

## **Dyadic death – depression and borderline personality**

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### **Summary**

**Aim.** This work aims to present the difficulties in the assessment of sanity of a perpetrator involved in the so-called dyadic death, which in Poland is identified with the occurrence of severe mood disturbances at the time of the crime.

**Methods.** A case of a man who killed his wife and two children is presented. The perpetrator himself tried to commit suicide by cutting his veins with a razor.

**Commentary.** The authors underline diagnostic difficulties which were encountered in the analysed case, they point out the necessity to go beyond the phenomenological aspect of “dyadic death” and the need for multidimensional clinical evaluation of the perpetrator. The rarity of similar acts and low survival rate of perpetrators leaves experts with relatively small amount of opinion giving experience. Thus, there is a need for high accuracy research and careful consideration.

**Key words:** depression, dyadic death, borderline personality

### **Introduction**

From time to time we hear about homicides of family members committed by a close relative, who subsequently dies in a suicidal attack. In English literature, such a situation is known under the term of “dyadic death”, which concentrates on the crime only to present the motives, both pathologic and non-pathologic, at a second level [1, 2]. In Poland, similar tragedies are known as “expanded suicides” (samobójstwo rozszerzone) According to Pużyński [3], they result from deep psychotic depressions, and they are seldom motivated by depressive balance. Rybakowski and Jarosz claim, in turn, that dyadic death may also result from reactive depressive psychosis [4]. It

has been accepted that the motives for „dyadic death” are related to a pathological drive to save the closest family members from disaster, pain or stalemate situation, in which – in the perpetrator’s opinion – they could find themselves.

In forensic psychiatry [5, 6], the diagnosis of psychotic depressive disorders results in mental incapacity of the perpetrator for the alleged act, whereas the motivation resulting from other, “lesser” mental disorders may only limit the sanity. The correct diagnosis of clinical state during the act is, therefore, a key element of expert opinion. Obviously, the presentation of the crime must be considered, but it should not prejudice the forensic and psychiatric evaluations. The judicial aspect becomes much more complicated if we deal with an act associated with “dyadic death” and the perpetrator is suspected to suffer from mental disorders [7]. This work is limited to the presentation of difficulties in diagnosing and judging a person having a recognised borderline personality and recurrent depressive disorder.

Over the last eighty years, efforts have been made to define the group of persons with borderline disorders. Initially, the disorder was perceived as atypical variant of other diagnoses. It was officially introduced to DSM-III in 1980. A DSM-IV-TR based diagnosis relied on detecting the presence of at least five traits of impaired personality from nine listed in the classification. It also had to meet general criteria for such disorders [8]. Since 2013 (DSM-5), the diagnosis of borderline disorders is based on two criteria: A – significant impairments in personality functioning, and B – traits covered by a five-factor model and pathological personality traits characteristic for a specific personality disorder [9]. In ICD-10, borderline disorders were positioned next to an impulsive type of personality (the group of emotionally unstable personalities). A separate coding of co-existing psychiatric disorders has been recommended [10].

Some of the borderline personality traits include affective disorders, impulsive and auto-destructive behaviours, apparently good social adaptation, superficial, dependency relations with the environment, and manipulative attitude. The line of thinking of the affected persons seems strange, delusional and illogical [11]. They show significant anger, emotional instability, real or imagined sense of abandonment [12], together with reduced ability to identify emotional state of other people [13]. Their life is characterised by disorganisation and chaos, forgetfulness and extreme attitudes. Their ability to excessively focus on negative aspects of life, exaggerate problems and downgrade self is also noted [14].

Personality disorders are often accompanied by a variety of mental disorders – depression, anxiety, psychosis, addictions [15]. It is similar in the case of borderline personality, which often coexists with affective disorders, both depressive (major depression, dysthymic disorder) [16–18], depressive-neurotic [19], and depressive-manic [12]. If the same person meets diagnostic criteria for borderline disorder and mood disorder, both should be diagnosed [9].

Dynamic presentation of borderline personality disorders, atypical course of depression, overlapping symptoms of both disorders and certain common symptoms make the differential diagnosis very difficult [9, 20].

