Michael G. Rayel,[1] *M.D.*

Clinical and Demographic Characteristics of Elderly Offenders at a Maximum-Security Forensic Hospital

REFERENCE: Rayel MG. Clinical and demographic characteristics of elderly offenders at a maximum-security forensic hospital. J Forensic Sci 2000;45(6):1193–1196.

ABSTRACT: The purpose of the study was to determine the clinical and demographic characteristics of the male elderly offenders admitted to a maximum-security forensic hospital. Charts of male elderly patients were reviewed to obtain clinical and demographic data. Seventy-seven percent of geriatric felons were involved in violent crime, 41% of which had psychotic symptoms. Forty-five percent of offenders with a history of head trauma/neurologic disorder were charged with violent offenses. Fifty-nine percent had previous psychiatric hospitalization. Most elderly male offenders involved in violent crimes had primary psychotic and mood disorders, cognitive impairment, and a history of head trauma/neurologic disorder. The small number of subjects precludes clear conclusions and needs further study.

KEYWORDS: forensic science, geriatric, psychiatric, prison hospital, elderly offenders, mental illness, violence

The elderly population is growing fast. By the year 2030, it is projected that older persons will comprise 20% of the total population in the United States (1). This change in demographics has serious consequences and entails heavy responsibilities. It is assumed that the "graying of America" would extend to the prison community.

The study of older persons in the maximum-security prison is still unexplored. The purpose of this study is to determine the clinical and demographic characteristics of the male elderly offenders admitted to a maximum-security forensic hospital. The data should provide important information to prison administrators, health care professionals, and public officials about the present and future needs of such hospitals.

Method

Charts of male elderly patients, defined in this study as 55 years old and above, who were admitted to Bridgewater State Hospital from November 1995 to November 1997 for forensic evaluation, were retrospectively reviewed. Repeated admissions of the same patient were considered only one admission. The following data were obtained: age, marital status, race, reason for the referral, religion, educational attainment, military service, vocation, history of alcohol abuse, arrest history due to assault and violence, charges on admission, psychiatric diagnosis, psychiatric history, neurologic illness, and past medical history.

Bridgewater State Hospital is a 300-bed forensic hospital. It is the only maximum-security forensic site in Massachusetts. This all-male facility provides various services to include competency evaluation (15B), aid to sentencing evaluation (15E), and evaluation for need of hospitalization (18A). Both psychologists and psychiatrists do forensic evaluation of offenders at various phases of the legal process. Offenders can be examined before or after trial, conviction, or sentencing.

Results of the Study

There were 22 elderly offenders admitted to the forensic hospital during the study period. Twelve were aged 55 to 64 and ten were 65 and older (Table 1-A).Only four were married at the time of admission, and the majority were unmarried, divorced, or widowed. The status of one patient cannot be determined from the chart (Table 1-B). Eighty-six percent of the elderly offenders were Caucasian. Two were African American and one was Native American (Table 1-C).

Fourteen of the elderly offenders came for competency evaluation. One third came for evaluation regarding need for hospitalization (18A) (Table 1-D). The religion of the offenders were varied. Eight were Catholics, six were Protestants, one was Jewish, and two had no religion. In five of the elderly, religion cannot be determined from the chart (Table 1-E).

On educational attainment, 73% reached secondary school and only four obtained a college education (Table 1-F). Sixteen served in the military with seven in the army and six in the navy (Table 1-G). Vocations of the elderly offenders varied. There were two entrepreneurs and six were laborers (Table 1-H).

Eighty-six percent of the elderly offenders had a history of alcohol abuse. Three cannot be determined from the charts (Table 2-A). One half had a prior arrest history for assault and violence. Two had a history of violence but were not arrested. A total of 13 offenders had a history of violence (Table 2-B). Almost 30% were noted to have a sexual assault history (Table 2-C).

Seventy-seven percent of the elderly offenders were involved in violent charges that included assault and battery, maldestruction of property, murder, threats, and intimidation. Nonviolent charges consisted of indecent assault and battery (sexual charge not involving rape). As noted in the chart, the number of charges did not coincide with the total sample because ten offenders had two or more charges (Table 2-D).

Thirty-six percent of the offenders had primary mood disorder and five had primary psychotic disorder. Five had organic impair-

[1] Staff psychiatrist, Dr. G. B. Cross Memorial Hospital, Department of Psychiatry, P.O. Box 1300, Clarenville, NV A0E1J0.

Received 8 Feb. 1999; and in revised form 26 July 1999; accepted 5 Nov. 1999.

