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Killing Family Members: Mental Illness, Victim Risk, and Culpability

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Lethal violence is unusual among persons with severe and chronic mental illness, but it happens. When it does, the victim is likely to be a member of the patient's immediate family. This column will discuss several cases in which family members became victims of violence related to psychosis, morbid depression, or paranoia with intractable narcissistic loss.

Schizophrenia and Other Chronic Psychotic Disorders

Four factors come to mind in cases of schizophreniform disorders and severe family violence.

The first is *hallucinations and delusions*. The general public fears them, and assumes they have more power over patients than they often do, but it is also true that they are associated with much of the danger that patients' families must sometimes face. Some violence is presaged by a pattern of delusions or hallucinations, such as those in Case Two, below. Other incidents are idiosyncratic and often inexplicable.

The second factor is *medication and medication compliance*. Our optimism for the large portion of patients whose illnesses are at least partially responsive to modern antipsychotics is tempered by the substantial number who either are not appropriately medicated or for some reason don't take their medications as prescribed.

The third factor is *poor access to, or insufficient time in, psychiatric hospitals*. Many tragedies occur soon after discharge from inpatient care that has been too short for adequate diagnosis, meaningful stabilization, or assessment of medication response.

The fourth factor is a simple social condition: *patients with schizophrenia or schizoaffective disorder who have no other place to live are commonly taken in by their parents, often mothers living alone*. This means that parents are more likely to be "victims of convenience" or to be in a "zone of danger" when something goes awry. Mothers may press their sons or daughters to take their medications, frustrate their impulses to do something, or simply be in the wrong place at the wrong time.

Case 1

Mr. S, a 28-year-old man, was a talented but disorganized artist with a long history of paranoid schizophrenia. He had been raised by a single mother, a lesbian artist who exposed him to highly ambiguous and sexualized environments at several stages of his development. She was enmeshed in his delusional system, and he apparently had illusions in which her features became those of a monster or demon.

During one of many periods in which he had stopped his medication, his mother allowed him to stay in her home in order to avoid his landlord, to whom he owed several months' rent. According to his statements, she appeared to him in her monstrous form, got very close to him, and he believed he had to kill the being she had become. Her body was discovered partially nude and sexually violated. Mr. S was found nude in a closet of his nearby apartment. He admitted the killing, but insisted that the victim was not his mother and that the monster had replaced her many years before. There was some evidence that she had tried to press him to take his antipsychotic medication.

Case 2

Mr. D, a 52-year-old divorced man with schizophrenia or schizoaffective disorder, had a long history of delusions and command hallucinations. Documentation from several hospitalizations and clinic visits revealed voices telling him to kill his mother, with whom he lived.

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Early one morning, Mr. D woke his mother, who was his guardian and managed his funds, and demanded money for cigarettes. His mother refused and went back to sleep. A few minutes later, Mr. D apparently ransacked his mother's purse, found little of value, and viciously stabbed the debilitated woman to death in her bed.

At psychiatric evaluation, Mr. D spoke of the voices telling him to kill his mother but said he was "not sick any more because they're giving me my medicine." Relatives spoke with frustration of his manipulating them in the past by referring to his "voices" when he wanted something. There were signs that he was feigning some symptoms in an ineffectual way within the greater context of his psychosis, at times trying to appear sane and at other times exaggerating his past symptoms. He had a sort of naive expectation that, since his behavior had taken place in the midst of a psychosis, the court would immediately release him to take medication as an outpatient (this had happened before when poor medication compliance had led to bizarre behavior).

Case 3

Mr. B suffered from chronic schizophrenia with both paranoid and undifferentiated features. He lived with his mother because he was unable to support himself or function in a group home. One night, with no known provocation, he poured gasoline over himself in the utility room of the house and lit himself afire. The house caught fire as well, and both he and his mother were killed. The patient was known to have been delusional, and had visited a local mental health clinic a few weeks before the immolation; whether or not he was taking his medications as prescribed was unclear.

Suicidal Depression

With the exception of peripartum disorders, which are discussed below, severe depression is often overlooked as a source of danger to others. Nevertheless, injury to family members occurs and the risk is sometimes reasonably foreseeable. Patients with suicidal depression, separated in these examples from those with postpartum depression, commonly endanger family members, either accidentally or by actually involving them in self-destructive behavior. The relatively high prevalence of severe mood disorders suggests that there are a significant number of potential victims and that the risk to them is well worth clinicians' consideration.

