

Suicide and Violence Risk Assessment

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I. Long term risk factors for suicide:

- A. Family history
- B. Males 3:1 ratio to females for completed suicides
- C. White race
- D. Unmarried status
- E. Living alone
- F. Lack of social support
- G. Alcohol abuse
- H. Medical illness

Persons with chronic illness suicide more than those with terminal illness.

- I. Unemployment
- J. Fall in social or economic status
- K. Rejection by spouse or lover
- L. Previous suicide attempts

Unprovoked suicide attempts (attempts that occurred without any negative events occurring) may be especially indicative of high risk for later suicide.

- M. Anniversary of important losses
- N. Freedom from responsibility for children under age 18.

II. Acute risk factors associated with suicide:

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Child-Murder by Parents and Insanity

Phillip J. Resnick, M.D.

"The murder of one single child is made negligible by nothing, not even Hiroshima."

Pamela Hanford Johnson, "The Sleep of Reason"

I. Definition of Terms

Filicide refers to cases in which the killer is a parent of the victim.

Two distinct types of filicide are evident.

Filicide is operationally defined as the killing of a son or daughter older than 24 hours.

Neonaticide, is the killing of a newborn before this age.

Neonaticide is a separate entity, differing from filicide in the diagnoses, motives, and disposition of the murderer.

II. Postpartum Depression and Psychosis

Women are more likely to experience psychiatric illness after childbirth than at any other time in their life (Kendell et al, 1987).

In the month directly following child birth, women are 25 more times likely to become psychotic (Marks, 1996).

Postpartum depression affects between 10 and 22% of adult women before the infant's first birthday (Stowe et al., 2001).

Postpartum psychosis occurs in only one to two per 1000 births.

The risk of infanticide associated with untreated puerperal psychosis has been estimated to be as high as 4% (Altshuler et al., 1998; Cohen and Altshuler, 1997; Carter et al., 2001.)

The relapse rate for postpartum psychosis is close to 80% (Stowe et al, 2001; Altshuler et al., 1998; Cohen and

Altshuler, 1997; Nonacs and Cohen, 1998).

Mothers with postpartum depression are reluctant to share their upset emotions because they do not want others to think of them as a bad mother.

III. Characteristics of Neonaticide

The great bulk of neonaticides are committed simply because the child is not wanted due to the stigma of pregnancy out of wedlock.

Many girls feel ashamed of having engaged in sexual relations and are fearful that their pregnancies will disappoint and even humiliate their families.

Passivity is the single personality factor which most clearly separates women who commit neonaticide from those who obtain abortions.

Women who seek abortions are activists who recognize reality early and promptly attack the danger.

In contrast, women who commit neonaticide often deny that they are pregnant or assume that the child will be stillborn.

No advance preparations are made either for the care or the killing of the infant.

IV. Classification of Filicide by Motive

Classification of Filicides by Apparent Motive

"Altruistic"	
Associated with suicide	38%
To relieve suffering	11
Acutely psychotic	21
Unwanted child	14
Fatal maltreatment	12
Spouse revenge	<u>4</u>
Total (N=131)	100%

V. Altruistic filicide

A. Associated with suicide.

These mothers see their children as an extension of themselves.

They do not want to leave a child motherless in a "cruel" world as seen through their depressed eyes.

B. Altruistic filicide to relieve victim suffering.

The suffering may be real or imagined.

These mothers may project their own unacceptable symptoms on to the child.

VI. "Acutely Psychotic" Filicide

This designation includes parents who killed under the influence of hallucinations, epilepsy, or delirium.

It does not include all of the psychotic child murders.

This is the weakest category because it contains those cases in which no comprehensible motive could be ascertained.

VII. "Unwanted Child" Filicide

These homicides were committed because the victim was not desired or was no longer wanted by the parent.

VIII. "Fatal Maltreatment" Filicide

A. These homicides are usually the result of a fatal "battered child syndrome."

Homicidal intent is lacking.

This is the most common cause of child homicide in the U.S.

B. Munchausen Syndrome by Proxy

Munchausen's disease by proxy, a syndrome where a caretaker causes illness in their child to gain attention, is a rare explanation for filicide (Lewis and Resnick, 1999).

IX. "Spouse Revenge" Filicide

This final category consists of parents who killed their offspring in a deliberate attempt to make their spouses suffer.

Proof or suspicion of infidelity is a common precipitant for spouse revenge filicide (Wilczynski, 1997).

X. History of Laws Regarding Infanticide

England passed Infanticide statutes in 1922 and 1938.