Unfortunately, the forensic and psychiatric case law needs to differentiate which of the pathologies of mental wellbeing played the dominant role in building the mo-

tivational context for the crime, and which formed an additional element only. According to Gunderson, borderline disorders have clearly a negative impact on the course of substance abuse, major depression, bipolar disorders and panic disorder, which in turn do not affect, or only in a limited scope, the course of borderline disorders [20]. There are differences in the duration of mood changes resulting either from personality disorders or from depressive disorders. The mood changes of borderline persons are usually limited to several hours or days, whereas in affective disorders, the minimum time amounts to two weeks (in case of depression). Persons suffering from depression often complain of sadness, gloom, anhedonia; whereas the feeling of emptiness is more typical for borderline personality [21]. Depressive episodes experienced by borderline persons are characterised by a longer duration, slow remissions and chronic persistence of symptoms [22]. Differentiation between major depression and borderline personality is also based on identification of symptoms accompanying endogenic changes of mood (insomnia, premature waking up, loss of appetite and body weight, decreased sexual drive, impotence, irregular menstruation, daily fluctuations in activity). Borderline persons are also prone to dysthymic reactions, where the symptoms of depression occur with a lesser intensity than in major depression, but they are chronic and lack a distinctly identifiable remission period [7]. The analysis of selected environmental conditions (insufficient care during childhood, abandonment by parents, parental psychiatric disorders, and sexual abuse in childhood) does not provide substantial indicators for differential diagnosis because they are related to emotional impulsiveness, auto-destructive behaviour or suicidal attempts in adulthood, recognized both in borderline personality and depression [23].

Among the persons with borderline personality, 8% to 10% tries to commit suicide, including 60–70% undertaking unsuccessful suicide attempts [13, 24]. These attempts are intended to sooth the inner pain, sense of emptiness, tension, anger, shame or guilt [7]. The constellation of such feelings also pushes toward impulsive aggressive behaviours, both verbal and physical [25]. Affective instability results from hyper-reactivity to events in the environment, whereas weak mechanisms controlling excessive impulses contribute to decompensation of behaviour and acts of aggression [26]. Aggression in the past and the feeling of hopelessness are perceived as factors predicting increased risk for suicide attempts [27]. Persons with this type of personality are often aware of irrationality of their behaviour (exaggeration of problems), but the emotions experienced by them are often too strong to be fully controlled [14]. Even a slightly depressed mood – dysthymia, particularly in persons prone to anger and aggression, increases the risk of suicide attempt [28]. On the other hand, the occurrence of actual aggravating factors and the resulting suicidal tendencies may herald a developing affective, depression-type, disorder and not a spontaneous reaction to the current difficulties [24]. Soloff et al. point out that the co-existence of borderline disorders and occurrences of depressiogenic events increases the frequency and intensity of suicidal attempts. Both, temporary states of depression and suicide are usually reactive in nature (forming response to factual or imagined stress factor), whereas the motivation for suicide attempt occurs spontaneously. It is different for persons with co-existing borderline personality and major depression. In such case,

suicide attempt develops over time and it is more serious (it lasts for weeks). These persons plan to take their life and make detailed preparations [29]. Some predictors of suicide attempts (ended in death) include environmental conditions (unemployment, low salary, financial problems, low education level), maturity (ca. 40 years), previous suicide attempts and long history of psychiatric treatment [30].

### Case report

A man aged 35 years, raised by parents abusing alcohol. As a teenager, he engaged in street fighting and performed acts of self-harm. He participated in job training. At 19, he married a 1-year older woman with whom he had two children (9 and 14 years old). He had no criminal record. He did not abuse alcohol or drugs. After several employment attempts, he founded his own renovation company, which was successful.

