# Prototypes of Intrafamily Homicide and Serious Assault Among Insanity Acquittees

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**Public concern with societal violence is intensified when persons who have been found not guilty by reason of insanity (NGRI) of having committed a homicide or serious assault are returned to the community. Successful management of such acquittees in the community requires a sophisticated understanding of the person and the illness within the larger context of the violent incident, the family, the community, and the culture. In this article, we present an analysis of psychotic violence within a family context. A qualitative study of 64 subjects who were found NGRI of killing or seriously injuring a family member resulted in four prototypes of intrafamilial homicide/assault: Till Death Us Do Part; Overwhelming Burden, Elimination of the Limit Setter; and Family-Focused Delusional Killing. The prototypes are presented as a model for developing management strategies both for future risk assessment and for successful transition of the insanity acquittee into the community.**

Intense public concern with societal violence has focused attention on the relationship between mental illness and violence.[1–3] Society's view that mentally ill individuals are violent has been influenced by dramatic media coverage of cases in which mentally ill persons have killed or seriously assaulted another individual.[4] These stories have often suggested that the potential for violence was obvious to all except the psychiatric community. After James E. Swann, Jr., was acquitted of shooting and killing four people and seriously injuring seven others over the course of six weeks in the spring of 1993, the *Washington Post* summarized the events thus: "Other people had noticed for years that something was very wrong with James E. Swann, Jr. . . . Perhaps the most remarkable thing about [the case] is that until his arrest, he had never received any mental health treatment . . .

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[although] he probably began showing the unmistakable symptoms of paranoid schizophrenia, a crippling disorder characterized by vivid hallucinations and delusions, in late adolescence."[5] In Connecticut, David Peterson had as a teenager committed a nearly fatal stabbing of an adolescent, for which he was found not guilty by reason of insanity (NGRI). Years later, he eloped from the hospital and stabbed to death a nine-year-old girl on a busy downtown sidewalk. The national press followed the story with reports of the public outrage and discomfort over the failure of psychiatrists to predict and control the patient's violence.[6] For years, the press documented the cycling of Larry Hogue, dubbed the "Wild Man of 96th Street,"[7] in and out of psychiatric hospitals[8] as the "symbol of New York's failure to effectively treat mentally ill. . . ."[9]

Although the headline events are relatively rare, there is mounting empirical evidence that mental illness is statistically associated with increased rates of violence.[10–12] However, Monahan's recent discussion of the relationship between violence and mental illness[10] noted that "demonstrating the existence of a statistically significant relationship between mental disorder and violence is one thing, demonstrating the legal and policy significance of that relationship is another" (p. 315).

The focus on the legal and policy implications of the link between mental illness and violence is intensified when a person commits a violent act and is found NGRI in a criminal court. With the court's decision, the mental illness and the violent act become one, leading to the popular view that there is an obligation not only to treat the acquittee, but also to protect the public. In some states, the mandate to protect the public is considered so important that it is imposed by statute.[12, 13]

This commitment to both treatment and protection is carried out in the context of a rapidly changing mental health service delivery system, which increasingly depends on community-based care. Hospitals, burdened by the high cost of treating insanity acquittees and fearing "criminalization" of the institution, search for safe ways to move insanity acquittees into the community.

Meanwhile, the public, already intolerant of mental illness, demands a guarantee that there will not be another violent act. Successful management of this challenge requires a sophisticated understanding of the context in which the acquittee will make the transition into the community. In our view, a key factor in the success of this transition is a clear understanding of the acquittee's relationship with his/her family, particularly when the acquittee has killed a family member.

Recent research findings support the view that the family is a powerful factor in the unfolding of an intrafamily homicide. For example, Estroff *et al.*[14] found that mentally ill persons who were financially dependent on their family were more likely to behave violently, particularly toward family members.