The law is premised on the belief that a woman who commits infanticide may do so because "the balance of her mind is disturbed by reason of her not having fully recovered from the effect of giving birth to the child" (Oberman, 1996)

Murder charges are reduced to manslaughter.

The 1922 Infanticide Act in England was restricted to "newly born" children in recognition of single women motivated by fear and a desire to conceal their birth.

The Infanticide Act of 1938 included children up til 12 months of age.

This was based on lactational insanity, now considered to have no medical basis.

In practice, women convicted of infanticide in England, do not show significant mental illness as technically required by the law (d'Orban, 1979).

As a result of the British Infanticide Act, women are more frequently placed on probation than imprisoned.

Twenty two nations limit the filicidal mother's culpability to the crime of infanticide, reducing murder to manslaughter (Meyer and Oberman, 2001).

Most of the countries that have specific laws on infanticide follow the British model and pertain to any infant killed by its mother within the first 12 months of life (Oberman, 1996).

American states have not adopted this model.

Some feminist groups criticize the Infanticide Acts for pathologizing childbirth.

XI. Response of the Criminal Justice System to Infanticide

Women who commit crimes are dichotomized into "good" and "bad," "madonnas" and "whores" (Heidensohn, 1985).

The stereotype of mothers is that they are supposed to act always in a loving, warm, selfless, and protective manner toward their children (Pagelow, 1984).

XII. General Principles of the Insanity Defense

A. Components of Insanity

Mental illness

Wrongfulness

Ability to refrain

B. McNaughtan test:

"To establish a defense on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it that he did not know he was doing what was wrong... [and] whether the accused at the time of doing the act knew the difference between right and wrong...in respect to the very act with which he is charged."

Types of Wrongfulness

The illegality standard: The accused lack criminal responsibility if, as a result of a psychiatric disorder, they lacked the capacity to know that their acts violated the law;

Example: Delusional self-defense toward teenage child vs. delusional belief the child was evil.

The subjective moral standard: The accused lack criminal responsibility if, as a result of a psychiatric disorder, they personally believed they were morally justified in their behavior even though they may have known that their acts were illegal and/or contrary to public standards of morality;

Example: Altristic filicide associated with intended suicide.

The objective moral standard: The accused lack criminal responsibility if, as a result of a psychiatric disorder, they did not know that society considers their acts to be wrong (i.e. to know that their acts were contrary to public standards of morality).

Example: A mother kills a child at the command of God as a sacrifice to save human kind.

C. Evidence of knowledge of wrongfulness:

1. Efforts to avoid detection

Wearing gloves during a crime

Waiting until the cover of darkness

Taking the victim to an isolated place

Wearing a mask or disguise

Concealment of a weapon on the way to a crime

Falsifying documents (passport or gun permit)

Giving a false name

Threatening to kill witnesses if they go to the police

Giving a false alibi

2. Disposing of evidence

Wiping off fingerprints

Washing off blood

Discarding of a murder weapon

Burying a murder victim secretly

Destroying incriminating documents

3. Efforts to avoid apprehension

Fleeing from the crime scene

Fleeing from the police

Lying to the police

4. Statement by the defendant that he knew the act was wrong
at the time of the crime
 5. Notifying the police that a crime was committed
 6. Expression of remorse or guilt immediately after the crime
 7. Rational alternative motive
 8. Absence of delusions and hallucinations suggesting the crime was the right thing to do (negative evidence).
- D. Assessment of ability to refrain:
1. Ability to defer versus refrain.
 2. Ability to refrain from general versus specific instructions.
 3. Ability to refrain due to mental illness versus concomitant intoxication or rage.
 4. Magnitude, likelihood, and imminence of consequences for not obeying.
 5. If the defendant was delusional, did he have alternative choices to address his problem.
- For example, could he have gone to the police instead of shooting his imagined persecutor?

XIII. Insanity Defense in Filicide

A. Altruistic filicide

1. Extended suicide-filicide

Severe depression, even without psychotic features may distort thinking so that a mother believes her children will be better off in heaven with her.

In these cases, it is usually clear that the mother knows the nature and quality of her act and that

killing is legally wrong.

However, the mother often believes she is doing what is morally right for her child.

Jury instructions vary on the meaning of wrongfulness.

Some explicitly include moral wrongfulness.

Some do not specify either way; it is then left to the collective conscience of the jury.

If the insanity test is phrased "lacked substantial capacity" to understand the wrongfulness, that may give sufficient flexibility to support insanity in spite of the fact that the defendant knew intellectually the legal wrongfulness of her act.

The wording "appreciate" rather than "know" wrongfulness also may encompass a mother who believes what she is doing is morally right.

This would qualify her for not guilty by reason of insanity (NGRI).

