

Utility of homicide-suicide constructs in forensic psychiatry

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Summary

In foreign literature, the term ‘dyadic death’ is used to describe a situation of a murder followed by the perpetrator’s suicide. It differs from the term ‘extended suicide’ used in Poland. While it is recognized that the occurrence of ‘dyadic death’ can be caused, apart from mental disorders, by unfavourable environmental factors, ‘extended suicide’ is equated with the occurrence of severe depressive disorders in the perpetrator. The above-mentioned constructs describing a homicide-suicide were analyzed from the psychiatric and criminological point of view. The study shall discuss a case of a young woman who drowned her young son in a public place, and then declared her suicide intentions. An analysis of the course of mental disorders in the perpetrator, her biological burdens, situational and family conditions was carried out, and the personality factors that led to her mental decompensation were taken into account. Pathological motivational background of the perpetrator of her son’s murder was clearly modified by her personality dysfunctions exacerbated by life difficulties. It differed from the motivation of a ‘typical’ perpetrator of ‘dyadic death’ or ‘extended suicide’ presented in the literature. Settlements in cases involving murder and subsequent suicide attempts require a thorough forensic-psychiatric and criminological analysis. In some cases, the terms describing such situations do not refer to the clinical condition of the offender but to the nature and image of the crime. Abuse of these terms may contribute to judicial errors.

Keywords: ‘dyadic death’, ‘extended suicide’, psychiatric expertise

Introduction

It is natural for man to strive to sustain life and preserve its species [1]. In opposition to this, there are tragedies in which family members die at the same time, caused by the action of a relative who subsequently commits suicide. Such acts of self-destruction have been known since ancient times [2]. Although the widely-publicised murder-suicides evoke social emotions and vivid discussions, there are relatively few scientific studies on this topic.

Among the sections of criminology, Hołyst [3] lists criminal symptomatology (phenomenology), dealing with, inter alia, the way of committing a crime and criminal aetiology, which focuses on the causative factors of crime (including individual predispositions determining criminal behaviour). Following this lead, forensic-psychiatric and psychological expertise in homicide-suicide situations seems closer to criminal aetiology, but it should also draw information from phenomenology.

Therefore, a question arises whether the homicide and the subsequent suicide of the killer should be treated as a clinical fact or rather as a criminological construct. Maybe both aspects interpenetrate and complement each other?

“Dyadic death”

In Anglo-Saxon literature, such situations are referred to as “dyadic death” (also equated with “postaggression suicide”). A typical murder-suicide killer is a middle-aged man who kills his spouse or life partner using a brutal method (e.g. a shot in the head) and is under the influence of alcohol during the act. More than half of the perpetrators are working people and have a criminal record [4, 5]. These perpetrators are characterized by a strong conviction that the decision to murder a loved one was right. Suicide is not the key goal of the perpetrator; it is supposed to be only a consequence of a murder that had been committed earlier – it is somewhat secondary to the murder [6]. The probability of committing suicide increases with the age and level of education of the perpetrator [7].

Motivation of criminal activities in “dyadic death” may be related to the underlying psychopathological disorders in the perpetrator (in extreme cases they are psychotic disorders) [6, 8, 9]. A critical event is then preceded by treatment discontinuation, lack of diagnosis or ignorance of disease symptoms by the environment and the perpetrator. The representation of psychotic disorders in the aetiology of this type of homicide-suicide is estimated in a broad range (20-75%) [8-10].

Among the non-psychotic causes of “dyadic death” are erotic jealousy, a feeling of pity towards a loved one, as well as stress factors related to family life, financial and social difficulties [5, 6, 8, 9, 11, 12]. Attempts are also made to explain the act of murder-suicide resulting from frustrations of intimate interpersonal relations [13-15]. The self-accusations of perpetrators, which are the effect of their personality traits or manifestations of personality disorders, are also significant in this context [14, 16, 17].

A homicide-suicide may also be preceded by a situation in which the motivation will be some combination of those triggers listed above. Deep emotional disturbances may result from a breakdown of family values, severe physical illness or material problems [18-20].

Thus, pathological factors may contribute to the occurrence of “dyadic death”; however, non-pathological elements predominate. In the literature, the most typical features of “dyadic death” (postaggression suicide) are the following: suicide as a consequence of a prior homicide, often perpetrated due to non-pathological triggers, related to the perpetrator’s personality disorders (antisocial, narcissistic personalities),

and the homicide is often preceded by acts of violence by the perpetrator against the victim. The bond between the perpetrator and the victim has a negative or ambivalent tinge. The murder is violent and brutal [13, 20, 21].