Prostrado and Lehman[15] found an association between family discord and rehospitalization and/or arrest of persons with serious mental illness. In contrast,

mentally ill individuals in families who functioned well were less likely to be rehospitalized or rearrested. Given that a relative is the most common target of violence for the person with a serious mental illness,[1, 14] it is not surprising that individuals who have harmed a family member constitute a high percentage of persons who receive an insanity acquittal.[12]

In this article, we present an analysis of cases involving persons who have been found NGRI for a homicide or serious assault. The purpose of the research was to identify the salient factors that differentiated the cases. The result was the identification of four distinct prototypes in which the patterns of illness, of family relationships, and of violence emerged.

## Method

***Design*** This descriptive study used chart review and qualitative techniques to identify the characteristics of insanity acquittees who killed or attempted to kill family members. To identify the salient issues in intrafamily homicide/assault among this group, we examined the data across four domains: demographic and social factors; the acquittee's psychiatric disorder and treatment history; structure and functioning of the acquittee's family; and the details of the homicide/assault.

***Setting*** The investigation was conducted in Connecticut, where the standard for the insanity defense is a modified American Law Institute standard, which requires the defense to show by a preponderance of the evidence that "the defendant, at the time he committed the proscribed act or acts, lacked substantial capacity as a result of mental disease or defect, either to appreciate the wrongfulness of his conduct or to control his conduct within the requirements of the law."[16, 17] If the defense is successful, virtually all acquittees are committed to the Psychiatric Security Review Board (PSRB), a quasijudicial board that is appointed by the governor and is mandated to protect the public.[18, 19]

***Sample*** The sample consisted of 64 acquittees committed to the PSRB between 1985 and 1994 who had been acquitted by reason of insanity of murder or manslaughter ($n$ = 38; 59%), or attempted murder or charges linked to a serious assault ($n$ = 26; 41%). The victims were related to the acquittees by bloodline or marriage. The demographic characteristics of the acquittees are summarized in Table 1.

**Table 1**
**Demographic Characteristics of NGRI Acquittees**

| | |
|---|---|
| Age | |
| Mean | 33.83 years |
| SD | 11.91 |
| Range | 17–68 |
| Ethnicity | |
| White | 52 (81%) |
| Black | 9 (14%) |
| Hispanic | 2 (3%) |
| Other | 1 (2%) |
| Sex | |
| Male | 51 (80%) |
| Female | 13 (20%) |
| Marital Status | |
| Single | 29 (45%) |
| Married | 20 (31%) |
| Separated/divorced | 13 (20%) |
| Widowed | 1 (3%) |

## Results

After reviewing each case, several critical factors emerged as important to developing an understanding of the homicide in the context of the family: the life stage of the acquittee, the family functioning and dynamics, the acquittee's current and long-term functional level, the chronicity and severity of the acquittee's illness, the acquittee's compliance with treatment, and the stressors on the acquittee and the family at the time of the homicide.

These data clustered into four prototypical patterns, which we have labeled Till Death Us Do Part, The Overwhelming Burden, Elimination of the Limit Setter, and The Family-Focused Delusional Killing. A description of each prototype with a generic case example follows.

***Till Death Us Do Part*** The acquittees in this group ($n = 4$; 6%) were three men and one woman who had killed or seriously assaulted their spouses. These older couples were part of strong, well-organized extended families. Each couple lived alone, and the spouses were highly dependent on one another. In the final phase of their life together, each couple was faced with a sudden acute stressor or a combination of stressors related to the aging process, such as serious illness, forced retirement, or loss of income.

With the failure of the acquittees' usual coping strategies, they became increasingly depressed. They typically sought help from the family physician and were treated for anxiety and mild depression in the months before the violent act. Shortly before committing the homicide or assault, the acquittees experienced deepening depression and developed terrifying psychotic delusions of disaster and death. The offenses took place in the context of a murder-suicide in which one spouse killed or attempted to kill the other, then failed in the suicide attempt.

*Case Example* Mr. X. was a 70-year-old man who had been married to his ailing wife for 45 years. She had always limited her activities due to the residual effects of a childhood illness. She did not drive and had always depended on her husband to manage the household. The couple had no children. Mr. X. lost his job in a corporate restructuring that took place six years before the homicide. He was unable to find another job and became very concerned about financial matters when it was rumored that his pension and health benefits would be lost. He developed a serious heart condition and, a few months before the homicide, developed symptoms of depression. He gave up a small business, one of his few remaining sources of pleasure. He was unable to sleep at night and lost considerable weight.

