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Homicidal Behavior in Schizophrenics

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ABSTRACT: This paper emphasizes that homicidal behavior may be part of the clinical manifestation of schizophrenia. The failure to hospitalize potentially violent schizophrenics contributes to the incidence of psychotic homicide. The tendency to diagnose homicidal schizophrenics as personality disorders combined with legal changes brought about a shift of this population from the mental health system to the criminal justice system.

KEYWORDS: psychiatry, mental illness, homicide

Psychotic Homicide

Some psychotics commit homicide as a result of being psychotic and, therefore, some homicides are symptomatic of psychosis. Unfortunately, psychotic homicide is relatively neglected in psychiatric literature and dealt with reluctantly in clinical discussions. Accounts of killings by psychotics often begin with a reassurance that psychotics rarely kill.

My impression is that psychotics kill more frequently than the nonpsychotics given the opportunity to kill. In the past, psychotics even though homicidal, rarely caused death since they were confined to psychotic institutions.

Comparisons of the homicide rate among psychotics and nonpsychotics are often misleading. The setting in which violence occurs determines the result of the violence. A homicidal attack in a hospital is not likely to have lethal consequences since weapons are not readily available and external control is quickly provided.

Clinical observations show that some psychotics are violence prone; unpredictable violence is a common symptom of psychosis. Whether or not this violence proneness results in homicide depends upon environmental factors.

The homicidal tendencies of schizophrenics and other psychotics are often neglected or denied. Schizophrenics who engage in violence are at times diagnosed as personality disorders. The case of Mr. K provides a good example of this trend.

Mr. K, a 21-year-old American Indian was born in North Dakota on an Indian reservation and was adopted by a military family. At the age of 16 he wandered aimlessly throughout the country and developed an uncontrollable urge to kill someone. This idea was unrelated to any environmental circumstances and became a compelling force in his life. In 1979 he stabbed to death a man who was standing at a urinal in a hotel washroom. While imprisoned, he made attempts to kill fellow inmates, and was, therefore, confined to a solitary cell. This precaution was not sufficient. Mr. K induced a fellow prisoner occupying an adjacent

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cell to place a rope around his neck which he fashioned out of a bed sheet and pushed through a small hole in the wall separating the two cells. He then pulled the rope until he was certain the man was dead. The first victim survived, but as a result of brain damage was unable to describe what transpired and was presumed to have been a victim of a suicide. Mr. K repeated the same procedure with the subsequent neighbor, this time succeeding in killing him.

In 1979 before the first homicide he suffered visual and auditory hallucinations. Nevertheless, a report from Michigan Center for Forensic Psychiatry concluded that Mr. K "showed absolutely no signs currently of a mental illness." He was diagnosed as having a personality disorder, found criminally responsible, and sentenced to life imprisonment without parole.

In May of 1983, subsequent to the homicide in the prison, the same examiner at the Michigan Center for Forensic Psychiatry concluded,

> the defendant's behavior exhibited on the day of the alleged crime was not a product of mental illness, but instead a result of his personality disorder. . . Mr. K has absolutely no regard for human life. . . it is the opinion of this examiner that the defendant's behavior on the day of the alleged crime was logical, coherent and well thought out. There was absolutely no indication of mental illness.[2]

Once again Mr. K was found sane and given an additional life sentence. All of his homicidal attacks are recorded as nonpsychotic. In my opinion, Mr. K presented a classic picture of schizophrenia. He was delusional, hallucinating, and exhibited flat affect.

Another young schizophrenic preoccupied with violent ideas and engaging in noninjurious violent behavior was hospitalized on six separate occasions within a three-year period. Shortly after his seventh discharge from the state hospital, he awakened in the middle of the night, grabbed the family shotgun, and fired at imaginary targets, killing his mother in the process and seriously injuring another relative. His symptomotology did not change outside of the institution. The tragic outcome was determined by the setting in which the patient found himself [*1*].

Psychosis and Violence: Recent Psychiatric Studies

Taintor et al. [*2*] reported that 6% of their study population have been involved in assaults before being admitted to in- or out-patient facilities. Tardiff and Sweillam [*3*] reported that 10% of their sample had been so involved before admission to in-patient wards.

Bell and Palmer found that, in a 3-month sample of 687 patients who appeared in a psychiatric emergency service, 140 (20%) were agitated and 106 (15.6% of the total sample) of the agitated group were so out of control that they had to be physically restrained [*4*].

Impulsive assaultiveness is associated with high level of anger, agitation, and low impulse control [*5*, p. 1262]. These three phenomena are often observed among schizophrenics and organic brain syndrome patients.