#### Psychiatric treatment before the act

At 23, he started treatment at a psychiatric clinic, which he visited due to “personality difficulties and mood disorders.” Initially, he was diagnosed with depressive syndrome and compulsive-obsessive personality disorders, then with recurrent depressive disorders. After 2 years, his wellbeing deteriorated with anxiety, suicidal thoughts, premature waking up, and psychomotor slowness. During a 3-month stay in the psychiatric clinic, he was diagnosed with borderline personality disorder. For the next 3 years, he continued to be treated at the clinic, and for the following 5 years, he was not treated psychiatrically. Then, he returned to therapy (in another psychiatric clinic) because – as he said – for several years, he had noted lack of energy and drive to work, he also experienced suicidal thoughts. At the second clinic, he was diagnosed with depressive disorders. After several months, he started experiencing sudden depressed mood or mood swings. His diagnosis was changed to borderline personality. The next month, he was admitted to a psychiatric hospital where he was diagnosed with recurrent depressive disorders and abnormal personality development. He presented depressed mood, psychomotor slowness and “loose” suicidal thoughts. At that time, he did not present daily fluctuations of mood, anxiety or psychotic symptoms. A month after being discharged, he returned to psychiatric clinic where he continued to complain of lack of energy, motivation and depressed mood. During the following months, he was described with improved mental wellbeing accompanied by temporary feelings of discouragement, decreased activity and sadness (the last visit took place a month before the act).

#### The act

The man was accused of acting with the intention to kill by striking the heads of his wife, daughter and son with an axe, causing damage to internal organs and ultimately the death of all three victims (Article 148 § 1 of the Polish Criminal Code). Next, he made deep incisions to his elbow pits. The surgeon admitting him to

hospital testified that the perpetrator was in the state of life-threatening haemorrhagic shock. The man confessed to committing the alleged crime. He said that for several weeks he was thinking about suicide, he searched for information about suicide in the Internet, he bought an axe for this purpose and planned the course of the critical day. He admitted that since being 8, he had had suicidal thoughts, which significantly intensified recently and he was not able to cope with them. He justified his decision by stating that following his previous suicide attempt his wife had become very upset and he was not able to bear her pain. Therefore, he decided to kill all his family as he did not want to leave them in despair following his death. According to witnesses, the relations between the accused, his wife and children were good. They stated that the family was well off and the accused looked after his family. Nobody has ever witnessed the man to be aggressive toward his family members. All of them confirmed that he had been treated psychiatrically and that in the period before the act, he had complained of deteriorating mental wellbeing.

#### Psychiatric evaluation following the act

On the day of the killings, the accused was admitted to a psychiatric hospital. His mood was assessed as “empty”, psychomotor drive as lowered. He spoke logically but the content was depressive, with low self-esteem. He was diagnosed with recurrent depressive disorders – an episode of major depression and a state following “dyadic” suicide attempt. Two days later, he underwent a forensic and psychiatric evaluation and he was diagnosed with depressive episode in the course of recurrent depressive disorders (he was not able to participate in the proceedings).

The second opinion included a request to observe the accused in a hospital setting due to the need for in-depth diagnostics. The man underwent observation three months after the critical events. His mental state was characterised by moderately presented symptoms: feeling of hopelessness, low self-esteem, guilt, decreased activity, depressed mood in the morning, premature waking up, feeling of irritation and tension. Psychological evaluation revealed significantly intensified traits of emotionally unstable personality – borderline personality: emotional instability, strong reactivity of mood, anxiety, irritability, dysphoria, unstable interpersonal relations, disturbed identity, recurring suicidal behaviours, sensitivity, perception of the world as enemy, low self-esteem. A team of experts diagnosed the accused with a psychiatric disorder, recognising a borderline personality, which in turn significantly limited his accountability for the act. During court proceedings, the experts again excluded depression as a motivation behind behaviour of the accused.

The court was not convinced and it appointed another group of experts who, eighteen months after the events, conducted an out-patient forensic and psychiatric evaluation. They concluded that after a single evaluation it was not possible for them to definitely decide on the mental state of the accused, and they drew attention to the fact of co-existence of borderline personality disorders and recurrent depressive

disorders, as well as inconsistencies in documentation (descriptions of mental state which did not always match the diagnosis, changes in diagnoses made by the same doctors, similar behaviour interpreted differently in different clinics).

In the fifth opinion, following another observation, the experts concluded that due to a severe depressive episode with no psychotic symptoms in the course of recurrent depressive disorders, the accused had, at the critical time, no capacity to recognize the nature of the alleged act and handle his behaviour. They requested to apply a detention order.

