First-Episode Psychosis and Homicide: A Diagnostic Challenge

Dominique Bourget, MD, FRCPC, CSPQ, Alain Labelle, MD, FRCP, CSPQ, Pierre Gagné, MD, FRCPC, CSPQ, Pierre Tessier, MD, FRCPC, CSPQ

Objective: To describe the demographic, psychiatric and social characteristics of a sample of murderers found to suffer from first-episode psychosis.

Method: We reviewed a series of 22 cases of murderers diagnosed after the act with a first psychotic episode. We collected various demographic, clinical and event-related variables for descriptive analysis. DSM-IV diagnostic criteria were used.

Results: Most were charged with killing a close relative. All subjects presented with an insidious onset of their psychotic illness, and most had gone unrecognized until their murderous acting out.

Conclusions: Homicidal behaviour may represent a distinct expression of the illness. In several instances, it was found to be a useful indicator to determine more accurately the nature of the psychotic illness. We discuss the relevant clinical indicators and the complexity of diagnostic issues in a forensic context.

Key Words: psychosis, schizophrenia, first-episode, violence, aggression

In the attempt to improve the prognosis of patients diagnosed with psychotic illnesses, the concept of first-episode psychosis has recently emerged. This concept promotes early detection and early interventions to reduce the harm associated with untreated psychosis. Although the concept of first-episode psychosis has become popular, its association with violence, and specifically homicidal violence, is not well understood.

Several researchers have concluded that schizophrenia increases the risk for violence in general and also for homicidal behaviour (1–7). In a study of incident cases of schizophrenia in London over a 20-year period, Wessely and others found that men with schizophrenia were nearly four times more likely to commit violent offences (7). In a review of 1,423 homicide offenders, Eronen and others found that the risk of committing a homicide was about 10 times greater in schizophrenia patients, compared with the general population (8). The same authors have shown that coexisting alcoholism compounds the risk generated by either condition alone and that, in male schizophrenia sufferers who abuse alcohol, the risk of committing homicide increased more than 17 times. Although an association between schizophrenia and an increased risk of violence has been demonstrated repeatedly, the timing of the violent acts within the course of the illness is often not reported (9). Previous reports have linked positive psychotic symptoms with violence that often occurs around the time of hospital admission or acute decompensation (9–12). Violence may be associated with a more restricted set of symptoms, such as hostility or suspiciousness, or it may involve more specific and organized persecutory delusions that are often focused on specific persons (13–15). Muzinic and others emphasized the forensic importance of psychotic jealousy in a recent retrospective study of 200 people who had committed or attempted homicide (16). These authors found that jealousy in the diagnostic categories of paranoid psychosis and paranoid schizophrenia was associated with the highest degree of danger and that the time span between the first manifestations of jealousy and the crime was shortest in schizophrenia.

Milton and others examined the relation between first-episode psychosis and aggression in a cohort of 166 individuals with first-episode psychosis (17). They found that 33.1 per cent exhibited aggression (predominantly minor) toward relatives. In contrast to previous reports (9–12), there appeared to be no specific relation to positive psychotic symptoms. Behavioural symptoms (for example, overactivity and emotional turmoil) had large and independent effects on the risk of aggression. Negative symptoms, insidious onset and longer duration of untreated illness were found in subjects who exhibited serious aggression. Comorbid substance misuse was found to be independently associated with aggression.

Comorbidity of first-episode psychosis and substance abuse is considered to be the rule rather than the exception (12). In a sample of 232 first-episode schizophrenia sufferers, Hambrecht and Häfner found that either alcohol
abuse or substance abuse often followed or occurred close to the first symptom of the illness but in the vast majority preceded the first psychotic symptom (18). The authors noted that the mean age at onset of schizophrenia was lower in those who had abused drugs.

**Case Review**

The cases reviewed here represent a cohort of 22 men and women who were referred for a forensic psychiatric examination by university-appointed, experienced forensic psychiatrists. Of the 22 individuals, 19 were charged with homicide and three with attempted homicide. DSM-IV diagnostic criteria were used to diagnose all the individuals with a first psychotic episode. All the persons in the cases reviewed here were diagnosed after the homicidal event, as in most cases the index of suspicion of mental illness was not high until it was too late to intervene preventively.

Demographic, clinical and event-related variables were noted for the 20 men and two women in this cohort. As to civil status, 13 were single, three were married or in common-law relationships and six were separated or divorced. Fourteen of the individuals were unemployed, six worked at least part-time and two were students.