Craig reports that 11.2% of patients hospitalized during a single year demonstrated assaultive behavior before admission. Another study from four New Jersey facilities gave a 36% prevalence of some form of violent behavior before admission [*5*, p. 1263].

Craig concludes, "Thus, it would appear that assaultiveness is specifically linked with emotional distress among patients with schizophrenia and that schizophrenia patients without overt agitation and anger are less likely to be assaultive" [*5*, p. 1265]. This observation does hold true for assaultiveness related to emotions (emotion assaultiveness). On the other hand, there are psychotics whose assaultiveness is rooted in their ideation (ideational assaultiveness).

Lamb and Grant conducted a study of male and female inmates of the Los Angeles County Jail referred for psychiatric examination by the male staff. In the study of the male inmates

[2]Case report on file with the author.

they found that 90% had psychiatric hospitalizations and 92% had prior arrest records, 75% of these for felonies. Eighty percent exhibited severe, overt psychopathology. More than 75% met the criteria for involuntary hospitalization [*6*].

These data indicate that a significant number of patients are cared for jointly by the criminal justice system and the institutions for the mentally ill. Psychiatric hospitalization and imprisonment have become interchangeable modes of intervention for the care of the mentally ill in the United States. Lamb and Grant found this to be the case among female psychotic inmates of the Los Angeles County Jail:

> We are struck by the large proportion (70%) of the female sample who had histories of serious physical violence ranging from assault to murder. Moreover, 23% were charged with violent crimes on this arrest. It may be that the violence factor resulted in many of these women being jailed rather than hospitalized . . . the great majority of women in this study who had children had demonstrated an inability to care for them. . . . many had simply abandoned their children. Others had abused their children or did not take even minimal care of them. . . . almost all persons thought to have committed a felony are arrested and brought to jail regardless of their mental condition. . . . *whatever specific reasons for arrest, there is evidence for diversion into the Criminal Justice System of persons who, before deinstitutionalization, would have been lifetime residents of state hospitals with little chance for possible arrest* [*6*] (emphasis added).

Lamb and Grant provide a typical clinical example.

> A 36-year-old woman who on this arrest had been loitering in the bus station was asked to leave. Instead, she hit a passing stranger in the eye and was charged with assault and battery. . . . She had her first psychotic episode at age 17, she married and had two children whom she tried to rear. She spent ten years in a state hospital following several episodes of violence—pushing her mother down a flight of stairs and pushing her aunt over a bannister. She was placed in a board and care home where she remained for one year, leaving after another violent episode to return to the state hospital. She has always been non-compliant with medication . . . she returned to Chicago briefly to live with her father but said she didn't like it there, returned to Los Angeles, and lived on the streets as a prostitute. . . . she was placed on 72 hour hold and transferred to the state hospital, where she was thought to be uncooperative and not amenable to treatment and returned to jail after two days. She served only a brief sentence for the assault and refused all efforts at placement and out-patient referral. She was back in jail two months later—charged with first degree murder [*6*, p. 367].

It can be safely assumed that this particular patient will remain a lifelong inmate in a prison.

Planansky and Johnson report a study of homicidal aggression in schizophrenic men. Since all of their patients were hospitalized, none of them caused any fatalities, although they were responsible for many assaults. They write, "In about one-third of the incidents the target was unspecified, the patient merely stating he was going to kill somebody" [*7*].

Fottrell studied violent behavior in British psychiatric hospitals. He defined three degrees of violence based upon the seriousness of the injury, if any inflicted on the victim. Violence of the first degree was present when no physical injury was detectable or suspected in the victim when examined by the doctor. Second-degree violence was when minor physical injuries such as bruises, abrasions, and small lacerations were present. The third degree, where physical injury was found or suspected in the victim, included all large lacerations, fractures, and loss of consciousness.

The results show that third-degree violence was exceedingly rare, whereas first-degree violence relatively common [*8*].

Fottrell found that schizophrenics were prominently represented among the violent patients.

Fottrell also observed that "patients exhibiting violence will be likely to be discharged early, and have but short explosive stays in the hospital. It is likely that these patients exhibit violence especially of a persistent kind outside rather than inside the hospital, or else in prison" [*8*, p. 220].

It can be assumed that outside of a hospital the violence committed by these patients would be higher in degree of seriousness than observed in the hospital.

The old image of psychotics as highly dangerous represented an exaggeration of the reality. The recent placement of psychotics into the community is likely to exacerbate the existing stereotype. Deinstitutionalization made the fears about high degree of dangerousness of psychotics more of a reality.

Deinstitutionalization and Schizophrenic Violence

Deinstitutionalization places a heavy burden on psychiatric out-patient clinics and private practitioners. Management of violent patients in psychiatric out-patient facilities is becoming an increasing problem.

