Female Offenders Referred for Pre-Trial Psychiatric Evaluation

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Introduction

Recently, female offenders have drawn attention from criminologists owing to the rapid rise in the rate of crime committed by women compared to men and to their increasingly active role in the crimes.[1] Widom (1978) has critically reviewed various etiological considerations such as biological as well as environmental stress hypotheses to explain female criminality. One aspect of the environmental hypothesis deals with psychopathology observed in women who commit various offenses. Findings from previous studies range from considering all female offenders as mentally-ill[2] to identification of specific characteristics such as preponderance of depression[3] and other psychiatric disorders such as antisocial personality, alcoholism, drug abuse, homosexuality and hysteria.[4] Investigators have stressed the need for systematic research on female offenders at various stages of the incarceration process beginning with the period awaiting for trial to long term after-incarceration.[1] The present study concerns the characteristics and disposition of women committed to a State Hospital for pretrial psychiatric evaluation (PTPE) for a period of five years (1974-79) and includes demographic variables, offenses associated with commitment, previous criminal and psychiatric history, present psychiatric status, associated medical conditions and types of disposition. It further attempts to study the age incidence of female commitment, relationship of psychiatric diagnosis to type of offense, as well as relationship of prior criminal and psychiatric history to the outcome of the evaluation.

Method

The study included all female patients admitted to a large state hospital in Missouri during a five-year period (1974-79) for pretrial psychiatric evaluation and on whom a report was rendered to court. The Forensic Service of the State Hospital evaluated 30-40% of the total referrals in the state which were randomly assigned by the courts. The examining psychiatrist was requested to determine: 1) presence of mental illness, 2) whether or not the defendant is capable of standing trial, 3) whether or not the defendant is

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criminally responsible and 4) to provide recommendations for any treatment. All patients received a comprehensive psychiatric and a physical examination and DSM II criteria were applied for diagnostic purposes. Demographic data such as race, education, marital status and work history were recorded. In most cases, information related to the past and present offenses was obtained from the police reports sent to the hospital. In others, data was gathered through phone calls by a social worker to the court, prosecuting attorney and/or other legal officers. Criminal actions were defined as violation of law against persons or property for which there was an official record. The two major categories of offenders were (i) person offenders (e.g., murder, assault, robbery), (ii) property offenders (e.g., arson, burglary, forgery, fraud, theft, etc.) and (iii) with a much smaller group known as offenders against public (e.g., parole violation). History of previous psychiatric hospitalization was obtained from the records and patients' self-reports. Medical problems, such as hypertension, diabetes, obesity, gynecological illness, surgical operations and other causes of physical ill-health during the one year prior to the index crime were noted.

Findings

i) **Demographic Data** (Table 1)

Of the total of 66 subjects referred during the study period, 49 (74.2%) were white and 17 (25.8%) were black. They ranged in ages from 17 to 54 years, with a mean age of 31.1 years. One subject, 14 years of age, was adjudicated as an adult. Of the total sample 7 (10.6%) were below 19 years of age, 32 (48.5%) were between 20-29 years, 9 (13.6%) were between 30-39 years, 13 (19.7%) were between 40-49 years and five (7.6%) were between 50-59 years, suggesting a possible second increase in pretrial commitment during the menopausal years. In an effort to determine whether this second increase in commitments is a unique phenomenon specific for women, the authors compiled commitment statistics for men during the corresponding period. We found that of a total commitment of 1,519 men for PTPE in the same hospital, 285 (18.76%) were below 19 years of age; 762 (50.16%) were 20-29 years of age; 275 (18.10%) were 30-39 years of age; 105 (6.9%) were 40-49 years of age; 58 (3.8%) were 50-59 years of age; 25 (1.64%) were 60-69 years of age and 9 (0.6%) above 70 years of age, suggesting a steady decrease in admissions after the age of 30 in men. A comparison of age incidence of male and female commitments is shown in Figure 1. It is of interest to note that one out of four women committed was above the age of 40 compared to one out of every eight men, suggesting that older female offenders formed a significant proportion of female referrals. As the figure indicates, there is a second peak in commitment around the age of 47, followed by a rapid decline among women when compared to a more gradual decline in the age incidence of male commitments in the same hospital. A chi-square analysis of age incidence of commitment between men and women was highly significant $[x^2 = 16.54 \text{ df } 4, P < .005]$.