2. Filicide to relieve suffering

The suffering may be real -- This is euthansia. It is not due to mental disease and would not qualify for insanity.

The perception of a child suffering may be due to a delusion by the parent.

The perceived suffering may be based upon a false belief that the child is possessed by Satan, being forced into white slavery, or being tortured by imaginary demons.

Cacodemomania is a delusion of being possessed by a demon.

Killing the child may be perceived as morally right because it is the only way to protect the child from severe suffering or to save the soul of the child.

B. Acutely psychotic filicide

If the act is done during the course of an epileptic seizure

or delirium, the parent may not know the nature and quality of their act.

Filicide during a seizure may lead to an automatism defense since the act is not conscious or voluntary.

In assessing command hallucinations, the examiner must always consider malingering.

Command hallucinations are more likely to be obeyed if the voice is familiar and if there is a hallucination related delusion.

Responding to a command hallucination by God may be perceived as right.

In addition, the parent may feel unable to refrain because the command is from God.

A command hallucination from Satan to kill a child may not be perceived as right, but the parent may not feel able to refrain due to a belief in some severe consequences.

In assessing whether the parent could refrain, one would have to consider whether the defendant did disobey previous commands and the magnitude of harm the parent expected if she failed to obey.

C. Fatal maltreatment filicide

Parental abuse and neglect rarely involve a major mental disease.

The parent is more likely to have a personality disorder.

However, it is possible for single mother to be so depressed that she neglects the care of the child.

Although Munchausen syndrome by proxy is a factitious disorder, it is not likely to serve as a mental disease for purposes of an insanity defense.

Furthermore, the acts are conscious, voluntary, and there is no delusional distortion of reality.

D. Unwanted child filicide

There is ordinarily no basis for an NGRI defense.

E. Spouse revenge filicide

Although borderline personality and dependent personality disorder are common diagnoses, these do not qualify as diseases for purposes of insanity.

The motive is rational and not based on psychosis.

Careful examination is required if there are elements of both "spouse revenge" and "altruistic extended suicide" in a single case.

F. Neonaticide

Most neonaticides fit into the unwanted child category.

Major mental illness is infrequent.

If a woman conceals her pregnancy, delivers her baby alone, and disposes of the baby secretly, it creates a strong inference that she knew the nature, quality, and wrongfulness of her act.

On the other hand, if a woman is found with her baby in a toilet and she made no effort to conceal the birth, it lends credence to her having had an altered mental state.

The altered mental state may be due to dissociation, shock, or acute blood loss.

XIV. Empirical Data on the Insanity Defense in Filicide

Women who kill their children elicit more empathy by jurors in raising an insanity defense than other types of murderers (Perlin, 1994).

Nonetheless, an insanity defense based on postpartum depression is not often successful in the United States (Reuters, 2001; Meyer and Oberman, 2001.).

A. Insanity Studies of Filicide

1. A Michigan study examined 20 women who were recommended and subsequently adjudicated NGRI for murdering their children between 1976 and 1989 (Holden, Burland, and Lemmen, 1996).

They were compared to 8 women adjudicated criminally responsible during the same period.

Mothers in the NGRI group were significantly less likely to have other children who were not victims, significantly more likely to make a suicide attempt, and significantly more likely to have experienced hallucinations, command hallucinations, or delusions.

The majority were married, their victims tended not to be newborns, a number had multiple victims, the majority attempted suicide at the time of the offense, very few attempted to conceal their crime, and none committed the murder out of motives of unwanted child, fatal maltreatment, or spouse revenge.

2. In the total group of Finland mothers, 63% were regarded as not legally responsible for their act due to their insanity, 29% were not fully responsible and thus were given a reduced sentence, and only 6% were deemed legally responsible and given a full sentence (Haapasalo and Petäjä, 1999).

Those found not legally responsible included 73% of the filicides and 40% of the neonaticides.

Successful insanity defenses in neonaticide are rare in the U.S.

XV. Conclusion

Each infanticide is tragic, not only for the infant, but also for the ongoing effect which the crime has on the life of the parent.

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Background for Videotape FV 11A (6 min)

Filicide Associated with Suicide

This defendant is a 25 year old married woman who is charged with the aggravated murder of her two children, three year old Julie, and her three week old son.

The defendant reported that she became depressed in the last month of her pregnancy. The depression was manifested by insomnia, anorexia, and weight loss.

After the birth of her baby she was unable to engage her son emotionally. The depression progressed so that she was barely able to complete the tasks necessary for child care.

She explains on the videotape her thinking at the time of the killing. She believed it would be best for her children to "rest in peace" with her after her suicide.