Richmond and Ruparel have reviewed the literature dealing with management of violent patients in outpatient clinics. They conclude,

> Several authors suggest that violent patients are best treated on an as needed basis within an emergency room setting, in order to reduce overwhelming anxiety in subsequent transference—counter transference difficulties within the patient-therapist relationship. . . . such patients may need to use the emergency room ward only twice a year or so, but they will return for help if their initial contact has been positive. Others may need daily contact through a crisis [*9*].

These authors provide case vignettes as illustration of the management of violent patients in a psychiatric walk-in clinic. Their first patient is described as a 26-year-old paranoid schizophrenic, "who had been refused treatment at several institutions because of violent behavior."

They then describe this individual as having history of threatening behavior toward his mother and having been arrested many times "for assaulting policemen and emergency room staff at several local hospitals, where he frequently demanded care. Several hospitals had simply refused to treat him because of his violent behavior."

The authors emphasize that a "positive approach," towards this patient made him accessible and manageable in their outpatient clinic.

What seems to be overlooked here is that this type of person represents a serious risk of future violence, including homicide. The legal criteria make the commitment of such an individual difficult; however, in the event that the patient commits a violent act, the treating psychiatrist may be sued for malpractice and held liable for damages.

Neither the patients nor those around them benefit from the attempts to keep them outside of a hospital at any cost. The anti-civil commitment crusade created a new reality for psychotic patients and psychiatrists who deal with them. Violent psychotics are now living in the community. Psychiatry attempted to adapt to this development by creating so-called violence clinics [*10*].

Richmond and Ruparel write, "Rather than creating a 'Violence Clinic' we have expanded our existing walk-in-clinic. With the increased demand for community clinics to treat violent patients we offer what we feel to be an attractive, practical and easily implemented solution to the treatment of the violent patient" [*10*].

The assumption that violent psychotics can be managed in an out-patient facility overlooks the nature of the problem itself.

Prevention of Schizophrenic Violence

The present state of our knowledge about schizophrenia does not provide means for primary prevention of this disorder. Kaplan writes: "It (primary prevention) involves lowering the rate of new cases of mental disorder in a population over a certain period by countering harmful circumstances before they have had a chance to produce illness" [*11*, p. 26].

Kaplan defined secondary prevention in terms of lowering the prevalence of the disorder in the community. He writes, "a reduction in prevalence can occur in two ways: either the rate of new cases can be lowered by altering the factors which led to the disorder . . . or the rate of old cases can be lowered by shortening the duration of existing cases through early diagnosis and effective treatment" [*11*, p. 89].

Tertiary prevention, is defined by Kaplan as "reducing the rate of residual defects" [*11*, p. 113]. The beneficial effects of psychopharmacological contributions to tertiary prevention have been counterbalanced by the undesirable impact of deinstitutionalization on primary and secondary prevention. We have taken one step forward and two steps backward.

The legal restrictions on the civil commitment of schizophrenics and the efforts of community psychiatry have brought about an increased prevalence of schizophrenia in the community. The long-term effects of the increased community presence of schizophrenics on the rate of new cases of mental disorder in a population has not been studied to my knowledge. Pathogenic effects of prolonged interpersonal involvements with schizophrenics within families are likely.

My clinical observations lead me to the conclusion that the incidence of schizophrenic violence in the community has significantly increased as the result of decline of involuntary hospitalization. In a hospital setting, the psychotropic drugs often control aggression associated with psychosis. A medicated psychotic patient is likely to be viewed as nonviolent. The level of compliance among discharged psychotics is rather low; therefore, it can be anticipated that various symptoms including aggressive behavior will reoccur after discharge and failure to take medication [*12*].

A paper entitled "Psychiatrists Response to Violence: Pharmacologic Management of Psychiatric In-Patients" by Appelbaum, et al. demonstrated that there was no significant difference in type and dose of medication before violent act and no significant changes afterward. It is apparent from the paper that the authors felt concerned by the assumption of lawyers and judges that psychiatrists overmedicate patients in response to violent behavior. "Fears that psychiatrists tend to try to prevent violent acts or respond to violence by prescribing excessive doses of medication (i.e. snowing the patient) were not realized in this setting" [*13*].

The authors conclude their paper with the statement, "whether the stereotype of psychiatric wards as places in which 'chemical restraints' are freely used to *stifle patients' impulses is valid,* a view of psychiatry that has been given credence in several recent court decisions, can only be determined by further nonanecedotal studies" (emphasis added).