Table 1: Demographic Data

Item	Frequency	Percentage
i. **Race**		
White	49	74.2
Black	17	25.8
ii. **Marital Status**		
Never married	21	31.8
Married	14	21.2
Separated/Divorced	27	40.9
Widowed	4	6.0
iii. **Education**		
Completed 12th Grade	26	39.3
Completed 8th Grade	18	27.3
Below 8th Grade	22	33.3
iv. **Work History**		
No consistent work history	54	81.8

Table 2: Relationship of Psychiatric Diagnosis with Index Crimes

Diagnosis	Murder	Assault	Forgery	Arson	Theft	Burglary	Others
Schizophrenia	7	5	1	—	2	—	—
Affective Disorder	—	—	3	2	—	—	1
Personality Disorder	7	3	3	—	3	2	1
Alcoholism	2	2	1	—	—	—	—
Neurosis	—	1	1	—	—	—	—
Mental Retardation	1	—	3	—	1	1	2
OBS with Psychosis	2	—	—	2	1	—	—
No Mental Disorder	3	1	—	—	1	1	—
TOTAL:	**22**	**12**	**12**	**4**	**8**	**4**	**4**

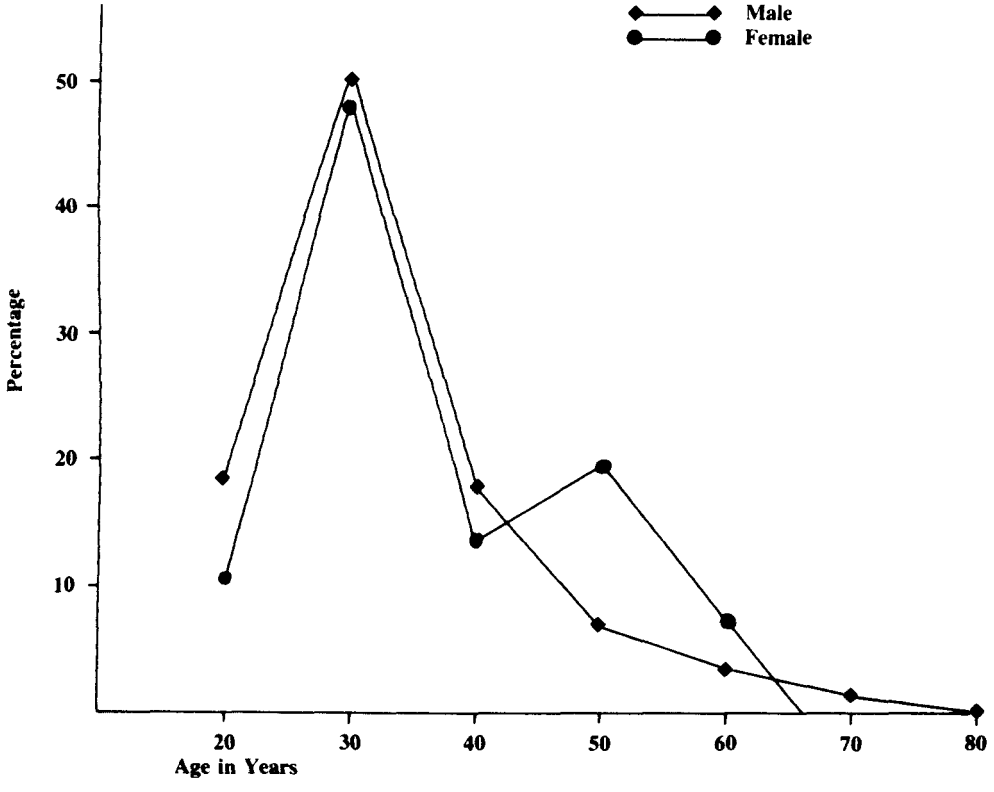

FIGURE 1: Comparison of Male and Female Commitments Between 1974-79.

