

What Treatments Do We Have for Children and Adolescents Who Have Killed?

Wade C. Myers, MD

This article examines the limited literature available on the treatment of homicidal children and adolescents. Various methods of treatment for this population are reviewed including psychotherapy, psychiatric hospitalization, institutional placement, and psychopharmacologic agents. The body of research on homicidal youths is progressing very slowly, and definitive treatments and prognostic data in this heterogeneous population are for the most part lacking.

On the one hand, the wish to commit murder is perhaps the most basic, most universal destructive wish, shared surely by the majority of human beings; but that, on the other, it is also the one hedged by the most fundamental objections, inhibitions, and taboos.¹

The youth who commits a homicidal act may or may not receive some form of mental health treatment. Possible treatment strategies include psychotherapy, psychiatric hospitalization, institutional placement, or the use of psychopharmacologic agents. More likely to occur are legal sanctions like probation, community service, or incarceration in juvenile correctional facilities. In the more monstrous cases of murder, the youth will often be waived to adult court where he is at the mercy of the adult

criminal system, including capital punishment. In some states those minors above a certain age charged with murder are automatically waived to adult court.

Children and adolescents who kill frequently have a constellation of psychological, cognitive, neuropsychiatric, educational, and family system disturbances that are amenable to treatment interventions. Lewis² has commented on the tragic lack of resources needed for the evaluation of these youths: "The clinical and legal services necessary to try to uncover these vulnerabilities are routinely unavailable to this population of juveniles." Moreover, studies have found that economically disadvantaged minorities who commit violent crimes tend to consistently receive the harshest dispositions,³ thus diminishing their chances for mental health evaluation and treatment. Whether this is related to racial status, social class, or other influences remains conjectural. In the

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author's experience, only the younger child (latency age or preadolescent) or the youth with severe mental illness holds a reasonable chance of having an appropriate and thorough court-ordered mental health evaluation.

The likelihood of psychiatric treatment for the homicidal youth diminishes as he enters adolescence, and typically is replaced by dispositions within the legal system. Rosner *et al.*'s⁴ study of 45 adolescents aged 16–18 charged with murder or manslaughter exemplifies the lack of treatment for the older juvenile offender. Of 45 adolescents referred for evaluation by the court, all but one were sentenced within the criminal justice system; the exception was a youth sent to a mental hospital following a finding of not guilty by reason of insanity.

There are few studies in the area of juvenile homicide, and even fewer address treatment. The majority of articles in this area are based on small case series. Furthermore, the relative infrequency with which juvenile homicide occurs makes it a difficult task to collect reasonably sized samples for analysis.

This article will provide an overview of the available scientific literature specifically pertaining to the treatment of homicidal children and adolescents. However, before moving on to treatment, it will be useful to review the commonly held theories and etiologic data that exist on homicidal behavior by juveniles. This information is necessary in the critical assessment, development, and application of various treatment methods.

Theory and Etiology of Juvenile Homicide

A number of theories and etiologic factors have been proposed as either contributory to or causative of homicide by children and adolescents. Psychodynamic explanations abound, and include: the expression of the death wish secondary to the intensification of the oedipal conflict or sibling rivalry⁵; aggressive behavior as a defense against feelings of passivity and femininity⁵; severe lapses of ego control allowing the expression of primitive violence resulting from previously unconscious traumatic experiences⁶; early experiences of deprivation leading to an underdeveloped ego vulnerable to outbursts of violent aggression⁷; homicide serving to save the ego from self-destruction by displacing the aggressive discharge onto someone else⁸; and the acting out of unconscious murderous parental wishes.^{9,10}

Sociocultural factors identified as possibly contributory to the occurrence of juvenile homicide include severe physical abuse^{11,17} and sexual abuse,² exposure to repetitive or extreme violence^{13,14}; disturbed, conflictual, enmeshed parent-child relationships or harsh, depriving, inconsistent parenting patterns^{7,11–13,15,16}; parental mental illness^{17,18}; and gang participation.¹⁹

The availability of guns and the continuing deluge of media violence in American society cannot be easily overlooked when discussing juvenile homicide. A gun is used in nearly 60 percent of murders by youth.²⁰ Moreover, it is estimated that 400,000 youngsters car-

ried handguns to school in 1987!²¹ Also of great concern is the exposure of children to media violence. The average child in America watches 45 acts of violence on television each day, mostly involving handguns.²¹ Although inconclusive, it is thought that some emotionally vulnerable youths may act aggressively in response to viewing violent material.²² The author is reminded of a recent case in which an 11-year-old boy watched a "slasher" movie, and then, without any apparent motive, went next door and brutally stabbed to death a middle-aged female neighbor.