TABLE 1—*Offenders' data outline.*

	No. of Subjects
A. Age Range	
55–59	4
60–64	8
65–69	7
70–79	1
80–85	2
B. Marital Status	
Single	6
Divorced	6
Widower	5
Married	4
Separated	0
Unknown status	1
C. Race	
Caucasian	19
African American	2
Native American	1
D. Reason for the Referral	
Competency Evaluation	14
Need for hospitalization	7
Aid to sentencing	1
E. Religion	
Catholic	8
Protestant	6
None	2
Hebrew	1
Unknown	5
F. Level of Education	
Primary	2
Secondary	16
College	4
G. Military Service	
Army	7
Navy	6
Marine	1
Coast Guard	1
Uncertain	1
H. Vocation	
Laborer	6
Retired	3
Auto-worker	2
Boxer	1
Grocery store owner	1
Machinist	1
Truck driver	1
Driving instructor	1
Purchasing agent	1
Restaurant owner	1

TABLE 2—*Offenders' history outline.*

	No. of Subjects
A. Alcohol Abuse History	
Yes	19
No	0
Uncertain	3
B. Assault and Violence Arrest History	
Yes	11
No	8
Uncertain	3
* History of violence	13
C. Sexual Assault Arrest History	
Yes	6
No	16
D. Charges on Admission	
Assault and battery	11
Indecent assault and battery	5
Murder	4
Maldestruction of property	2
Disorderly person	1
Trespassing	1
Breaking and entering	1
Threats	1
Intimidation	1
Violent charges	17
Nonviolent charges	5
E. Psychiatric Diagnosis	
Mood disorder	8
Psychotic disorder	5
Organic-induced	3
Personality disorder	2
Paraphilia	2
Dementia	2
Adjustment disorder	1
Anxiety disorder	1
* Organic impairment and violence	10
* Psychosis and violence	9
F. Psychiatric History	
Psychotic disorder	6
Mood disorder	4
Organic-induced	2
Paraphilia/gender identity	1
Personality disorder	1
Impulse control disorder	1
* Psychiatric hospitalizations	13
* Suicidal/self-injurious behavior	7
G. Neurologic Illness	
History of head trauma	8
Dementia and other cognitive disorders	4
Seizure disorder	2
* Neurologic disorder/head trauma and violence	10
H. Past Medical History	
Yes	16
No	1
Uncertain	4
Cardiovascular	6
Endocrinology	6
Surgical history	4
Gastrointestinal	3
Infectious	3
Accident	2
Joint disease	2
Eye	2
Nutritional	1
Neurology	1
Respiratory	1
* Offenders with more than two medical problems	8

ment including two with dementia. Forty-one percent of the offenders with psychotic symptoms were involved in violence. Ten elderly with some form of organic impairment were involved in violent crime. Only two out of five offenders who were charged with indecent assault and battery were diagnosed with paraphilia (Table 2-E).

Six elderly offenders had a prior history of psychotic disorder and four with mood disorder. One offender was previously diagnosed with transvestism and gender identity disorder, and one with trichotilomania. Sixty percent had psychiatric hospitalizations in the past. Seven had suicidal or self-injurious behavior (Table 2-F).

Almost one third (eight cases) of the offenders had a history of head trauma. Four were diagnosed with dementia and other cogni-

tive disorders. Ten offenders who had a history of head trauma and/or seizure and cognitive disorder were arrested for violent behavior (Table 2-G).

Seventy-three percent of the offenders with significant past medical history. Cardiovascular and endocrinologic problems were the most common. Eight offenders had more than two medical problems (Table 2-H).

Discussion

The majority of the 22 elderly offenders belong to the 60 to 69 age range. Eighty-six percent were Caucasians. Seventy-seven percent of the geriatric felons were unmarried at the time of admission. This may suggest that lack of a support system reduces avenues to express emotions in a positive way. Unexpressed rage may increase the potential to commit a crime.

Seventy-three percent of the offenders served in the military. This has several possible implications. First, some of those who are "trained to kill" have an the increased tendency to violence. Second, persons with a strong potential or tendency for violence may be more inclined to join the military. Third, persons who have been exposed to violence either through actual combat or training for combat are likely to perpetuate or re-enact the same violent scenario.

Eighty-six percent of the elderly offenders had an alcohol abuse history. This not only indicates an increased tendency to violent behavior during alcohol use, but more important, may suggest that sequelae from chronic alcohol abuse along with mood/psychotic disorder or cognitive impairment can result in violence. It is essential to carefully assess and treat forensic patients for alcohol-related problems. The need for addiction services in a forensic hospital and in the community cannot be overemphasized.

Fifty-nine percent of elderly offenders had a history of psychiatric hospitalization, and 32% had a history of self-injurious behavior. This may suggest that psychopathology in the elderly is chronic and that failure to provide maintenance medications and to treat exacerbations could result in poor judgment and impaired reality testing, hence the crime.

Seventy-three percent had significant past medical history. Thirty-six percent had more than two medical problems. This stresses the importance of medical examination and the need for medical facilities in a forensic hospital. Additionally, the medical illnesses themselves, or the patients' frustration and helplessness with their medical problems, may provoke violent behavior.