One wonders if it would not be appropriate for psychiatrists to respond to the violence of psychotic patients with high dosages of antipsychotic medication. If one views violence as a particularly malignant symptom of psychosis, then the accusation that psychiatrists are "stifling patients' impulses" is unreasonable. Psychotic violence, like profuse bleeding, is a dramatic symptom often requiring drastic interventions. It has been my experience that some violent psychotics have a remarkable tolerance to medication, and, therefore, significant increases in dosage are indicated.

The failure to control the violence of a psychotic is not only physically dangerous to the patient and others, but does also adversely affect the prognosis. In spite of psychotic disorganization, patients are aware of the inappropriateness of their conduct. Thus, violent behavior becomes an additional burden for the sick person.

Management of Schizophrenic Violence and Public Opinion

The management of schizophrenia involves some interventions which are significantly affected by legal regulations and public opinion. These social forces are not directly influenced by psychiatric research or psychiatric literature.

In the last 20 years ideological and social factors brought about a drastic change in the

image and management of schizophrenia. The potential for violence associated with this illness has been minimized and denied. The results have been detrimental to schizophrenics and persons exposed to them. Secondary prevention of schizophrenic violence has declined since it requires recognition of existing risk factors.

Clinical management of psychotic patients is hampered by the denial of propensity for violence among psychotics. The view that violence is not one of the symptoms of psychosis makes the imposition of external controls difficult. Many psychiatric facilities in the United States specializing in the treatment of psychotics have provisions for the physical control of violent patients. Suicides and homicides result from the absence of readily available controls of psychotic violent behavior in an institutional setting. Treatment and care of some psychotic patients requires availability of coercive measures.

Parker reported in 1979 that the reduction in the number of patients in government psychiatric institutions "has resulted in an increase in murder committed by the mentally ill, an opinion shared by all forensic psychiatrists throughout Australia" [*14*].

Cancro, the acclaimed schizophrenia researcher states,

> This writer in reviewing more than 30 years of psychiatric practice devoted primarily to the treatment of psychosis has found that more than 30 persons have been killed by psychotic patients he has either known or treated. That averages out to one healthy person a year killed by psychotics, most of whom were schizophrenics" [*15*].

Some treatment modalities, even though technically appropriate, become incongruent with the spirit of the times. Long-term hospitalization as a treatment modality became distasteful to the American public in the seventies and in the eighties. The current vogue in the United States is to admit an acutely psychotic patient, stabilize the clinical picture by psychopharmacological treatment, and then discharge the patient after a brief stay in the institution. Some schizophrenics are able to respond to this approach with relatively long intervals of adequate adjustment, others relapse within weeks or days. The dogma of brief hospitalization does not provide for a differentiation based upon prognostic assessment of violence potential.

Ideological and fiscal considerations have decreed that short-term hospitalization is the prevailing treatment of chronic psychotic illness. The fact that some schizophrenics require lifelong supportive custodial care in institutional settings is not acceptable to influential segments of the American public.

Psychiatry, particularly forensic psychiatry, has an ethical obligation to promote public awareness that violence is one of the symptoms of schizophrenia. Public policy in relation to involuntary hospitalization should be based, at least in part, upon clinical realities.

Propagandistic efforts of the seventies have obscured schizophrenic propensity towards homicidal behavior. The result has been that the patients, their families and communities, and last but not least, innocent victims suffer.

Psychiatric knowledge of psychosis no longer prevails in legal disposition of most cases. The law requires that a person, in order to be involuntarily hospitalized, has to be mentally ill and also someone who can be reasonably expected to do harm to himself or others. Furthermore, that expectation has to be confirmed by some recent overt act or threat. An uncooperative psychotic patient may not be hospitalized unless there is some evidence of behavior which, excluding suicide, can also be viewed as criminal. Thus, virtually every patient who is a suitable subject for civil commitment may also be charged with criminal conduct, placed in jail, and faces good prospects of criminal conviction. There is a contest between the criminal justice system and the mental health system for the management rights of the same individuals. At the present time, the mental health system is interested in keeping the numbers of individuals under its management as low as possible. The criminal justice system, on the other hand, is motivated to keep the rate of case finding as high as possible. Given this situation, the chances are that a mentally ill individual who has engaged in some overt dan-

gerous behavior will be vigorously claimed by the criminal justice system and disclaimed by the mental health system.

There has been no explicit public policy declaration to the effect that the mentally ill persons who have been violent, are to be managed by the criminal justice system. Nevertheless, as a practical manner, this is often the case. Changes in civil commitment laws which took place over the last 15 years render involuntary hospitalization of potentially violent schizophrenics difficult. Legal restrictions upon use of insanity defense and prevailing public opinion make psychiatric confinement of schizophrenics after violent behavior less likely.

The result has been that county jails and state prisons are holding large numbers of chronically psychiatric inmates. These institutions are ill equipped to provide treatment and care required by a schizophrenic population.

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