Homicide in a Psychiatric Institution

JIŘÍ MODESTIN and WOLFGANG BÖKER

Summary: A unique case of a homicide committed by a young male psychotic inpatient on a fellow-patient is reported and discussed with regard to the special victim-offender relationship, the relationship between suicide and homicide, the phenomenon of aggression and the question of the management of a highly suicidal psychotic patient, including the issue of continuous observation.

Psychiatric inpatients sometimes have assaultive and homicidal feelings, even though they are much more prone to be self-destructive (Hagen *et al*, 1972). Cases of murder committed by released or escaped patients from special hospitals are known (Editorial, 1973; 1977). Homicide committed by a patient in a psychiatric institutional setting is probably an extremely rare event. Turns & Gruenberg (1973) investigated the hospital response to a murder of an attendant by a patient; they did not investigate the act as such in detail, classifying it as unpredictable and psychotically motivated. Torre & Varetto (1983) described the case of a young oligophrenic inpatient killed by a psychopathic fellow-patient; the authors were more interested in an unusual homicidal method (impalement) than in analysis of the event itself.

We report a very exceptional case of a male psychiatric inpatient who killed another male psychiatric inpatient at the end of January 1983. We regard the circumstances and dynamics of this case to be of theoretical as well as of practical interest.

Case report

The victim

Mr V., single, was born in 1935 as the second of four children of a travelling business representative and a nervous housewife. From the age of four, the patient spent the major part of his childhood and adolescence with various relatives. He studied modern languages at university but did not finish his studies and worked afterwards as a translater. At the age of 22 years he was admitted for the first time to a psychiatric institution, presenting a distinct loosening of associations, accompanied by inappropriate affect and grossly disorganised behaviour. Thereafter, he repeatedly presented the same symptom pattern along with persecutory paranoid ideas as well as pronounced disturbances of identity (doubting whether he was really Mr V., etc.). In 1975 a distinct social decline had been registered and a year later the patient received a disability pension. From the beginning of his illness he was admitted to hospital on average every three years for about one to three months. For years he had been treated with various neuroleptics, latterly receiving methotrimeprazine and thioperazine. The patient fulfilled the Research Diagnostic Criteria (RDC) for chronic schizophrenia, undifferentiated type.

At the beginning of 1982, the patient was again admitted for a short period and he was assaultive towards his treating physician. In November 1982 he came spontaneously to the hospital and asked for admission on a voluntary basis. He was anxious and agitated, and repeatedly uttered self-accusatory ideas. He felt responsible for all the evil in the world, and claimed he had offended God. He feared death and damnation.

The offender

Mr O., single, was born in 1958 as the second of two children in a typesetter's family. Among his second degree relatives were two cases of suicide. The patient did not finish his apprenticeship as a mechanic, becoming ill and being admitted for the first time at the age of 20. At that time he felt depressed and uttered vague ideas of reference, presented signs of cancerophobia and suffered from homosexual as well as castration anxieties. In addition, he was violent towards his mother. Since April 1979 he was continuously under treatment, predominantly as an inpatient. In the further course of his illness he frequently manifested suicidal as well as hypochondrical ideas and felt depressed. He intermittently complained of hearing women's voices talking about him in a deprecatory way and a loosening of associations was also observed.

He was treated with neuroleptics, and latterly received flupenthixol decanoate. Attempts to place him outside the institution and to engage him in work failed. It was therefore decided to place him in a special unit which aims at preparing patients for discharge to a flat-sharing community. The transfer took place in the middle of January 1983.

Soon after the transfer to the new unit the patient became overtly psychotic. He felt depressed and guilty because of masturbation, and he expressed the hypochondriacal delusional idea that his penis was getting steadily smaller. He doubted whether he was really a man. Several days later he became very tense and suicidal and manifested paranoid ideas, imagining he was being sought for a murder he had committed. He also expressed fears concerning his own aggression and, possibly as a reaction formation against his aggressive impulses, desired to stay in bed and to be fed. He furthermore expressed a delusional belief that he was not in a psychiatric institution but in a concentration camp. At that time he fulfilled RDC for a probable schizoaffective disorder, depressed type. Because of his continuous suicidal ideas, a new transfer had to be undertaken from the special unit to the intensive treatment unit of the clinic. This was also where Mr V. was being treated.

The act

After his transfer Mr O. remained very tense. He was, on the one hand paranoid and aggressive, and on the other

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depressed and suicidal. Thioridazine was added to his previous medication. On the third day at the new unit, the patient became highly suicidal. He drank a bottle of aftershave lotion with suicidal intention, and later tried to take to pieces and swallow an electric lamp battery. He thereafter attempted to hang himself with the electrical cable of the ceiling lamp. He only survived this suicide attempt by chance, as the installation tore out. Because of the pronounced suicidal danger he was put under continuous one-to-one observation. The next day the patient was, as before, very tense, and in an aggressive attack he tore off a door plate. Apart from this act, although with considerable effort, he succeeded in controlling his aggresssion. In the evening he watched TV. He left the TV room for a short time and went to his dormitory which he shared with Mr V.