Case 4

Ms. R had suffered for several weeks from a major depressive episode. She committed suicide by sitting in her car while it ran in a closed garage. The garage happened to be directly under her children's room; carbon monoxide seeped into the room above and killed her infant. A second child, several years old, survived. There was no indication that Ms. R knew that the children would be in danger.

Case 5

Mr. P, a severely depressed and emotionally disabled man in his fifties, had seen a counselor for several months and was taking antidepressant medication. His symptoms included hopelessness, inability to work or concentrate well, and suicidal thoughts but no frankly psychotic ideation. He was usually passive and anergic, but sometimes argued with his wife. Although neither he nor his wife had ever described paranoia or threats of violence toward her, he eventually shot and killed her, then killed himself. An autopsy indicated that intoxication was not involved and that he had probably been taking his antidepressants regularly.

Post- and PeriPartum Syndromes

Postpartum killings of children are arguably the most sensational familicides. Some occur with little warning and no other apparent psychiatric illness. In other cases, the person seems, although sometimes only in retrospect, to have been made more dangerous by a preexisting mood or schizophrenia-like disorder. Whatever the circumstance, children are particularly vulnerable to behavior arising from their parents' delusions, hallucinations, and/or morbid impulses and clinicians should not hesitate to act to protect them.

Case 6

Ms. T, the mother of three small children, was diagnosed with a postpartum mood disorder with psychosis a few weeks after childbirth, hospitalized briefly, and discharged with antipsychotic and antidepressant medication. She had experienced postpartum depression after at least one of the previous births. Early one morning, she killed all three of the children in their beds by cutting their throats. The acts took a total of at least 5 minutes. She then dressed each body in clean nightclothes, leaving them posed as if they were sleeping. She was discovered by her husband a bit later, sitting in the infant's

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room reading a Bible. The husband had been asleep. He later testified that he knew she had gotten up and had heard a brief cry from one of the children, but he thought she was merely tending to the children as usual.

Overwhelming Sensitivity to Loss or Humiliation

This dynamic, of combined real and narcissistic loss, often with a perception of great humiliation, is common in men who kill their wives. Many perpetrators are overtly paranoid, sometimes with delusional systems; others have no known history of major psychiatric disorder or treatment. The killings often occur in a context of intoxication which compromises defenses and the reasoning ego, decreasing impulse control. Unfortunately, most perpetrators are not referred for psychiatric evaluation unless they are frankly psychotic.

Case 7

Mr. and Mrs. K had marital problems. Mr. K was known locally as "a man's man," who was rather controlling of his wife. He had had several affairs but would profess his love for Mrs. K whenever she discovered them. When they eventually separated, he was incredulous, assuming an unbelieving posture and convincing himself that she needed him and would soon return. One afternoon, however, he came home to find divorce papers in his mailbox.

Taken aback by this new firm evidence that the impending divorce was really going to occur, he searched for his wife by car and found her in a supermarket parking lot. He begged her to cancel the divorce proceedings. Instead of recanting, however, she became uncharacteristically angry at him. She loudly belittled him, averred that he had never satisfied her sexually, and abruptly drove away. Unknown to Mrs. K, her husband had a loaded shotgun in the trunk of his car. He followed her to her apartment and shot her to death.

Case 8

Mr. P had been separated from his wife for several weeks when he became aware that she was seeing another man. When he confronted her with this knowledge, she told him she had found someone far better than he and would never return to him. He was devastated by both the loss and the humiliation, became suicidal, and was hospitalized on a psychiatric unit. He was discharged 2 days later, after the immediate crisis appeared to have abated and he had assured staff that he could adjust to life without his wife.

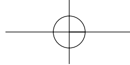
A few days after discharge, Mr. P was called to pick up his 8-year-old son at the couples' former home (now occupied solely by his wife). When he arrived, the boy was sitting on the front porch. He said that Mommy and her friend were inside and he had been sent outside to wait for his father.