Neurological abnormalities have long been described in juvenile murderers. For instance, in 1959, Bender²³ described organic brain damage, abnormal EEGs, and epilepsy in such youths. More recently, Lewis *et al.*^{2,17,24} have emphasized the presence of major neurological impairment in this population as evidenced by histories of severe head injury, EEG abnormalities, present and past seizure disorders, abnormal head circumferences, deficits on neuropsychological testing, and soft neurological signs.

From a diagnostic perspective, most homicidal youth meet criteria for conduct disorder.^{25,26} It appears that the prevalence of actual psychotic disorders is rare,^{26,27} although Lewis *et al.*^{2,17} have reported frequent psychotic symptoms, especially paranoid ideation. Below average IQs are common,^{2,28} as are learning disabilities^{2,23,29} and possibly language disorders.³⁰ Substance abuse is also frequently found in the juvenile murderer.^{2,19,20,25,27} A 1987 U.S. Department of Justice study²⁰ found that, at the time

of the commission of murder, 42.5 percent of juveniles were under the influence of either alcohol (17.3%), drugs (15.2%), or a combination of both (10%). This finding is particularly important in that alcohol most illicit drugs have been associated with increased aggressive behavior.³¹

It is presumed that many youthful murderers have developmental delays in their moral reasoning. Impaired moral reasoning has been reported in delinquent and psychopathic youths,³² although these findings are not directly applicable to those juveniles who have committed homicide. Investigative efforts in this area are clearly needed.

Treatment Methods

Psychotherapy The overall view of the psychiatric community has by and large been pessimistic regarding psychotherapeutic approaches for antisocial youth—in spite of many studies to the contrary. Significant evidence is available that psychotherapeutic interventions can be useful and effective treatments in at least a proportion of antisocial children. Keith³³ has written a careful review of this area, and his work helps to explain some of the origins of the prevailing pessimism regarding psychotherapy. For instance, past studies have been conspicuous for inadequate lengths of treatment, flawed study designs, lack of trained therapists, not actually providing "psychotherapy," etc. It should be kept in mind that not all juveniles who commit homicidal acts have antisocial personality structures or histories of delinquent or violent acts. In some cases, no signs of

emotional or behavioral disturbances other than the murderous act can be found, either shortly after the crime or at follow-up years later.³⁴

Seven studies addressing the use of psychotherapeutic treatment for homicidal youth were found in the literature, and consist of either individual case studies or small case series. Three of these studies addressed the treatment of children. Paluszny and McNabb³⁵ described their successful use of insight-oriented play therapy for a six-year-old girl who killed her four-month-old brother by inflicting fatal intracranial injuries.

Tooley¹⁰ used psychotherapy for the treatment of two six-year-old children who had each tried to murder younger siblings in response to their mother's unconscious wish to be relieved of the burden of these extra children. A good response to treatment occurred in one child, while the later adjustment of the second child was not given.

Pfeffer¹³ emphasized the need to first promote an empathic, inquisitive, and objectively neutral attitude toward the homicidal child so that an atmosphere of trust and a therapeutic alliance can be established. Immediate goals of intervention include the channeling of aggressive impulses into play and verbal expression. Consequently, conflictual and transference material can be further elaborated and then worked through.

Four studies concerning the treatment of homicidal adolescents were found. Smith⁷ conceptualized youthful murderers as suffering from character structures influenced by early oral deprivation and early childhood development disturbed

by disintegrated family relationships. Their underdeveloped egos lead to a vulnerability to outbursts of aggression. The core of the psychotherapeutic process is "being able to enter into a regressive transference that momentarily reinstates the patient's symbiosis with the mother," and then successfully exiting this symbiosis in such a way that the patient realizes its lack of reality and therefore then recognizes the existence of two separate people.