Consistent with the findings of Milton and others (17), all the individuals in our cases presented with an insidious onset of their psychotic illness. The total duration of illness, operationally defined as the period of time after the first symptom, was estimated from collateral source information from relatives and from the patients’ recollection of abnormal behaviours and symptoms. Fifty per cent had been ill for more than one year, and most had gone unrecognized until their murderous acting out. Schizophrenia was diagnosed in 15 individuals (68.2 per cent).

Psychiatric history, when present, involved past contacts for non-specific complaints. In four individuals, psychosis had gone undetected. One patient (case 5) had consulted repeatedly for numerous somatic complaints and believed he had an incurable and terminal illness, a belief that was not substantiated medically. After the crime, these complaints were eventually recognized as somatic delusions. Another individual (case 17) had been hospitalized for a substance abuse disorder, and two others (cases 7 and 9) had consulted for symptoms of anxiety and depression.

Consistent with the literature findings, most of the individuals in the study group (81.8 per cent) had murdered a close relative or a close acquaintance. In seven of the cases, a parent was the target victim, with two cases of double parricide (nine parents killed). There was one case of filicide, one case of fratricide, one case in which the victim was an aunt, six cases in which the victim was a spouse and two cases in which the victim was a close acquaintance. One man (case 6) who had killed his spouse also killed the cousin with whom his wife had an affair. While this could have passed for a revenge homicide, the patient suffered from severe depression and withdrawal and showed clear paranoid delusional thinking. Of the three cases involving a stranger victim, two were double murders, amounting to a total of five victims. One subject had attempted to kill a prominent public figure, and another entered parliament and shot several people while in a disorganized psychotic state. The most dangerous individual was considered to be a subject who murdered two strangers and presented with paranoid delusions, believing that he was the envoy of the devil, together with command hallucinations ordering him to kill young women. His particular profile was unpredictable: he was only arrested several years after his first murders, when another woman was able to escape from the apartment in which he held her hostage. He was eventually declared a dangerous offender.

A history of violent behaviour was reported for only one individual. Four individuals were using drugs or alcohol at the time of the homicidal event. A history of alcohol abuse was noted in two patients, while eight patients had a history of using cannabis and (or) other drugs.

All the individuals in the cohort had exhibited symptoms of their illness prior to the offence. For instance, all but one person suffered from delusional thinking, and nine of the individuals experienced hallucinations, including those of a commanding nature. One individual (case 5) who believed he had a terminal illness also felt that his wife did not support him. He felt angry and betrayed when his wife asked him for a separation. This man had called the police one day before he murdered his wife, asking whether there was a warrant to arrest him for the murder he thought he had already committed. In another case (case 8), the individual became progressively preoccupied with delusions, including the belief that others could read his thoughts. He thought that he would avoid other people knowing where he was going by pretending to himself that he was heading in a direction different from that he was actually taking. This man also believed that God talked to him while he slept and that he woke up “in a trance” the next day and had to obey the orders. Another individual (case 2) killed his mother on a sudden impulse. While it was difficult to elicit the presence of delusions or hallucination, this man displayed severely disorganized thinking and behaviour, including strong preoccupations about his own death. He thought that he might be dead already and that he was “a zombie.” This man was very withdrawn socially and had only patchy recall of the day of his murderous behaviour.

While it could be established retrospectively that all the individuals in the cohort had exhibited symptoms of their illness prior to the offence, these symptoms did not attract sufficient attention to trigger a referral for a psychiatric assessment. It was the identification of evident disorganization of behaviour at the time of the homicidal event that allowed the examiners to connect the various psychotic symptoms in a coherent clinical manner. Thus, for all the perpetrators, the crime represented the ultimate element that allowed the illness to be identified. In all but four cases, it was found that the homicidal behaviour and
behaviour related to the homicidal events met the definition for grossly disorganized behaviour characterized by numerous inappropriate, unpredictable acts that connected loosely and had little or no logical sequence. The examiners were alerted by the lack of preparation for events surrounding the homicidal acts, most of which occurred on impulse. Further interviewing revealed that patients either had no intent or a psychotic intent (one individual, case 3, killed his father in self-defence, believing the victim was an impostor about to kill him).

Discussion

In the cases presented here, homicidal behaviour represented a critical expression of the psychotic illness. The association between psychosis and homicidal violence is troubling and points to the importance of early identification and early intervention. The circumstances and factors surrounding the homicidal behaviour were useful indicators that enabled a more accurate determination of the nature of the illness. While it is well established that schizophrenia accounts for most first-episode patients, our figure (68.2 per cent) is higher than the 30 per cent rate of schizophrenia noted in McGorry and others’ prospective follow-up study of 200 first-episode patients (12). This may suggest that first-episode psychosis in violent offenders is more likely to be schizophrenic in nature. A history of violence is often said to be the best predictor for future violence, yet only one individual from this sample had a history of violent behaviour.