“Extended suicide”

In Poland, we usually come across the term “extended suicide”, most often identified with the perpetrator’s severe mental disorders that led to the murder and, in consequence, to the suicide. According to Pużyński [22], it occurs in severe psychotic depression; less often its motive is depressive balance. It has been indicated that the perpetrator’s pathological experiences are implicated in the drive to protect loved ones from imaginary misfortune, suffering and a situation with no way out. The perpetrators kill family members convinced that their loved ones will be subjected to lack of care or livelihood, or exposed to danger [23]. Apart from deep depressive symptoms, altruistic behaviour (in a pathological sense) can also result from other disease states, such as reactive disorders with depressive delusions and schizoaffective disorders [24].

Psychiatrists and psychologists looking for the causes of “extended suicide” primarily focus on the possible pathology of the perpetrator’s mental health. They treat other possible factors as secondary: severe somatic diseases, breakdown of family ties or financial problems of perpetrators or their families [25-27].

Bolechala et al. [23] emphasize that among the most characteristic criminological features of “extended suicide” (also multiple killings by insane perpetrators) are the following: the murder is not the result of a quarrel or a row; the perpetrator is not under the influence of alcohol; killing members of the immediate family, especially children; there are elements of action planning; the attack takes place while the victim is asleep – it is surprising, sudden, direct, but rarely carried out facing the victim; the injuries are concentrated in one region of the body; the perpetrator aims to quickly kill the victim. However, according to Stukan and Staszak [21], “extended suicide” is characterized by the fact that suicide intentions take precedence over the murder. It is dominated by delusional-suicidal motivation resulting from the presence of psychotic disorders in the perpetrator. In principle, there are no previous conflicts with the victim (especially the child), and no prior violence against the victim is found either. The emotional bond that connects the victim with the perpetrator has a positive tinge and this is probably why the murder is carried out in such a way as to minimize the suffering of the victim [13, 21].

When it comes to the motivational background of the perpetrators of “dyadic death” (postaggression suicide) and “extended suicide”, we encounter significant differences. In the case of the former, non-pathological factors are mentioned as dominant (most often personality and environmental factors), while in the latter, severe psychotic disorders predominate (although other disorders are not excluded). In both constructs, the perpetrators are more often men who take the life of their wife or partner [6, 8]. Women usually kill their children [12, 28, 29]. Both types of homicide-suicides are committed primarily within the family system [8-10]. A comparison of differences between “dyadic death” and “extended suicide” is included in Table 1.

Table 1. Fundamental differences between “dyadic death” and “extended suicide”

Criteria	“Dyadic death”	„Extended suicide”
Perpetrator’s mental disorders at the time of action	personality disorders, addictions, psychotic disorders	severe psychotic depression, psychotic reactions, schizoaffective disorder
Other causative factors	can be of significant importance (jealousy, intimate relationship frustrations, pity, revenge; financial, family, social difficulties)	usually of low significance (severe somatic diseases, family breakdown, financial problems)
Conflicts with the victim (including aggression preceding the murder)	usually present	usually absent
The emotional relationship between perpetrator and victim	ambivalent / negative	positive
Planning of action	usually impulsive/reactive behaviour	usually planned behaviour
Desire to protect loved ones from danger (realistic and unrealistic)	usually absent	usually present
Primary goal of perpetrator	murder	suicide
Sobriety of perpetrator	usually intoxicated	usually sober
Method of murder	without taking into account the suffering of the victim	minimalising the suffering of the victim

The subject matter of the case

Zofia K., 32 years old during the period of relapse, came from a family with many children. Her father suffered from depression and had died many years earlier by suicide. The respondent graduated with a master’s degree and had been employed as an office worker for 8 years. Eight years before the incident, she got married. The first pregnancy ended in a miscarriage; the second pregnancy (with a complicated course ended with the birth of a healthy child.

She was suspected of having had thrown her few-year-old son into a water reservoir with the direct intention to kill him, causing her child to suddenly die as a result of drowning (an act under Art. 148 § 1 of the Criminal Code). Interrogated on the day of the incident, Zofia K. stated that the perpetrator of the act was a man whom she met by accident and it was he who threw the child into the water. The next day, she admitted that what she had said was not true because she could not believe that she had committed the murder of her own child. On the day of the incident, she went with the child to visit her friend. Ultimately, she did not meet her and ended up at the marina. There she spent the whole night with her son. She spoke on the phone with her husband, mother, sister and brother until 3:00 in the morning. The child fell asleep in her arms. It was then that the thought appeared that she would not be able to cope

with her son's upbringing and household matters. She stated: "I killed the child because I loved him." She felt an impulse to jump into the water with her son and take her own life as well as his. Several times she approached the railing and backed away. She did not remember the moment of throwing the child into the water. Later, she descended down the ladder into the water to save him. She was standing in the cold water, feeling numb and shocked. She thought about swimming but she did not know how to swim. At this moment, random people pulled her out of the water. Subsequently, the police were called who arrested her. Later on, she said: "I wanted to commit suicide and take my son with me"; "I fought with my thoughts, I didn't know what to do, I thought I would jump in with him but I was somehow afraid of it." In addition, she said that her mother-in-law criticized her for everything. A month before the incident, she wanted to punish her husband for not being able to "get along on a lot of things." She did not come home for the night then and was with her son at the marina. Afterwards, she was afraid that her parental rights would be taken away. The very first thought of ending her own and her son's life had appeared ten months earlier. After the baby was born, everything was fine, she took care of him together with her husband. She did not take psychiatric medications regularly because she did not believe that they would help her.