The day preceding the homicide, he was told by his family physician that he must be hospitalized for tests. He returned home convinced that he would not leave the hospital alive. In the early hours of the following morning, he shot and killed his sleeping wife, then turned the gun on himself, inflicting very serious injuries.

***The Overwhelming Burden*** All of the acquittees in this group ($n = 5$; 8%) were women, and the victims were an elderly parent or a dependent child, a

generation removed from the acquittees. Because of age and physical condition, the victims were highly dependent on the acquittees. These women functioned well until the responsibility of caring for the victims fell exclusively on them.

These acquittees, who typically functioned as the family caregivers, found themselves isolated from their usual social supports by the increase in caretaking responsibilities. In charge of their helpless and often demanding victims, they no longer felt free to see friends or to pursue activities outside the home. Worn down by their victims, they began to feel overwhelmed and increasingly depressed.

These women also had little or no psychiatric history, typically sought help from their family doctor, and were treated for mild reactive depression and anxiety. As in the previous prototype, shortly before the violent act, the depression deepened dramatically, eventually reaching psychotic proportions.

*Case Example* Ms. J. was a 68-year-old widow who had nursed her husband and two sisters through terminal illness. She lived alone but was active in church and community affairs and was close to her grown children and grandchildren. When her frail, very elderly father came to live with her, she became totally involved in his care. She had no time for her usual activities with family and friends.

Ms. J. found herself unable to sleep; she lost weight and began to think about killing herself. As she grew increasingly depressed, she experienced auditory hallucinations telling her that it was her duty as a daughter to kill her father. She consulted her family doctor who decided hospitalization was not necessary. A few days later, she smothered her father with a pillow.

***Elimination of the Limit Setter*** This prototype, familiar to mental health professionals, constituted 25 (39%) of the cases. These acquittees were generally young males in their teens to early thirties who had a severe and persistent mental illness. Their course of treatment was characterized by revolving-door hospitalizations and noncompliance or nonresponsiveness to treatment. As these young men entered adulthood, both their families and the mental health system found it increasingly difficult to cope with the manifestations of their illness.

These acquittees were chronically disorganized. They had never effected separation and individuation from the family or functioned as independent adults. Rather than moving toward independence, they worked sporadically, if at all, lived at home or in unstable situations, and depended on their families for financial support. Despite these difficulties, the families, often with a great deal of support from the mental health system, remained connected to the acquittees and tried to set limits on their behavior.

In these families, the principal limit setters could be identified: generally the fathers, but sometimes both parents or single-parent mothers. The limit setters persistently attempted to give the acquittees' lives some structure, urged compliance with treatment, pressured them to find a job, return to school, and become functioning adults. These limit setters became the victims of the homicides and assaults.

A number of these families had histories of chronic violence. The acquittees were often threatening, sometimes assaultive, and were seen as potentially violent. In 25 percent of the cases, the limit setter had abused either the acquittee and/or other family members.

The violent act in question generally took place in the context of yet another argument between the acquittee and the limit setter. Grossly psychotic, often suffering paranoid delusions, the acquittees lashed out to kill the limit setters.

In contrast to the Overwhelming Burden prototype, in which the acquittees were worn down by the victims, the victim-limit setters were worn down by the acquittees. The homicides and assaults were often preceded by a change in the family structure and/or an erosion of prior support from the mental health system. For example, the acquittees' parents grew older and had less energy to cope with recurring crises; there was a change in the family financial circumstances or living situation; insurance benefits or entitlements were cut off, hospital admission criteria were tightened; a familiar community program was no longer available.