Please form an opinion on her sanity at the time of the act using the following test.

Ohio Statute (1990)

A person is "not guilty by reason of insanity" if he proves that at the time of the offense, he did not know, as a result of a severe mental disease or defect, the wrongfulness of his acts.

- A. Severe psychic anxiety
- B. Anxious ruminations
- C. Global insomnia
- D. Psychosis with delusions of poverty or doom
- E. Recent alcohol abuse

III. Suicidal ladder

How bad do you feel?

Do you wish you were dead?

Have you had thoughts of ending your life?

How often do you have these thoughts?

When do they come up?

How long do they last?

Have you thought about a particular way to end your life?

Do you have access to this means to do it?

How close have you come to committing suicide?

1999 Suicide Study by Kessler, et al.

The cumulative probabilities of going from suicidal ideas to a suicidal plan was 34%.

26% went from suicidal ideas to an unplanned attempt.

72% went from a suicidal plan to an attempt.

IV. Evaluation of deterrents to suicide (protective factors).

- A. Responsibility to family -- caring for them and not wanting to induce guilt.

The effect on one's children.

- B. Fear of the actual act of killing oneself.
- C. Fear of the unknown.
- D. Fear of social disapproval.
- E. Religious beliefs that it is wrong.

V. Suicide risk assessment in mental status exam

- A. Specify risk as:

Minimal

Moderate

Severe

- B. Example: Although Mr. Jones denies any suicidal ideas, his risk is moderate due to his history of 2 past suicide attempts, severe depression with delusions, and acute anxiety.
- C. If moderate or severe, order some suicide precautions.

VI. No-suicide contracts

- A. Unwillingness of the patient to agree is significant.
- B. There is no research evidence that they are effective.
- C. They are unlikely to be successful unless there is a positive working alliance between the clinician and the patient.
- D. They are contra-indicated in an agitated psychotic or impulsive patient.
- E. They should not be relied upon if a prior suicide attempt has occurred in spite of a no-suicide contract.
- F. More than half the successful inpatient suicides had no-suicide contracts in force (Busch et al., 1993).
- G. If you do enter into a safety contract with a patient, specify the reason for it in the chart.

For example, you may attempt to use it to act as a deterrent in a patient with whom you have a strong therapeutic alliance; or you may use it as an assessment tool of the patient's ambivalence and to see if the patient is unwilling to enter a "no-suicide" contract.

VII. Patient attitude toward therapist

- A. Ally -- when patient has a desire to live.
- B. Adversary -- once the patient has decided to die by suicide.
 - 1. The patient's goal is to die by suicide.
 - 2. The therapist's goal is to prevent the suicide.
- C. Two-thirds of inpatients who die by suicide had denied any suicidal intent or ideation, even shortly before their deaths.

Most had denied suicidal intent as their last communication before their death.

- D. Although the patient may deny suicidal thoughts when questioned by clinicians, the patient may directly or indirectly express them to significant others.
 - 1. Thus, clinicians should routinely question close relatives of suicide prone patients about suicidal communication.
 - 2. Communications of suicidal ideation in completed suicides were 60% to their spouses, 50% to relatives, and only 18% to helping individuals like physicians.

VIII. Suicide malpractice risk reduction:

- A. Out-patient suicide risk reduction:
 - 1. If a suicidal patient must stay at home, having a relative stay with them reduces sharply the risk of a suicide attempt.
 - 2. In an out-patient with significant suicidal risk, the clinician should consider suggesting that any firearms in the patient's possession are placed in

the hands of a third party (Bongar, Maris, and Berman, 1992).

3. Increasing frequency of office visits means placing less reliance on long term estimates of the likelihood of suicide.
 4. Ask for permission to brief supportive family or friends.
 5. Have the patient check in by telephone periodically between sessions.
- B. Document a risk/benefit analysis about your treatment decisions.
1. Benefits of hospitalization include:
 - a. Reduced risk of suicide.
 - b. Time away from stressful situation.
 2. Risks of hospitalization include:
 - a. Stigma which can affect the patient's view of himself.
 - b. Stigmatization in the eyes of others because the patient is away from work.
 - c. Financial burden.
 - d. Disruption of the therapeutic relationship in an unwilling patient.

IX. Demographics of Violence

Age - violence peaks in late teens and early 20s.

Sex - males more than females.

Social class - the lower, the more street violence.

IQ - the lower, the more violence.

An epidemiologic study by Swanson et al., (1990) provided a survey of over 10,000 persons in the community regarding self reported violence in the last year.