Within this cohort, there were eight instances in which opposing experts testifying either for the defense or for the prosecution expressed contrary diagnostic opinions, although similar material was available to both sides. The main difficulty encountered was in identifying the presence of psychosis. Differing diagnostic opinions resulted because some of the experts dismissed from their diagnostic analysis the accused’s behaviour at or around the time of the homicidal event and were therefore left with a partial clinical picture to validate their diagnosis. Experts face a diagnostic challenge in cases that show no clear delusions. In one such instance, it was the gross disorganization of behaviour at and around the time of his homicides that provided a better understanding of the pathology of a young man (case 2) who had murdered his parents. For three years, this young man had been exhibiting severe negative symptoms including apathy, amotivation and avolition, together with a major decline of his functioning. Often, negative symptoms do not attract attention and may be overlooked in the prodromal or early stage of the illness. Beiser and others have commented that the first noticeable symptom of psychotic illness is often difficult to date (19). Häfner and others found no significant difference between patients’ descriptions of early signs of mental disorder and those made by relatives or other sources (20); however, patients perceived their psychotic symptoms 12 months earlier. Seventy per cent of patients’ initial symptoms were negative. Milton and others found that negative symptoms and deficits in communication appeared to be characteristic of young men with insidious illness onset who exhibited serious aggression toward others—specifically, after illness onset and before service contact (17). Our data are in keeping with these findings: 18 of the 22 individuals in our sample presented with prominent negative symptoms, and all had insidious illness onset.

Sufficiently validated tools are not yet available for early diagnosis of first-episode psychosis, much less for predicting who will commit a homicide. At best, we may be able to identify individuals with high risk factors for a psychotic disorder, such as those with a positive family history for psychotic disorder or those who have demonstrated recent changes in behaviour. However, evidence exists to support indications that early intervention in first-episode psychotic disorders results in better outcome (21–24). Scholten and others (21) found that, after changes to referral and assessment systems, designed to improve access for potential first-episode patients, the number of identified patients requiring treatment increased and led to reduced duration of untreated psychosis. Delays in treating psychosis may also occur owing to the timing of treatment with respect to symptom level. A recent review of initial reports of early intervention noted possible benefits of early intervention during the prodromal period in terms of identifying those at risk for a psychotic disorder and reducing the prevalence of diagnosed cases (21). The importance of early recognition of nonpsychotic symptoms and behavioural changes that characterize the period prior to the onset of psychosis is underscored by the homicidal behaviour evidenced in the cases we have reviewed.

Conclusion

In a medico-legal context, forensic psychiatrists examining individuals who have committed a homicide are called upon to offer an opinion on the mental state of the person at the time of the offence. This assessment involves gathering all pertinent information on the person’s symptoms and clinical signs and making a clinical judgement or diagnosis. A question therefore arises: Could the murderous behaviour represent an expression of the illness? Needless to say, not all homicides result from a psychopathology. However, various psychotic symptoms, such as delusions, hallucinations, perceptual abnormalities, or disorganization of thinking and behaviour, may be associated with pathological homicide. If homicidal behaviour is an expression of the illness, it naturally follows that it should be used as one diagnostic element among others.

The diagnostic challenge facing experts is greatest in cases of first-episode psychosis in which the offender has no psychiatric history. Given the nature of the crime and the likely temptation to elude legal consequences, these cases naturally raise a high degree of suspicion. A thorough and objective medico-legal examination requires that all relevant information be considered, including past and present behaviour. Experts need to include the homicidal behaviour or event in their diagnostic analysis,
because the objectivity and accuracy of their assessment will be enhanced by considering all relevant data available to their review.

The threshold by which an individual suffering from psychosis is perceived or ultimately judged is also subject to a process that may be biased owing to personal and subjective perceptions. It is also likely affected by the inherent nature of an adversarial justice system such as Canada’s. When extreme violence is directed toward human beings, subjectivity, rather than consideration of objective findings, can affect the attitude of both clinicians and jurors. From a symptom perspective, there is no evidence that a person exhibits different pathology when the violence is directed toward an animal or an inanimate object.

This study is descriptive. Further exploration of the timing of violent events within the illness course will be useful to provide deeper insights into predicting violence and recidivism in individuals with schizophrenia and related disorders. It will likely also influence the forensic dispositions of these patients.

References