A high incidence of single marital status (31.8%) and marital dissolution and disorganization (40.9%) was noted at the time of the offense. Six out of 14 married women had become eventually widowed by killing their husbands; 61% had not completed high school and over 80% did not have a consistent work record.

ii) Previous Criminal History

Thirty-three (50%) had committed offenses in the past. The mean number of charges, excluding present offense, filed in the past against those who had a prior criminal history, was 1.72. Among the recidivists, 20 (60.6%) repeated the same type of offense as the index crime, namely, fraudulent check writing, child abuse and assault.

iii) Present Crimes

Thirty-four (51%) were involved in crimes against persons. Out of the 34, 22 (64.7%) committed homicide. Among the victims of murder, 10 (41.7%) were children, followed by husbands, eight (33.3%), acquaintances, four (16.6%), father, one (4.2%), and stranger, one (4.2%). Incidentally, two subjects killed their twin children. As noted, members of the subjects' family constituted the largest target group. By far, the most common mode of killing was shooting when an adult was the victim. Children were murdered by a variety of methods such as physical assault, drowning and suffocation.

Among those who committed property offenses (28), the largest group was comprised of fraudulent check writers (12) followed by theft (eight) and arson (four). Four women were charged with parole violations. Analysis of data of present offenses shows that almost all subjects were charged with felony counts.

iv) Associated Medical Conditions

A survey of medical problems present within one year of committing the index crime showed that 25 (37.8%) had associated medical conditions. They included chronic ill-health (eight), hysterectomy (five), hypertension (four), obesity (four), venereal disease (three), cancer (two), physical deformity (one), multiple sclerosis (one) and neurofibromatosis (one). Three subjects who had had hysterectomy and one with obesity had associated hypertension. Chronic ill-health was generally due to presence of multiple physical illness such as chronic respiratory infection, dermatitis, vaginitis, etc.

v) Psychiatric Diagnosis

Forty-five (68%) had a history of previous psychiatric hospitalization. The total number of previous hospitalizations was 148 with a mean of 3.3; 60 women (91%) had at least one recognizable psychiatric condition present at the time of the current evaluation. The most frequent diagnosis was personality disorder, 19 (28.7%). Out of 19, 15 were diagnosed as having antisocial personality disorder. This was closely followed by schizophrenia, 15 (22.7%). There were six subjects with affective disorder, six with mental

retardation, five each with alcoholism and OBS with psychosis and two with neurosis. Amongst the women who had a primary diagnosis of personality disorder, six had alcoholism and another five had drug dependence as secondary diagnosis. Six subjects did not have any psychiatric diagnosis; 39.3% were diagnosed as psychotic and 60.7% as non-psychotic. Psychotics included 15 patients with schizophrenia, five with OBS with psychosis and six with affective disorder.

Using a complex chi-square analysis, the diagnostic groups were found to be significantly different, as to the type of offense $x^2 = 13.748$, df 6, $P < 0.05$. An examination of Table 2 shows that patients with schizophrenia commit person offenses four times that of property offenses, while such a difference is not evident with women diagnosed as having personality disorders. Four women with the diagnosis of alcoholism were charged with person offenses when compared to only one with property offense. Notably, only one woman with a diagnosis of mental retardation was charged with person offenses while seven were charged with various property offenses. It is of interest to note that all those women who were charged with murder of their children were severely impaired because of psychosis (87.5%), or mental retardation (12.5%). Five of them were actively harboring paranoid delusions involving the child.

vi) Outcome of the Evaluation

Three distinct subcategories emerged from the evaluation. The first group was comprised of 41 (62.1%) who were considered as competent to stand trial and criminally responsible. The second group comprised of 10 (15.1%) who were considered as competent to stand trial, but not criminally responsible. The third group comprised of 15 (22.2%) women who were considered as not competent as well as not criminally responsible. The second subgroup was mainly constituted of women with psychiatric condition of episodic or short lived nature such as affective disorder, paranoid schizophrenia in remission and OBS with psychosis (drug induced) so that, at the time of the evaluation, they were considered as competent to stand trial, but not criminally responsible for the alleged offenses. The third subcategory was formed of psychiatrically seriously-ill individuals with high frequency of hospitalization and less prior criminal history and generally these women were qualified to an insanity plea as defense. Out of the 25 women who were not criminally responsible, as per our own evaluation, 88% were found not guilty by reason of insanity (NGRI) and were committed to a psychiatric hospital.