***Case Example*** Mr. S. was the 27-year-old son of parents who immigrated to this country from Europe when Mr. S. was 10 years old. He excelled in high school but dropped out of college shortly before graduation. He lost a series of menial jobs and became totally dependent on his parents. He was voluntarily hospitalized several times with symptoms of paranoia, auditory hallucinations, and delusions. He was always discharged from the hospital against medical advice.

His aging parents, in a desperate attempt to help their son, arranged for Mr. S. to return for a visit to the quiet European village where he was born. When he became assaultive and acutely psychotic, he was returned to the United States by relatives. He refused to stay with his parents or to seek treatment, and his condition continued to deteriorate. He went home broke and hungry to ask for money. An argument ensued, and Mr. S. shot and killed his father.

***The Family-Focused Delusional Killing*** This prototype comprised 30 (47%) of the acquittees. Prior to the homicide or assault, the acquittees had been treated for mental illness, but had been hospitalized infrequently. The acquittees functioned well, generally complied with outpatient treatment, and may have held highly responsible jobs.

The violent incidents took place in the context of a sudden, completely unexpected onset of the acquittees' illness. Beset by persecutory delusions, the acquittees responded to command hallucinations to kill a specific family member. Prior to the act, the acquittees had not been viewed as violent. There was seldom an identifiable trigger for the violent act; the acquittees' violence came as a shock to their families, mental health providers and friends. The acquittees had been able to maintain surface control, disguising from everyone their deepening psychotic fear and rage almost until the moment of the act. The homicide or assault, however, precipitated a decline into severe and long-lasting psychosis.

*Case Example* Mr. Y. was the 48-year-old father of two young children.

His psychiatric history dated back to his service in Vietnam, where he was treated for depression. He and his wife of 15 years were both professionals. In the years before the homicide, he was treated episodically for depressive illness, primarily on an outpatient basis.

Two weeks before the homicide, during a family vacation, he became convinced that the hotel staff were following him and reporting his activities to his boss in Connecticut. When he returned home, he continued to believe that he was being followed and that people were conspiring with his employer and his family to harm him.

On the day of the homicide, his wife took him to his outpatient therapist who recommended immediate hospitalization. Mr. Y. returned home and waited for the insurance company to call, authorizing his admission. His wife and son went to the corner store for milk, leaving him with his seven-year-old daughter. Shortly after they left, in response to a command from God, he stabbed his daughter to death.

***Comparison of the Prototypes*** The characteristics that distinguish the prototypes can be identified with respect to premorbid functioning and characteristics of the illness or the violent event. Although all of the acquittees in this sample had a psychotic illness, the course of the illness, its precipitants, and the larger context of the family were the factors that distinguished the groups. Table 2 shows the demographic characteristics among the different prototypes. The small number of subjects restricted statistical analysis; however, several observations may still be made from the data. All subjects in the Till Death Us Do Part group were employed (or had been prior to retirement) with half in the executive and professional level of socioeconomic status, a level no other subjects had attained. The Overwhelming Burden group were involved in caregiving. Not surprisingly, they were all females. Finally, the Elimination of the Limit Setter group were all male.

Clinical characteristics differed across groups, as shown in Table 3. The Elimination of the Limit Setter group was distinguished by the lowest level of functioning over time with dependence on family and little success in living independently. The Family-Focused Delusional Killing group was distinguished by a lack of external precipitants and the sudden onset of persecutory delusions. In contrast, the Overwhelming Burden group had a distinct external stressor related to care-taking demands which wore down the person's capacity to maintain a previously high level of functioning. Similarly, the Till Death Us Do Part group showed a decline from a high level of functioning in reaction to the stressors of aging and isolation.