At the time we are describing, Mr V. also was relatively restless, at times even agitated and exceedingly anxious. At night he suffered from anxiety attacks and frequently shouted loudly in his sleep. He claimed he would prefer to die if he had no fear of death, his relationship to death thus remaining highly ambivalent. He also continued to experience intense guilty feelings (he thought he was responsible for a war in Lebanon), and he felt doomed. He gave a general impression of immense suffering. In spite of the distinct depressive component of his symptomatology he did not fulfill the RDC for a full depressive syndrome.

The moment of Mr O.'s leaving the TV room was the one and only time since his last suicide attempt that an orderly had lost sight of him for even a short period. Nobody else was in the four-bedded dormitory apart from Mr V., who was already in his bed. Without any forewarning, Mr O. took a wooden stick (it was prepared for occupational therapy and nobody could explain how it came to be in the dormitory) and hit Mr V. several times with full force on the head. Mr V. died shortly after being transferred to the neurosurgical station.

The victim-offender relationship

Mr V. and Mr O. were well known to each other. They had already got to know each other on some occasion outside the hospital. During the last admission they not only shared a dormitory, but spent much time together and frequently talked with each other in a friendly manner. They therefore certainly knew each other's symptomatology and complaints. In particular, the anxiety attacks and the ideas of Mr V. regarding death were known to Mr O. as well as to other patients of the unit. Mr V. had presented them quite publicly on various occasions.

Immediately after the homicidal act Mr O. said: "Now I have released him". Later on he added: "Mr V. told me he would like to die. He suffered from tremendous anxiety. He had the same illness as me". On another occasion, Mr O. gave the following reasons for the act: "Huge spiders wanted to attack Mr V. I realised that this would be very cruel for Mr V. and so I preferred to kill him". Still later, Mr O. took a slightly more distanced attitude, commenting on the act, "I heard voices telling me I had to redeem him. At the beginning I had some doubts, but the voices won".

Discussion

It is sometimes possible to understand and account for violent interpersonal acts from the dynamics of the offender-victim relationship; the behaviour of the victim playing a major role in respect to the realisation of the act (Rasch, 1964). Lalli & Turner (1968) confirmed that most homicides are committed where there is a close relationship between the victim and the offender. This finding fully applies to the violent acts committed by mentally abnormal offenders (Haefner & Boeker, 1982). Between our patients there was indeed a close and very special relationship. Not only did both patients know each other very well; there also was a deep mutual inner relatedness. They both possessed considerable aggressive potential, this being recently evident in Mr O.; whereas Mr V. had been assaultive during his previous admission. Both patients shared paranoid and depressive symptoms, and both suffered from cancerophobia. However, the most important psychopathological element they had in common was their preoccupation with death, which on the part of Mr V. remained mainly on a verbal level, whereas Mr O. was inclined to act it out. Furthermore, both patients presented complaints pointing to loosening of their ego boundaries and to lack of a firm identity—including a sexual identity. The lack of firm ego boundaries along with mutual, very intense and continuous projective identification, possibly also including a homosexual component might have contributed to the development of a close symbiotic relationship. Distinct confirmation of this interpretation was provided by Mr O. two days after the act: he stated he "felt like dying", even "like being definitely dead".

There is a relationship between homicide and suicide. Bromberg (1951) proposed that some murders might actually be projected and acted-out suicides, and Wolfgang (1968) showed that a proportion of homicides (so-called victim-precipitated homicides) were really an unorthodox type of suicide; the victim, a suicide-prone person, precipitates his death by engaging another person to perform the act. This would seem to be exactly the situation concerning the dynamics of our patient, Mr V. These dynamics presuppose an ambivalent attitude towards suicide on the part of the victim and indeed, such ambivalence was strongly present in Mr V. On the other hand, and this seems to have been stressed insufficiently, the victim-precipitated homicide cannot be realized unless there is a specific preparedness on the part of the committer. Such a preparedness was present in Mr O. Apart from his high suicidal potential which he shared with Mr V. and which enabled him to sympathize with the latter intensively, there also was a readiness for a hetero-aggressive assaultive behaviour on his part, which he manifested in phantasy as well as in reality, in the past as well as recently. In all, the dynamics of the victim and of the offender have to complement each other and this occurred in a perfect way in our case.

Before killing his fellow-patient, Mr O. very seriously attempted suicide. This only failed due to chance. Freud (1917) pointed to the close intrapsychic relationship between suicide and homicide when he stated "no neurotic harbours thoughts of suicide which he has not turned back upon himself from murderous impulses against others", and Menninger (1938) considered the wish to kill to be one of the most important components of every suicidal act. Correspondingly, suicidal and homicidal behaviours frequently go hand in hand. Suicide after a committed homicide occurs in 3 or 4% of homicides in the United States (Robins, 1981; Wolfgang, 1958), but as frequently as in 42% in Denmark (West, 1965). In these cases, the murder and the suicide are assumed to be parts of the same act (Cavan, 1928), the murderer wishing to die *with* his victim and not because he has killed him (Dorpat, 1966). Our observation confirms the inner relatedness of both acts in these cases; the (unsuccessful) suicide of our patient Mr O. did not follow but had preceded the homicidal act. It cannot, therefore, possibly be regarded as being of a reactive nature to it.