The suspect's husband stated that the evening before the critical event, his wife and son went to their friend's place, where they were supposed to spend the night. Later that night, she spoke by phone with family members until her phone ran out of battery. His wife suffered from postpartum depression. From the beginning of the illness, she would say that she wanted to kill herself – turn on the gas, jump from a high-rise building. The husband reported: "She kept saying it was all because of the son"; "The wife did not accept our son, he irritated her;" "She said she wouldn't return to work because the child was stifling her." She never hit her son, but sometimes she would suddenly use vulgar words towards him, such as: "Go away brat, don't touch me" or "Stop screaming your head off."

The suspect's mother said that Zofia K. was worried that she would be dismissed from her job and that she would not be able to support the child. "The most important thing for her was work."

Psychiatric treatment

Three years before the incident, the subject started treatment in a psychiatric outpatient clinic. At that time, she was not coping with her responsibilities. She was diagnosed with an episode of severe depression with psychotic symptoms and then schizophrenia. She presented a blunted affect, restricted facial expressions, emotional tension, and an angry mood. Her statements indicated magical thinking. Features of personality breakdown and autism were noted.

Two months later, for two hours, she was in a psychiatric hospital where she was diagnosed with a depressive syndrome. She was discharged at her own request. After another week, she was admitted to an in-patient psychiatric clinic where she stayed for four months. She was diagnosed with a severe episode of depression with psychotic symptoms (suicidal thoughts, depressed mood, fear for loved ones, feeling of helplessness).

ness in caring for her son, depressive delusions). However, it still raised diagnostic doubts – “observation towards schizophrenia”.

One month after leaving the clinic, she reported to another psychiatric outpatient clinic. She stated that she had not been taking the medications prescribed in the hospital. During the visit, she mentioned that she felt that she would not be able to raise her son and considered placing him in an orphanage. Throughout the following year, the medical history records from the clinic described a deteriorated mental state – distinct delusional-depressive symptoms. Eventually, she was admitted to the day-care psychiatric unit – a depressive syndrome was diagnosed.

Half a year later, she was admitted to a different in-patient psychiatric centre because of recurrent depressive disorder – severe depressive episode with psychotic symptoms. During hospitalization, she reported a vague sense of danger for her son’s future, a feeling of being unfulfilled as a mother, a sense of chaos and disorder in her head, and internal anxiety. She claimed that the child should not have been born, and that the decision to become pregnant was ill-considered. She felt a sense of guilt, but also held the family (especially her son) responsible for her health situation at the time.

Three months later, she went to another (third) psychiatric outpatient clinic, where she was diagnosed with recurrent depressive disorder – in remission. In the four months preceding the incriminating act, the patient’s mental state was balanced. At that time, she only reported disagreements with her husband and a critical attitude of her mother-in-law towards her. During that period, she denied aggressive impulses towards her son and self-aggressive behaviour. She did not show any psychotic symptoms or suicidal thoughts.

Throughout the entire documentation, there were notes that the subject was taking medications irregularly and without conviction.

Various records contained numerous entries relating to the son of the subject. Zofia K. said, among other things, that the child had wasted her life and therefore she was worth nothing. “I may not have had him at all, I was a good worker, I had a sense of self-worth.” She wanted to put the child up for adoption. “I wish the baby had never been born.” She was afraid she would do something bad to him. She confided to her sister that she “sees two coffins, her own and her son’s.” At the same time, she feared for her son’s health and life. She believed that she could not cope with his upbringing.

Results of forensic examinations

During the outpatient examination, which took place the next day after the incident, experts did not find any acute psychotic symptoms. At that time, she denied suicidal thoughts. She explained the incriminating behaviour with a “nervous breakdown”. According to experts, she made depressive complaints. They noted that the subject considered solving the problems by extended suicide.