Scherl and Mack¹⁵ outlined the psychotherapeutic treatment of a 14-year-old boy who committed matricide in response to an intensely sadomasochistic relationship he had with his mother. The mother allowed her son no meaningful human relationships or opportunities for instinctual gratification outside of the family, and she presented to him a constant incestuous threat that proved to be overwhelming to his primitive defense mechanisms. Psychotherapy centered on exploring issues of trust and promoting self-examination. The therapist deliberately remained a "real person" during psychotherapy by keeping the boy aware of the therapist's thoughts and feelings, and by contrasting these with the boy's projections for clarification. The prognosis remained "guarded" after treatment.

McCarthy³⁶ used psychoanalytic treatment for 10 homicidal adolescents whose intrapsychic structures manifested narcissistic disturbances, and who had underlying narcissistic rage and an impaired capacity for self-esteem regulation. Although attempts at therapeutic change during their hospitalization provided

generally poor results, two aspects of therapeutic intervention were believed to hold some promise. First, the use of an active, confrontational approach was felt to be necessary in trying to make the overt expression of violence ego-dystonic and anxiety provoking. Second, the need to target narcissistic disturbances for treatment was also considered crucial.

Myers and Kempf²⁶ described the short-term treatment of four incarcerated homicidal adolescents using either psychotherapy or behavior therapy depending on the DSM-III-R conduct disorder type. Those with conduct disorder, undifferentiated type, had emotional relationships with their victims, were suicidal, and responded to brief focused psychotherapy. In contrast, those with conduct disorder, solitary aggressive type, shot strangers, directed their aggression outwardly, and were managed with behavior therapy (contingency management). The choice of treatment was determined by the ego strengths available to the youths and also by their ability to form a working relationship early on with the clinician.

The use of psychotherapy for the child or adolescent who has committed a homicidal act is considered by most authors to be an important adjunctive treatment, and at times may play the central role in therapy. The capacity to form emotional attachments with others, thus potentially allowing the establishment of a working relationship with the clinician, is a common indicator of treatability in these studies. Other positive indicators for the use of psychotherapy in this population include the ability for self-examination

and insight. Qualities such as frequent and severe aggression, low intelligence, and a poor capacity for insight weigh against the reliance on psychotherapy as a primary means of treatment. When the clinician determines that psychotherapy is indicated, he or she should avoid feeling discouraged if therapeutic gains come slowly; these patients are often a very disturbed and difficult population to work with in treatment. They frequently come from chaotic, abusive backgrounds, and may develop therapeutic alliances reluctantly.

As can be seen, most studies on psychotherapy for juvenile murderers have been of a psychodynamic nature. Future studies might usefully assess cognitive-behavioral psychotherapy for juvenile murderers; this form of treatment has been applied to other types of young offenders with reasonable success.³⁷

Psychiatric Hospitalization Inpatient treatment is a frequently used and important treatment method for the homicidal child, whereas it is rarely used in the case of the adolescent offender. This can in part be explained by the younger child who commits murder being viewed by society and the court as psychologically disturbed or under environmental duress, whereas the adolescent murderer is more likely to be seen as expressing criminal tendencies.

Three studies addressing psychiatric hospitalization were found. Carek and Watson³⁸ used a combination of psychiatric hospitalization for a 10-year-old murderer and conjoint therapy for his parents in their treatment of a family involved in fratricide. This boy, who was

baby sitting his siblings while his parents were out, fatally shot a younger brother with a shotgun while pointing it at him to "scare him" into behaving appropriately. Initially, the shooting was described by the newspaper and the parents as an accident, but the boy was unable to handle it as such. Multiple psychiatric symptoms developed in the boy and also in the other family members as a result of the disrupted family system. Psychiatric hospitalization of the boy was carried out to provide treatment both for him and his family. Insight-oriented treatment focused on his depression, anger management, and guilt. Interpretive conjoint psychotherapy for his parents was provided to address their relationship, which was marked by hostility, poor communication, and a lack of intimacy. Positive treatment results were reported for the boy and the parents after nine months of hospitalization.