Discussion

Although it is generally assumed that criminal propensity declines over advancing years, female criminality may show significant increase during the menopausal period. Although replication is needed, especially since the sample was selective and small, the finding that there was a second peak in the age incidence of female offenses during midlife, unlike men, is compati-

ble with that of d'Orban.[5] Menopause, marking the end of reproductive life, is a dominant factor in the midlife phase of women.[6] While the biological and hormonal changes may be the basis of this developmental phase, much of the personality and behavior changes may be determined by the psychological and social role changes produced by midlife stress and strain. While for some it may pave the way to a fuller and healthier life, for others it may lead to loneliness, depression and various adjustment problems which may include antisocial behavior.

Previous studies[7–8] have consistently shown that, in the background of female criminals, there is considerable marital disorganization, low socioeconomic status, poor work history and marked educational underachievement. Our sample is in no way different from this general pattern and might have been heavily influenced by the fact of being selected for PTPE in a state hospital. Indeed, a substantial number of these individuals were isolated, resourceless and frequently represented by court-appointed counsel.

In this study, almost all women were charged with felony counts. This is in contrast to the findings of Geller and Lister,[9] who reported that the pretrial commitments (both sexes included) to a State hospital were mostly for misdemeanors (69% in their study) and have seriously questioned the contention that pretrial commitments would serve sequester hardcore criminals. Our finding of high referral involving person offenses, such as murder and assault and other serious property offenses, suggests that women are actively involved in criminality, as opposed to the general view that they commit only concealed crimes. That the victims of female crimes of violence are usually members of her immediate family circle shows that the degree of stress present in the relationship and the proximity of potential victims in the environment are important determining factors. Furthermore, it is of interest to point out that another frequent offense committed by women is fraudulent checkwriting, which indicates the easy availability of the vehicle of wrongdoing.

It appears that medical conditions play an important role in female criminality, as previously noted by Gibbons.[10] In our study, 38% had significant medical conditions, including hypertension, obesity, chronic ill-health.

High frequency of psychiatric abnormality among female criminals had been reported in the literature. Cloninger and Guze[4] in their study of 66 convicted female felons showed that three major diagnostic categories accounted for 62%, and there was only one case of psychosis. This is not inconceivable, as individuals with psychosis usually use insanity defense and may be committed to a psychiatric facility for treatment rather than being convicted; however, prevalence of psychosis and personality disorders among women referred for PTPE has not been studied exclusively, although findings of some studies involving both sexes show that prevalence for psychosis varies from 32%[11] to 47.2%[12] and for personality disorders

from 39.4%[11] to 50%[12]. In our study of women, psychosis and personality disorders were found to be 39.3% and 28.7% respectively.

Our study suggests no outstanding relationship between psychiatric diagnosis and individual crimes; however, women with schizophrenia and alcoholism commit more person offenses when compared to mentally-retarded women who commit more property offenses. Personality disorders were evenly distributed among person and property offenders.

Some comments have to be made about the possible reasons why these women have been referred for PTPE originally, although we have not specifically looked at them. It appears from our study that a history of previous psychiatric hospitalization,[11] high frequency of serious and violent crimes[13] and legitimate concern over mental status may have played important roles. This, of course, does not preclude other legal strategies such as preventative detention,[14] controlling social deviance or delaying accused individuals' day in court. Our findings suggest that there are two categories of referrals: one in whom criminal behavior is directly associated with mental disorder (group two and three) and another representing a larger criminal population that contains a certain number of mentally ill individuals.

Conclusion

The age incidence of female criminality may be affected by midlife changes influencing any assumed inverse relationship between advancing years and criminal propensity. Over 90% of women referred for pretrial psychiatric evaluation have at least one recognizable psychiatric condition and a good number of them have associated medical conditions. These factors directly or indirectly influence criminal behavior. It is known that the targets of female violent crimes are immediate family members, and, furthermore, most of the referrals formed of women who were actively involved in criminal activity. No outstanding relationship between specific psychiatric diagnosis and individual offense was observed. Nevertheless, patients with schizophrenia and alcoholism were more often charged with person offenses as opposed to mentally retarded women who were charged with more property offenses. Finally, previous psychiatric hospitalization history, nature of offense and legitimate concern over mental status were some of the factors affecting the referral.

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