The acquittees in the Till Death Us Do Part and the Overwhelming Burden prototypes had a prodromal depression that was reactive to either aging or the demands of a stressful environment. In contrast, the acquittees in the Elimination of the Limit Setter prototype were known to the mental health system as chronically ill and difficult to manage, with a high potential for violence. From a clinical perspective, the Family-Focused Delusional

**Table 2**
**Demographic Characteristics Across Prototypes**

| | Til Death Us Do Part $N = 4$ (6%) | | Over-whelming Burden $N = 5$ (8%) | | Elimination of the Limit Setter $N = 25$ (39%) | | Family-Focused Delusional Killing $N = 30$ (47%) | | Total $N = 64$ (100%) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | *n* | % | *n* | % | *n* | % | *n* | % | *n* | % |
| Sex | | | | | | | | | | |
| Male | 3 | 75 | 0 | 0 | 25 | 100 | 23 | 77 | 51 | 80 |
| Female | 1 | 25 | 5 | 100 | 0 | 0 | 7 | 23 | 13 | 20 |
| Marital status | | | | | | | | | | |
| Single | 0 | 0 | 0 | 0 | 21 | 84 | 8 | 27 | 29 | 45 |
| Married | 4 | 100 | 2 | 40 | 0 | 0 | 14 | 47 | 20 | 31 |
| Sep/Div | 0 | 0 | 1 | 20 | 4 | 16 | 8 | 27 | 13 | 20 |
| Widowed | 0 | 0 | 2 | 40 | 0 | 0 | 0 | 0 | 2 | 3 |
| Education | | | | | | | | | | |
| Degree | 0 | 0 | 0 | 0 | 1 | 4 | 3 | 10 | 4 | 6 |
| > HS | 2 | 50 | 1 | 20 | 7 | 28 | 7 | 23 | 17 | 27 |
| HS | 0 | 0 | 2 | 40 | 7 | 28 | 7 | 23 | 16 | 25 |
| < HS | 2 | 50 | 2 | 40 | 10 | 40 | 13 | 43 | 27 | 42 |
| Socioeconomic status | | | | | | | | | | |
| Executive/professional | 2 | 50 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 3 |
| White collar | 1 | 25 | 2 | 40 | 1 | 4 | 10 | 33 | 14 | 22 |
| Blue collar | 1 | 25 | 1 | 20 | 10 | 40 | 11 | 38 | 23 | 36 |
| Welfare/entitlement | 0 | 0 | 2 | 40 | 12 | 48 | 8 | 27 | 22 | 34 |
| Student | 0 | 0 | 0 | 0 | 2 | 8 | 1 | 3 | 3 | 5 |
| Offense | | | | | | | | | | |
| Homicide | 3 | 75 | 3 | 60 | 15 | 60 | 17 | 57 | 38 | 59 |
| Assault | 1 | 25 | 2 | 40 | 10 | 40 | 13 | 43 | 26 | 41 |

Killing was the least predictable. The sudden onset of persecutory delusions and hallucinations in persons who have demonstrated social effectiveness in the past challenged accurate clinical assessment and prediction of risk.

## Discussion

Analysis of the homicide in the context of the family provides a mechanism for exploring the questions that haunt a violent experience. Why did this happen? How can it be prevented from happening again? These prototypes represent a model for answering these questions by integrating an array of factors beyond a specific diagnosis. By incorporating information about past illness, family functioning, and social characteristics, clinicians can identify factors and patterns that may place the acquittee and family at risk in the community.

In the Till Death Us Do Part and Overwhelming Burden prototypes, the emergence of depression in relationship to the factors of aging and environmental stres-

**Table 3**
**Clinical Characteristics Across Prototypes**

| | Till Death Us Do Part | Overwhelming Burden | Elimination of Limit Setter | Family-Focused Delusional Killing |
|---|---|---|---|---|
| History of psychiatric illness | None | None to minimal | Frequent contacts with mental health system | Few hospitalizations; episodic treatment |
| Prior level of function | High functioning, then decline and isolation during aging process | High functioning; isolation/ decline with caretaking demands | Chronically impaired function; dependence on family | Apparent high functioning; acceptable social demeanor |
| Presentation of symptoms | Reactive to aging process; depression escalates to psychosis | Reactive to caretaking demands; depression escalates to psychosis | Chronic severe psychosis; delusions; hallucinations | Sudden onset of persecutory delusions, command hallucinations |
| Psychiatric status at time of incident | Unrecognized symptoms or insufficient management by family physician | Unrecognized symptoms or insufficient management by family physician | Acutely symptomatic because of noncompliance or intractability | Compliance with outpatient treatment; undiagnosed and contained delusional disorder |
| Risk of violence prior to the incident | None | None | High violence risk managed by families and revolving-door hospitalizations | None |