Pfeffer¹³ discussed the psychiatric hospital treatment of assaultive homicidal children between the ages of six and 12 years. She believed hospitalization to be the best first phase of treatment, and identified the main goals of hospitalization to be the redirecting of homicidal impulses, strengthening of ego functioning, and reduction of conflicts for the child and parents. A holistic approach was advocated so that factors such as constitutional vulnerabilities, environmental stressors, intrapsychic conflicts, and the child's state of ego functioning are assessed. The hospital setting allows the child to regress while in a safe and empathic therapeutic environment, thus enabling intense affects and conflicts to

be worked through. Common types of conflicts encountered in the assaultive homicidal child are: attempts to master trauma, repetition of parental violence, paucity of internalized positive identifications, and the effects of severe ego deficits. Pfeffer also noted the importance of the staff serving as trustworthy, empathic, and nondestructive role models for the aggressive child. Additionally, therapists and other hospital staff may need education and reassurance to deal with their fears and anxiety that can commonly arise in working with the homicidal child.

Mouridsen and Tolstrup³⁹ described the hospital treatment of a nine-year-old Danish boy who fatally shot his mother in a premeditated fashion. Psychiatric symptoms before the murder included preoccupation with themes of death and violence, anxiety and fears, an exaggerated interest in guns, delusions of persecution, disturbed affect, and disorganized behavior such as firing a rifle carelessly in the presence of others. As Danish law prohibits the punishment of criminal acts before the age of fifteen, the boy instead received long-term inpatient psychiatric treatment for a schizophrenic disorder along with EEG abnormalities suggestive of epilepsy. Pharmacological intervention included perphenazine, valproic acid, and oxazepam, but no convincing beneficial effects resulted despite a normalization of his EEG. Ongoing care at a long-term treatment center was necessary after one year of psychiatric hospitalization.

Psychiatric hospitalization for the homicidal youth may be necessary for the management of psychosis or for those

who remain homicidal or require intensive psychopharmacological management. Inpatient treatment allows for a setting in which a stabilization of ego functions, redirection of homicidal impulses, and the internalization or reduction of intrapsychic conflict can occur. This is often in stark contrast to the juvenile's home environment or a correctional facility. Furthermore, hospitalization permits a comprehensive psychiatric evaluation of the offender, his behavior, and the family system; such an evaluation could not be accomplished nearly as effectively if it were conducted on an outpatient basis or if the youth remained in a detention center or other juvenile justice or criminal facility. The psychiatric hospital is an environment where the youth's potential for further violence can best be assessed. The need to educate and demystify inpatient staff about working with the child who has committed serious violence is often necessary for successful hospital evaluation and treatment. The staff as a principal component of the milieu can serve as influential and healthy sources of identification for the offender.

Institutional Placement Placement in juvenile offender institutions is a not infrequent disposition for the child or adolescent who has committed a murderous act, and may be the only "treatment" that is afforded. Typically, a bare minimum of mental health care is available at best, and reasons for this are usually due to insufficient financial resources and an inadequate understanding of this population's psychological needs. Interestingly, the institutional placement

approach seems to work in a significant number of cases when lack of recidivism (no committal of further serious crimes) is used as a criterion for successful treatment at follow-up.^{1,40}

Reasons for the efficacy of these "preventive detention" programs might include:

1. The allowance of time for further neurodevelopmental, cognitive, and emotional growth, thus allowing the youth to gain better control of his emotions and aggressive impulses. The neurological development of the brain progresses throughout most of the life cycle, as evidenced by the increasing complexity of myelination in the cortex that appears to continue at least into the fifth and sixth decades of life.⁴¹ How this might explain an improvement in aggressive or delinquent behavior with the passage of time remains speculative.

2. The homicidal act was a one-time occurrence, perhaps due to the presence of extreme environmental stressors, outside influences, and/or psychological conflicts, and thus such an act of violence would never be repeated regardless of the disposition by the court or whether treatment was provided.