Violent Behavior in the Last Year

<u>Diagnosis</u>	<u>Percent</u>
No disorder	2
Obsessive-compulsive disorder	11
Panic disorder	12
Major depression	12
Mania or bipolar disorder	11
Schizophrenia	13
Cannabis abuse or dependence	19
Alcohol abuse or dependence	25
Other drug abuse or dependence	35

The combination of substance abuse with other major psychopathology is more volatile than either alone.

X. Components of Dangerousness

- A. Magnitude
- B. Likelihood
- C. Imminence
- D. Frequency

XI. Psychosis and violence:

- A. Paranoid schizophrenics in the community are more violent than other diagnostic categories.

However in hospitalized patients, non-paranoid patients are more likely to be violent.

In paranoid patients with delusions, their violence is usually well planned and in line with the

delusion.

The violence is directed at a specific person who is seen as persecuting the patient, often relatives or friends.

Paranoid patients are more likely to be dangerous because they often have recourse to weapons, since they are more likely to be in the community.

Paranoid schizophrenics are likely to commit the most serious crimes because of their ability to plan and their retention of some reality testing.

B. Hallucinations and Violence

Hallucinations that evoke negative emotions (anger, anxiety, sadness) generate more violence.

Violence is associated with having less successful strategies to cope with voices.

Command hallucinations are associated with violence.

C. Compliance with command hallucinations:

1. Increased with a hallucination-related delusion.
2. Increased if the voice is familiar.
3. Dangerous commands are obeyed less often.
4. Increased with history of compliance.

D. Delusions and violence:

More violence is due to delusions than hallucinations.

Risk of violence is increased by:

- (1) Patients who either fear imminent harm, or
- (2) Experience external forces as overriding their personal control.

"Threat/control-override" symptoms associated with increased aggression include:

Mind feels dominated by forces beyond your control.

Feelings that thoughts are being put into your head.

Feelings that there are people that wish you harm.

Psychotic delusions not associated with increased aggression:

Feeling dead, dissolved, or not existing.

Feelings that your thoughts are broadcast.

Feelings that thoughts are taken by external force.

Violence is more likely if delusions are:

Persecutory.

Systematized.

Preceded by fear or anger.

Acted on before.

XII. Assessment of Risk of Future Violence

The history should include:

A. Careful assessment of the patient's past use of violence.

Past violence is the single best predictor of future violence.

1. Patient's account of prior violence.

What is the most violent thing you have ever done?

Frequency of violent acts.

Assess each prior violent act.

Who said what?

Degree of injury.

2. Obtain collateral information.

(a) Talk to family to gather information.

Are you concerned that Mr. X might hurt someone?

(b) Victim's account of details of past violence.

B. Look for patterns of violence.

1. Violence may occur only in acute psychotic episodes.
2. Assess whether the past violence was precipitated by an interpersonal condition which diminished the patient's self-esteem.
3. Ego dystonic vs. ego syntonic attitudes toward violent impulses.

Is there remorse for past violence?

4. Affective vs. predatory aggression

C. Evaluate the use of drugs and alcohol.

Amphetamines, PCP and alcohol diminish controls.

Stimulants predispose to violence through disinhibition, grandiosity, and paranoia.

XIII. Tarasoff v. U.C. (1976)

When a therapist determines, or should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim from danger.

XIV. Summary:

Focus on acute risk factors for suicide.

Remember that once the patient has decided to die, you will be perceived as an adversary, not an ally.

You should document a complete suicide risk assessment.

Take a formal violence history.

Look for increasing fear in a paranoid psychotic.

Formulate a formal violence reduction plan.

Risk Assessment Exercise

BACKGROUND FOR VIEWING VIDEOTAPE FV 100

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The patient is a twenty-eight year old African American man who was admitted to the Cleveland VA Hospital with a chief complaint of increased thoughts of killing his supervisor at work. Mr. Smith was employed for the same company for about two years. He had a note with him leaving his property to his wife. He said that if he were killed by the police, his family would be able to collect his insurance.

The patient had a history of binge drinking, primarily on weekends. Three weeks before admission, the patient was separated from his wife often years by mutual agreement because they "got on each other's nerves." Mental status examination revealed no defect in cognitive functions. No delusions were evident and the only phenomenon resembling a hallucination was the patient's statement about a single voice telling him to kill his supervisor.

On the sixth hospital day, he got into a physical altercation with another patient. He was placed on "special watch" for two days. He showed remorse about the incident and thereafter remained in good control. The videotape was made on the tenth hospital day.

Please identify as many violence risk factors as you can from the videotape and this background sheet. Put a star by the single most ominous risk factor.

If you were the treating clinician, what steps would you take to protect the supervisor, George, before discharging the patient?

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