradition are more likely to experience the delusion that they are Christ than those living elsewhere (31). If an individual misidentifies the self as an evil religious figure, then the specific cultural symbols that characterize that figure may very well have some impact on the genesis of aggression. In Mr. D's case he believed that the antichrist represented a figure intent on causing physical harm and even death on others, consistent with his interpretation of the Biblical Antichrist. The expectation on Mr. D's part that he had become an evil persona therefore fueled his tendency to become hostile. Such expectation can be conceptualized as a culturally formed pathway mediating an individual's tendency to engage in aggressive behaviors.

In addition to analyzing the antichrist delusion from a phenomenological and psychosocial viewpoint, it is important to stress that the formation of delusional thinking also appears to be related to underlying cerebral deficits that may themselves not be easily conceptualized in psychological terms. The available psychiatric literature suggests that right brain deficits may be particularly important in the causation of delusional misidentification syndromes (32,33). Other studies suggest that bilateral symmetrical abnormalities such as atrophy in the frontal lobe and temporal lobe areas of the brain may be present in individuals suffering from delusional misidentification (34,35). However more recent studies using brain neuroimaging technology suggest a more complex process in both hemispheres involving both bilateral as well as asymmetric patterns (36–38). The way in which the neural structures related to delusional misidentification are relevant to the neural substrates associated with violent behavior is unknown and therefore represents a potential area for the study of psychosis and aggression.

In conclusion, antichrist delusions are complex systems and many cases involve delusional misidentification. Some cases of the antichrist misidentification delusion may carry a significant risk for violence. In cases of antichrist delusional misidentification, other components such as paranoid, grandiose, and somatic delusions may also contribute to the genesis of violence. Moreover, other symptoms and predispositions such as hallucinations and impulsivity may be important contributors in the causation of aggression. Individuals who suffer from antichrist delusions should be carefully evaluated for risk of violence. However, it should also be stressed that antichrist delusions may not necessarily be associated with aggressive behaviors. Furthermore, the extent to which antichrist delusions lead to violent behaviors in comparison to other types of delusions remains unknown.

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