3. The influence of the program's therapeutic milieu on the youth's character structure, such as through healthy role models, consistent setting of limits, and education and/or vocational training, which allow for a sublimation of the aggressive drive and provide for a new source of self-satisfaction.

4. The provision of a safe setting so that "tincture of time" can go to work by allowing the youth to "outgrow" the de-

linquent behavior⁴²; in other words, the phenomenon of the "spontaneous remission rate" in antisocial youths. Robins,⁴³ in her landmark study on childhood predictors of adult antisocial behavior, found that "spontaneous recovery is frequent[;]...most highly antisocial children do not become highly antisocial adults." Admittedly, this may simply be a different explanation of the process described in reference 1.

Gardiner's¹ detailed case histories of 10 homicidal juveniles provide an in-depth exploration of the factors during their institutionalization that contributed either to a positive or negative outcome in later adjustment. Learning a vocation, the establishment of meaningful relationships, the presence of social support systems, and not returning to their former pathological environments all appeared instrumental in their effective reintegration back into society.

Sorrells⁴⁴ raised the concern that correctional programs emphasize respect for authority, orderliness, and impulse control, and youths with significant potential for later violence often "graduate" from such programs without any real change in their character structures. He saw the need to teach "empathy" as a major goal of the programs which handle homicidal youths, and added that he is aware of no program which does this. He further emphasized the need to have correctional programs that are relevant to the emotional needs of the children within them and that do not focus their programs solely on group conformity of behavior.

In Scotland, Fiddes⁴⁵ also lamented the lack of programs in prison and young

offender facilities that aim rehabilitation efforts at an individual level. Instead, their system views conformity to the needs of the institution as a measure of progress and success, and the individual psychopathology of the offender is neglected except in extreme cases, i.e., a psychotic inmate with disruptive behavior.

A similar situation exists in Florida's youthful offender programs. These programs were designed:

To improve the chances of correction and successful return to the community of youthful offenders sentenced to imprisonment by providing them with vocational, educational, counseling, or public service opportunities and by preventing their association with older and more experienced criminals during the terms of their confinement.⁴⁶

A significant proportion of juvenile murderers in Florida are sent to a specific youthful offender institution that is designed for violent offenders. Juvenile murderers make up 10 percent of the population (50 of 500) of the inmates in this facility who are 14 to 19 years old. The only psychologically oriented treatments available in this institution are a substance abuse program and one weekly group therapy meeting. This group can accommodate just 1 to 2 percent of this population at any given time.

The lack of individual and specialized treatment for the psychopathology of youthful offenders in this and similar institutional settings is a serious concern in light of evolving knowledge about the high prevalence of psychiatric illness and other vulnerabilities in this population. Furthermore, there is undoubtedly a subgroup of juvenile murderers who

would benefit from a "corrective emotional experience" that could theoretically be provided in at least some juvenile institutions. This subgroup is composed primarily of youths with some degree of psychological problems (e.g., adjustment disorders, depression), disturbed family functioning, and concomitant stressful life events.^{1,12,16} Additionally, they have murdered during interpersonal conflict and not during the commission of a crime.^{26,27} The value of placement in a therapeutically designed institution that affords: (1) consistent exposure to genuinely interested adults who would be empathic, supportive, prosocial role models; (2) sensitivity to the individual's psychological and mental health treatment needs; (3) educational or vocational programs tailored with the youth's ability; and (4) a structured, limit-setting environment should not be underestimated. Such a placement would likely be of significant therapeutic benefit to this subgroup, in addition to having a positive impact on their long-term prognosis.

Psychopharmacological Management

Studies addressing the use of psychotropic medications in homicidal children and adolescents are lacking. Nevertheless, medications can be a useful intervention in this population. Indications for pharmacological treatment may include temporarily facilitating ego control over murderous impulses, controlling intractable aggression, and managing psychotic illnesses. Eichelman⁴⁷ has outlined four principles in the pharmacotherapy of aggressive and violent behavior that are applicable to the juvenile murderer when medication is indicated: (1) treat

the primary illness, (2) use the most benign interventions when beginning empirical treatment, (3) have some quantifiable means of assessing efficacy, and (4) institute drug trials systematically. Stewart *et al.*⁴⁸ recently reviewed the pharmacologic treatment of aggressive children and adolescents, and guidelines from this article can be readily applied to the homicidal youth.