Seventy-seven percent of the elderly offenders were involved in violent charges and about 45% had two or more charges. These violent charges include assault and battery (11) and murder (4). Fifty percent of the geriatric felons were arrested in the past for violence and assault. Rosner et al. (1984) found that 22 out of 25 geriatric felons were accused of violent crimes. Six were accused of murder, six of manslaughter, and eight of assault. They also noted that the number of defendants accused of violent crimes between two groups, ages 62 to 69 and age 70 or more, were almost equal (12 and 10, respectively). They concluded that the elderly are not necessarily "harmless as they are helpless" (2).

Nine of those who were charged with violence had psychosis. Only four of the elderly offenders who had affective disorder were involved in violent behavior. The association of psychosis and violence was noted in several studies. Ticehurst et al. (1992) found that 8 of 14 elderly homicidal patients had delusions (3). Eronen et al. (1996) found that schizophrenia with or without associated alcoholism increased the odds of committing homicide (4). In studying maximum-security forensic psychiatric patients, Martell (1992) noted that 60% of the subjects had psychotic disorders, the most common of which was schizophrenia (46%) (5). Petrie et al. (1982) found that 44% of the 18 violent geriatric patients admitted to the state hospital were diagnosed with psychotic disorder. They observed that the most dangerous elderly patients were those who experienced paranoid delusions, hallucinations, or both (6).

Consistent with other studies, ten elderly offenders who had a history of head trauma and/or neurologic disorder were charged with a violent offense. Martell (1992) found that subjects with a diagnosis or history suggesting brain dysfunction were more likely to have been indicted on violent charges. Seventy-five percent of those patients diagnosed with organic brain disorder were charged with murder, manslaughter, or attempted murder (5). In other studies (Shah, 1991; Haller et al., 1989; Petrie et al., 1982) dementia was noted to result to violence and aggression (6–8). Ticehurst et al. (1992) found that 12 out of 14 geriatric patients involved in homicidal behavior had cognitive impairment accompanied by delusions (3).

Limitations of the Study

The patients included in this study were from an all-male maximum-security forensic hospital and were expected to have been involved in violent or major offenses. It may not, therefore, be fair to assume that the elderly are involved in more violent behavior. Moreover, comparison with a group of young felons may shed more light on the association of violent behaviors and certain characteristics of the elderly offenders. The retrospective nature of the study has its inherent limitations.

Conclusions

To my knowledge, this is the first study that identifies the clinical and demographic characteristics of elderly offenders admitted to a maximum-security forensic hospital. Seventy-seven percent of geriatric felons were involved in violent crime, 41% of which had psychotic symptoms. Moreover, 45% of offenders who had a history of head trauma and/or neurologic illness were charged with violent offense. Finally, one half of violent elderly offenders had a prior history of violent behavior.

It should be noted, however, that the small number of subjects precludes clear conclusions and therefore needs further study.

Acknowledgments

The author is very grateful to Dr. Ramon Ray Rayel for his advice and critical editing of the manuscript, and to Drs. Thomas Gutheil and Gayzelle Meneses for their encouragement to conduct this research. Work should be attributed to: Harvard Medical School, Massachusetts Mental Health Center, Program in Psychiatry and the Law, Boston, MA.

References

1. Longino CF, Mittelmark MB. Sociodemographic aspects. In: Sadavoy J, Lazarus L, Jarvik L, Grossberg G, editors. Comprehensive review of geriatric psychiatry. Washington, DC: American Psychiatric Press, Inc. 1996:135–52.
2. Rosner R, Wiederlight M, Schneider M. Geriatric felons examined at a forensic psychiatry clinic. J Forensic Sci 1985 July;30(3):730–40.
3. Ticehurst SB, Ryan MG, Hughes F. Homicidal behaviour in elderly patients admitted to a psychiatric hospital. Dementia 1992;3:86–90.

4. Eronen M, Tiihonen J, Hakola P. Schizophrenia and homicidal behavior. Schizophr Bull 1996;22(1):83–9.
5. Martell DA. Estimating the prevalence of organic brain dysfunction in maximum-security forensic psychiatric patients. J Forensic Sci 1992 May; 37(3):878–93.
6. Petrie WM, Lawson EC, Hollender MC. Violence in geriatric patients. J American Med Assoc 1982 July;248(4):443–4.
7. Shah AK. Violence and psychogeriatric inpatients. Int J Geriatr Psychiatry 1992;7:39–44.
8. Haller E, Binder R, McNiel DE. Violence in geriatric patients with dementia. Bull Am Acad Psychiatry Law 1989;17(2):183–8.

Additional information and reprint requests:
Michael G. Rayel, M.D.
Dr. G. B. Cross Memorial Hospital
Department of Pychiatry
P.O. Box 1300
Clarenville, NF A0E1J0
Canada