The last evaluation was conducted in an out-patient setting at the Department of Forensic Psychiatry of the Institute of Psychiatry and Neurology in Warsaw in 2013. During the evaluation, the accused maintained good, factual contact. He provided extensive answers with a tendency for depressive deliberations accompanied by withdrawal attitude. His mood was mildly depressed. His mimics, body language, and voice pitch were not very distinct, but appropriate for the content. He complained of attention impairment and disturbed social contact. He confirmed slightly improved mood in the evenings. In the course of evaluation at the Department, the observed man stated that due to tragic events he felt guilty, he was filled with remorse and gloom. He broadly characterised the period surrounding the act stating that “it was my best time of life, I had savings, my children graduated from school with honours, we renovated our apartment, my wife got a pay raise”, but “experiencing pain myself, I did not want them to suffer similar pain.” About his state of health, he said: “I felt a strong anxiety in my chest, the desire for death dominated my mind and there was no place for reasonable thoughts. Thus, the death – I thought to die with them.” In the past, numerous suicide attempts took place, as early as at school – they were ad hoc, depending on the situation. The last such attempt took place when he was 19, during his engagement, provoked by his mother’s behaviour. Subsequent suicidal thoughts and attempts were related to depressed mood, states of gloom and intensified feeling of low self-esteem, general weakness, insufficiency, strong “painfulness” and anxiety within his chest. In those periods he became indifferent to positive events around him, avoided social contacts, experienced anxiety and precordial fear of various intensity, hopelessness. He located the feeling of intense suffering in the chest area. He had difficulties with making decisions, meeting every day, repetitive duties. Experts from the Clinic sustained the diagnosis of borderline personality disorder, and in the period of the act, they recognized psychiatric illness – the episode of deep depression – and concluded that he had no ability to recognize the importance of his action and control his behaviour.

The experts determined the social and criminological prognosis as definitely unfavourable. The man still showed the symptoms of depression of various intensity, accompanied by suicidal thoughts, together with deep personality dysfunctions – the experts concluded that there were psychiatric and mental premises to apply Article 94 § 1 of the Polish Criminal Code.

### Psychological composition and diagnosis of motivational context

According to the conducted psychological tests, the observed man was of average intelligence with a prevalence of very serious disorders concerning basic regulatory and integrative functions of personality.

They related to emotional, cognitive and executory sphere. The prevalence of introverted personality traits, high level of anxiety, low stress resistance and distorted image of self did not foster practical use of his cognitive abilities, particularly when he found himself in a situation of deteriorated mental wellbeing (chronic psychological stress, crisis, conflict). He perceived the world and social environment as threatening. He blamed other people and the illness for his life difficulties and failures. He was not resourceful enough in solving life problems having internally contradictory value system. He was not able to draw constructive, practical conclusions from his life experiences and was characterised by certain disability in the sphere of the so called social intelligence.

Emotional disorders manifested themselves with immaturity, tendency to cumulate emotional tension, feeling of injustice and guilt, loneliness and emptiness, significantly low self-esteem. He showed an above average tendency to experience states of anxiety and fear, self-control disturbances and distorted interpretation of environment. The observed man perceived himself as an unattractive person, less valuable, rejected and unaccepted by others. He was characterised by significant frustration, the need to stress his self-value and acceptance. The states of emotional tension were cumulated or relieved through auto-aggression. In difficult situations, he was prone to blur the borders between his feelings and the real world.

Disturbances in mental functioning of the accused formed personality background for motivational processes leading to the alleged acts. An integral role in the genesis of the described abnormalities played the mental disorders in the form of depression, revealed during evaluations and occurring during the alleged acts. Deterioration of mental state lasted for some time before the act itself, it hindered his ability to perform various tasks, particularly those relating to duties in a religious group to which he and his family belonged. The observed man informed selected persons of his anxieties, including his wife, but in the face of deteriorating wellbeing and the occurrence of dangerous thoughts, he did not go to psychiatric hospital where he had been treated several times before. Depressive disorders fostered generation of emotional tension, fear and anxiety, impulsiveness, tendency to regulate mental activities at the level of instincts and emotions, decreased self-control. Deterioration of health was responsible for using such defence mechanisms as denial, suppression and displacement. It also weakened his criticism and intensified the rigidity of responses, thus fostering inadequate and untrue interpretation of environment and intentions of others.