sors erupted into psychotic violence. In these groups, the history of high functioning and the lack of previous psychiatric treatment may have contributed to an underestimation of the severity of depression and potential for violence. The acquittees had a profile similar to that of many elderly and overwhelmed family members, usually managed clinically by family practitioners, who do not kill or assault a family member. However, with the acquittees in the present study, the confluence of depression and fulminating psychosis made a tragic difference. In these cases, the illness progressed without the scrutiny of a psychiatric assessment that may have identified and treated the mounting psychosis. Family physicians who have long-standing relationships with their patients may miss the signs of severe depression by maintaining a view of their clients as resilient and high functioning, although experiencing temporary distress or the inevitable crisis of aging. In the climate of managed care, previous high functioning and a lack of past psychiatric history may mean that a newly depressed patient will not meet the threshold for obtaining a level of assessment and treatment typically afforded to seriously mentally ill patients.

Just as the Till Death Us Do Part and the Overwhelming Burden groups remind us that the general practitioner is called upon to assess depression in previously nonpsychiatric patients, the Elimination of the Limit Setter prototype (which comprised the largest number of people) signals the psychiatric community that risk management requires an ongoing assessment of the balance between the potential for violence of the mentally ill individual and the capacity of the family and community to contain the violent impulses and behavior. In this prototype, the acquittees had been assessed as being at high risk for violent behavior during their earlier treatment. However, the years of difficult behavior and the success of the family in managing this behavior muted the evidence for the violence potential. In many cases, there was little change in the client's potential for violence; what changed was the effectiveness of the deterrence. Indeed, in these clients, the ever-present risk that never erupted was as much a barrier to accurate prediction as was the past history of no risk in the other prototypes. In the Elimination of the Limit Setter prototype, the erosion of the family's capacity to contain the violence, rather than a substantive change in the acquittee's behavior, resulted in the violent episode.

As managed care shifts more of the burden for risk management to outpatient treatment services and ultimately to families and communities, the importance of assessing potential violence increases. Containment of the violent behavior that is a component of mental illness will become a more urgent issue as family members age, hospitalizations become shorter, treatment sessions are fragmented across levels of care, and communities support fewer resources for the mentally ill. In the assessment and management of violence, the age and vulnerability of an elderly father who has in the past held his own against the blows of his schizophrenic son are factors equally as important as a pa-

tient's level of psychotic symptoms and medication compliance.

The prototype of the Family-Focused Delusional Killing represents the greatest challenge for risk management and the prediction of future risk. The transformation of a successful person with little or no psychiatric history into a psychotic killer is not understood by mental health professionals and is even less understood by the public. This prototype represents a subset of acquittees for whom the onset of the violence remains unexplained and the risk for future violence high. Since for this group the relevance of family and community context is not evident, those factors cannot be assumed to mitigate the risk for future violence. It might be hypothesized, therefore, that acquittees in this prototype will be held in maximum security hospitals the longest of all acquittees. This is a question for future empirical research.

Overall, these prototypes underscore the need to analyze questions of criminal responsibility, future risk, and treatment need from a broader perspective than the limited one of diagnosis and course of illness. Each insanity acquittee is a central character in a complex social, family, cultural, and historical drama that has its beginnings long before the violent episode. It becomes the clinician's task to weave a narrative that presents a coherent account of motive and behavior in the context of mental illness, which can then direct future treatment and risk reduction.

It is not clear whether the prototypes presented in this article will generalize to other populations. The sample consisted solely of acquittees from Connecticut. If the same methodology were applied to acquittees from other states and to other types of family violence, new prototypes would undoubtedly emerge. The merit of this initial step is the development of a mechanism for incorporating rich clinical, family, social, and cultural information into distinctive profiles that can direct clinical treatment and the prevention of future violence.

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