It appears that most juvenile murderers meet criteria for conduct disorder,^{25,26} and studies on the pharmacologic treatment of aggression in this condition can help guide the clinician in choosing an appropriate medication when necessary. A well-designed, controlled study found that haloperidol and lithium⁴⁹ both significantly reduced aggressive symptoms in the treatment of youths with aggressive conduct disorder. In a small controlled study, methylphenidate significantly reduced aggressivity in those with the diagnoses of aggressive conduct disorder and comorbid attention-deficit hyperactivity disorder.⁵⁰ No controlled studies yet exist that look at the use of stimulants in the treatment of juveniles with aggressive conduct disorder not associated with attention-deficit hyperactivity disorder. Open trials suggest that carbamazepine,⁵¹ imipramine,⁵² and propranolol⁵¹ may be helpful in treating the youth with conduct disorder and aggressive symptoms.

Other diagnostic entities to be aware of in juvenile murderers that respond to medication are affective disorders, schizophrenia, and organic mental disorders. Irritability and aggression are frequently found in children and adolescents with

either depression or mania,⁴⁸ and such clinical symptoms may warrant a trial of antidepressants, lithium, or other mood-stabilizing drugs. Aggressive behaviors are also a common and distressing problem in youths with schizophrenia. Antipsychotic medications remain the medication of choice in the aggressive schizophrenic child who is reacting to delusions or hallucinations, although lithium may also be beneficial.⁵⁴ Organic mental disorders are probably a common finding and often overlooked in child and adolescent murderers who have a history of serious brain injury. Neuroleptics should not be the first line drug for aggression associated with this diagnosis in view of their serious side effect profile and the lack of evidence for a specific anti-aggressive effect. Lithium and propranolol show promise in the empirical treatment of aggression in children with organic mental disorders.⁴⁸ Studies on the use of carbamazepine for this diagnosis in youngsters are lacking. As in the treatment of any emotional or behavioral disorder, medication is always only an adjunct to a comprehensive treatment plan.

Summary

This article has provided an overview of the scant literature available on the treatment of homicidal children and adolescents. Psychotherapy, psychiatric hospitalization, institutional placement, and psychopharmacological agents can all potentially have an important place in the treatment of the juvenile murderer. Treatment planning for this population should take into account all of the possible ingredients that lead to the murder-

ous act. Particular attention should be paid to the diagnostic evaluation of both the offender and his family system. When neuropsychiatric vulnerabilities are discovered (i.e., learning disabilities, language disorders, psychomotor seizures), appropriate treatment should be initiated as indicated. Substance abuse treatment will be necessary in a significant percentage of homicidal youths.

Currently, there are no well-designed studies that have evaluated the use of any of these treatments for juvenile murderers. Research studies with long-term follow-up of more clearly defined subgroups of juvenile murderers are needed to determine the optimum treatment strategies for this heterogeneous group, and also to help guide the juvenile and criminal justice systems in their handling of this population.

It may seem that little progress is being made in the understanding and advancement of treatments for homicidal youths. A German newssheet from 1603 describing the execution of two "diabolical good-for-nothings" aged fourteen and fifteen who poisoned their drunken father and uncle helps illustrate the therapeutic advancement that western civilization has actually made over the past few centuries:

All the youths of the town were there to watch, convened by the civic authorities, because it is good to instruct young people by such examples. They began by stripping the two boys, then they whipped them in such a way that their blood abundantly covered the ground. Then the executioner stuck red-hot irons on their wounds, at which they screamed such screams that it is impossible to describe them. Next they cut off their hands. . . The execution lasted about twenty minutes. Boys and girls attended,

as well as a great crowd of adults. In this torture, one and all admired the just judgments of God and learned from this example.⁵⁵

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