The observed man has not been previously prone to solve his problems and satisfy his needs through an open and direct attack on others. In contrast, he was distinctly susceptible to auto-aggressive thoughts and behaviours. In his case, there has been noted a contradiction between the nature of alleged acts and the more stable mechanisms of functioning of his personality. The evaluations revealed that extremely

aggressive nature of alleged acts had their basic source in intrapsychic processes, i.e. experienced inner conflicts and tensions multiplied by deteriorated mental wellbeing in the form of depression. Due to the disturbances in mental activity described above, the observed man acted, during the critical period, in a state of disturbed self-control which prevented both recognition of the importance of the alleged acts and control of his behavior.

### Discussion

The analysed case is an example of diagnostic and judiciary difficulties in a situation when in addition to recurrent depressive disorders there are also deep personality disorders present, with some symptoms of both disorders overlapping. Borderline personality disorders manifested themselves in the accused with many traits described in the literature. Particularly interesting was his seemingly good social adaptation in the presence of distinct emotional disturbances and auto-aggressive behaviours [12, 13]. A key role in the genesis of incriminatory behaviours played, in contrast, deep depressive disorders. As long as several years ago, borderline personality gave rise to terminological and diagnostic controversies [31]. Over time, the diagnosis started to play a more practical role. According to Gunderson this type of personality is much more disharmonious and the most frequent [32]. At the same time, it became necessary to recognize, in addition to personality disorders, other parallel mental abnormalities, particularly in affective presentation [12, 18]. In the described case, a multidimensional analysis of long-term course of mental disorders became necessary, taking into account their reciprocally modifying symptoms and mental experiences, which in their presentation went beyond a single diagnosis. They formed certain mix of personality and depressive symptoms. During the period of depression, the borderline persons can present a more intensive inconsistent and dynamic disease situation. It happens that these persons present dominating hostility, hate and sometimes paranoid attitude, intensifying anxiety and a profound feeling of deep loneliness. Weak defence mechanisms are unable to control aggressive tendencies [15].

A highly detailed and careful analysis of affective disorders is necessary. Judicial problems in the case of recurrent depression result from diagnostic difficulties: disorders occurring in phases, the possibility of committing a crime during any phase of the illness (deep depression, sub-depression or remission) as well as variability of presentation during subsequent exacerbations, which in case of co-occurrences of borderline personality disorders makes the forensic and psychiatric evaluation more difficult. With the co-occurrence of these dysfunctions, it is not always possible to categorically differentiate individual phases of mood disorders [22]. Differential diagnosis between borderline personality disorder and the so-called major depression requires a long-term clinical observation and causes more difficulties than differentiation between personality disorders and bipolar affective disorders [7]. Analysis of the discussed case allow us to note that the position of experts is often incomprehensible or insufficiently justified for the court, hence it happens that in one case the court appoints several teams of experts to give subsequent opinions.

The discussed case was additionally complicated by the presentation of the so-called dyadic death, which however – as evidenced by all opinions – formed only a background judicial element. In their analyses, all experts (regardless of their evaluations) were not driven by phenomenological picture of the crime but focused on assessing the state of mental health of the accused during the critical events. Chronic suicidal ruminations, deliberations over the ways of taking own life and meticulous preparation for the killing of self and family members confirmed the depressive motivation rather than personality one [29]. It should also be remembered that the “design” and execution of the crime is not an element determining the non-pathological intentions of the perpetrator. In forensic psychiatry and psychology an important role is played by an accurate analysis of mental dispositions leading to the crime, which gains support in the research material. The issue not to be underestimated in experts’ opinions should be the timing between the critical events and the evaluation for judicial purposes. It causes substantive difficulties, particularly in case of mental disorders recurring in phases. In the discussed case, the time between the alleged crime and the evaluations lasted from several months to over two years. In addition, the course of reciprocally modifying disorders turned out to be atypical. It made the retrospective evaluation of mental state more difficult. The analysis thus required a more extensive use of data contained in the case files, psychiatric and psychological opinions, as well as in other documents.

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