In both our patients, especially in Mr O., considerable suicidal ideation as will as problems relating to aggressiveness had been present for a long time. Suicidal patients select a violent solution for their difficulties (Whitlock & Broadhurst, 1969). Suicidal individuals, including psychiatric out- and inpatients, frequently manifest aggressive behaviour (Farberow *et al,* 1966; Myers & Neal, 1978; Hagnell & Rorsman, 1980; Tardiff & Sweillam, 1980a). Those patients who are suicidal as well as assaultive also frequently present signs of psychosis and depression (Tardiff & Sweillam, 1980b) as did both of our patients. Psychotic patients are frequently under a strong inner aggressive tension, a fact so far insufficiently appreciated (Ringel, 1969). Murder and suicide may sometimes serve as defences against ego-disintegrating effects of the psychosis (Reichard & Tillman, 1950). Suicidal notes confirm that aggression against others is the principle motive for suicide (Capstick, 1960); while hostility is often a cover for underlying suicidal ideation (Gale *et al,* 1980). Some patients present a high level of aggression which they may turn against others or against themselves according to circumstances (West, 1965), an observation which is also fully confirmed by our case. Both suicide and homicide are aggressive behaviours. According to Banen (1954), they are the opposite sides of the same coin, the difference being that in the former the aggression is internalised whereas in the latter it is externalised. The supposition, however, that the strong suicidal impulses as a form of inward oriented aggression would go hand in hand with a reduction in overt external aggression has proved to be incorrect, as evidenced by the studies just quoted as well as by our case report.

Having presented unequivocal suicidal behaviour, Mr O. was put under continuous, one-to-one observation. The question arises whether this was the most appropriate action. There seems to be no uniform opinion regarding this issue in the literature. Special precautions against suicide may be so exaggerated as to bring about the attempt through suggestion. Too severe restrictions of a patient's activities for the purpose of preventing suicide may so increase his discomfort as to add to the urgency of the attempt (Wooley & Eichert, 1941). The social response to suicidal symptoms determines whether the suicide will follow. Efforts to prevent suicide also may precipitate suicide: the patient adopts a suicide's identity and conforms to the expectations others have of him (Kobler & Stotland, 1964). Rushing (1968) summarises this kind of reasoning as follows: there is some (clinical) evidence for the assumption that if psychiatric personnel do not treat a patient as a suicide risk, the probability of suicide will decrease. On the other hand, it has recently been quite clearly stated (Gale *et al,* 1980) that suicide precautions must be carefully adhered to by staff, and include constant observation while patients remain acutely psychotic. Lapses in observation should not be permitted while the patient is in the bathroom or in his room. In our experience, it is rather a good supportive general atmosphere on the ward that exerts a positive, comforting effect on the suicidal patient than strict adherence to intensive constant observation. On the other hand, an acutely psychotic patient might be in a condition in which he cannot reflect on or experience the beneficial effects of the ward atmosphere. We agree with the fear that constant observation might contribute to narrowing the patient's horizon, thus markedly restricting his choice of action to the direction suggested by his primary action, which might even be strengthened by the reaction of the staff. We are not sure whether this mechanism could not have played at least some role in provoking our patient to act. It may be asked whether there are practicable alternatives to continuous observation in the case of a highly suicidal psychotic patient.

We feel there is indeed an alternative in the form of rapidly initiated, appropriate and intensive therapeutic efforts. It seems both patients should have received antidepressant therapy in addition to their neuroleptics. Both presented a depressive syndrome, and some schizophrenic patients with symptoms of clinical depression benefit from the use of a neuroleptic-antidepressant combination (Siris *et al,* 1978). Patients who suffer from a schizo-affective disorder are recommended to be treated as if they had an affective psychosis (Carpenter & Heinrichs, 1981). Nevertheless, Mr O. decompensated quite rapidly so that

antidepressant drugs probably would not have influenced his condition to a great extent in an acceptable space of time. Inadequacies concerning the appropriate treatment of suicidal patients include reluctance to give ECT (Ottosson, 1979). There is a prejudice against ECT in Switzerland (Ernst, 1982) and this therapeutic method was consequently not taken into consideration. Even ECT, however, does not always work quickly enough; so that probably the most appropriate initial short-term treatment for a highly suicidal patient with psychotic depressive symptomatology and a high level of tension—as with Mr O.'s presentation—would be immediate powerful sedation, to the extent of inducing pharmacological sleep using sedative neuroleptics, if necessary in combination with benzodiazepines or barbiturates. This therapy also necessitates constant attention to the patient on the part of the staff. As it occurs in the frame of medical measures in the strict sense of the word, however, it might be perceived by the patient as void of the persecutory component inherent in the method of constant observation.

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*Jiří Modestin, M.D., *Psychiatrist*

Wolfgang Böker, M.D., *Director, Psychiatric University Clinic, Bolligenstrasse 111, CH-3072 Berne, Switzerland*

*Correspondence

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