Mr. P took the boy back to his duplex and put him to bed on the living room sofa. He then took a shotgun from a closet, climbed out a rear window (to avoid being seen by the boy, whom he did not want to frighten), returned to the house, and killed both his wife and her lover.

A somewhat analogous, and very dangerous, situation occurs when certain men (the perpetrators are almost always male) are confronted with other kinds of psychologically perceived critical weaknesses, such as threats to their masculinity, in settings they cannot easily escape. Many bar fights and killings, for example, take place when one man derides or challenges another, the second man believes he cannot back down without humiliation, and there appears (to him) only one way to resolve the situation with his (internal) reputation intact—to erase the threat. The author has also evaluated men in whom homosexual impulses were stimulated and who then struck out lethally against the source of the stimulus (often other men who had approached them sexually or transgender prostitutes who appeared female before disrobing) in order to attenuate their homosexual panic.

Culpability

Although legal culpability for one's acts is an individual matter usually determined by function and behavior rather than diagnosis, schizophrenia and similar disorders are the most common diagnoses associated with criminal insanity pleas and evaluations. Mr. S (Case 1) raised an insanity defense in his trial. The prosecution focused on convincing the jury that his story of his mother as a demon was inconsistent and self-serving, and that he had fled the scene because he knew his actions were wrong. The sexual aspect of the killing was highlighted as particularly repulsive. The defense clearly established Ms. S's severe chronic and acute mental illness and the fact that he had not taken his medication for weeks. Several of his deceased mother's friends testified that he had recently been extremely delusional. He was convicted of second-degree murder (impulsive



murder lacking prior planning) and committed suicide in prison several years later.

Mr. D's case (Case 2) is still awaiting trial. Some of the relevant prosecution issues likely to be addressed if an insanity defense is raised include the presence of a motive (money and/or anger), earlier statements that he might kill his mother, and the fact that he tried briefly to hide his part in the killing. The defense will probably note his long history of severe mental illness, the fact that the previous comments about killing his mother were made when he was psychotic and in a context of command hallucinations (as described by several treating psychiatrists and nurses), his very recent hospital discharge, the unreasonably small financial motive, and a lack of any attempt to flee or—except for one short statement—to mislead the police.

Ms. T (Case 6) was found not guilty by reason of insanity (NGRI). Some of the factors important to her defense were the lack of any effort to flee or hide the killings, her committing them while her husband was in the house, and the apparent lack of reasonable motive (her own statements suggested a bizarre religious motive). The prosecution attempted to use the time and care spent in the killings to convince the jury that her behavior was purposeful and methodical.

Ms. T's case represents a circumstance that, until a couple of decades ago, commonly ended in a verdict of not guilty by reason of insanity, sometimes largely on the premise that "no sane mother would kill her children." Today, however, many filicides (killings of one's children) in a context of postpartum psychosis result in guilty verdicts. Filicide itself hasn't changed very much over the years, which leaves one to speculate that the recently-increased likelihood of conviction may be related to changes in the wording of the insanity defense statute in many states (in the wake of Hinckley's shooting of President Reagan, for which he was found NGRI), public dissatisfaction with insanity as a so-called "excuse" for the sensational act of killing a child, more zealous prosecution of such cases, and perhaps, as one attorney quipped, juries that are simply more mean-spirited.

Neither Mr. K (Case 7) nor Mr. P (Case 8) raised an insanity defense. It was clear that they knew what they were doing, knew that it was wrong, and (relevant in many jurisdictions) were able to control their behavior (at least to the point of delaying their actions). Each had a motive acceptable to prosecutors, although a psychiatrist would probably also impute some of the psychological factors already discussed. In these two cases, the charge was first-degree murder; in one case, the defendant (Mr. P) was charged with capital murder (generally associated with exposure to the possibility of a death sentence), and psychiatric defense testimony designed to mitigate sentencing did not deter the jury from sentencing the defendant to death.

The Last Word

Juries are frightened by people who kill other people. They are often even more frightened when defendants have mental illnesses and psychotic symptoms that they find horrible and/or unpredictable. The very factors that both clinicians and lawyers consider mitigating, and sometimes exculpating, may instead influence a jury to incarcerate the defendant (or recommend execution). We often believe our psychiatric view of mentally ill defendants is enlightened and humane, but those of us who work within the judicial system must remember that it is not a clinical realm.