One and a half months later, Zofia K. was admitted for forensic psychiatric observation. She provided information consistent with the documentation on mental disorders and treatment. She claimed that until the time of the incident she had made only one suicide attempt – she wanted to poison herself with gas. During this hospitalization,

she behaved in accordance with the instructions of the staff. She was taking medications systematically. She was interested in psychiatric treatment, social matters, her professional situation, and contacts with her family. She ate meals, took care of hygiene, clothes, tidiness and her appearance. She did not avoid contact with other patients. She organized her time (embroidering, reading, writing letters), which – as she claimed – gave her a relief because she did not think so intensely about the event. She showed typical depressive symptoms, but without a psychotic component.

The psychological examination showed that her intelligence was in the upper limit of the average norm and there was no organic damage to the central nervous system. The personality of the subject was assessed as bearing histrionic-narcissistic features. It has been reported that difficult, internally contradictory situations caused her emotional tension and disturbances in information processing, which in turn led to misinterpretations of events and difficulties in understanding the consequences of her actions. It was found that the respondent felt constant overload, inability to control her own behaviour, and chaotic actions while openly manifesting her attitudes, expectations and feelings, disregarding social expectations and requirements. Despite the felt need for achievements and high aspirations, she did not take actions to implement them, and the decisions aimed at achieving these goals were taken hastily, thoughtlessly, ineffectively and resulted from an immature emotional sphere and a state of illness. It was noted that she easily made shallow and superficial contacts with other people, focusing on meeting her own needs. She concentrated on the external aspects of a relationship (appearance, clothing, age). She had no insight into the emotions and needs of others. She felt a strong need for acceptance, expecting interest, care and support from her surroundings. In the absence of the expected reactions, she felt anger and hostility – she denied the emotions and revealed them indirectly (through tension, depressed mood, irritation, theatrical and demonstrative behaviour). According to the psychologist, she was emotionally immature and egocentric. On the intellectual level, she was able to identify with the role of wife and mother, but the necessity of sacrifice, commitment, and giving up pleasure caused an attitude of resistance and aversion in her.

The team of experts found that Zofia K. had a mental illness in the form of recurrent severe depressive disorder with psychotic symptoms, which made her insane in relation to the allegation. Her behaviour was defined in terms of extended suicide. The experts requested the use of a precautionary measure.

Discussion

The presented case illustrates the difficulties of forensic and psychiatric judgments, as well as criminological ones. Is it possible to classify the act committed by Zofia K. to one of the aforementioned categories of homicide connected with an attempted suicide by the perpetrator?

The material of the case showed that the subject had been intending to take her own life for many months. For almost a year she had been thinking about killing herself and her son at the same time. Moreover, one cannot ignore the fact that in the months preceding the event, she was in a balanced mental state and she even denied

self-destructive intentions towards herself and the child. The material does not provide information that could indicate that the incriminating act was a result of the so-called depressive balance. It seems more likely that in the last period before the event, there was a clear and rapid worsening of depressive symptoms with elements of pathological thinking. This could support the motivation to act described in “extended suicide”, which the experts considered the next day after the incident. In this case, the term “dyadic death” turns out to be too general. However, we encounter a significant doubt of diagnostic nature here. It is true that, over the course of three years, Zofia K. received treatment in several independent psychiatric centres where she was diagnosed with severe depressive disorder with psychotic symptoms, i.e. a diagnosis that is most often associated with the term “extended suicide”, but it is impossible to ignore diagnostic ambiguities regarding the schizophrenic process. If it turned out that such a process did indeed develop in her, would it not be safer to define the incriminating behaviour in terms of “dyadic death”, which does not have such diagnostic connotations?

The respondent herself emphasized that before the critical event she was ambivalent in her decision, which was reflected in several “attempts” to approach the protective barriers. She claimed that she was “struggling with her thoughts,” which is attributed to her personality traits (as defined in the psychological test). Although no unequivocal relationships between attempted suicide (a suicide attempt) and a specific type of personality disorder have been proven, sometimes suicide attempts are associated with a histrionic or immature personality [30]. According to Kępiński [31], in histrionic individuals the most important decision in life – to live or die – is not strong enough. Simultaneously, there are opposing states – contemplations about suicide, but also doubts: “Maybe I should stay alive”. The dominant trait of an immature personality inclining to suicide is low resistance to stress and a self-destructive response to threatening situations [32], which was also characteristic of the perpetrator.

Assuming that the depressive symptoms coincided with the predisposition of her disturbed personality, it is difficult to clearly define which of these elements was then dominant [33]. In this context, it cannot be categorically determined whether the original intention of the perpetrator was murder (this would speak for “dyadic death”) or suicide, preceded by murder (the argument for “extended suicide”).

The medical records and her husband’s testimony showed that the respondent had a variable attitude towards her son, from positive and concerned, through ambivalent, to negative – this criterion also does not facilitate the choice between the included constructs. Zofia K.’s actions do not contain altruistic motives (also of a pathological nature). According to her account, she was concerned not so much with the child’s welfare as with her own concerns about the ability as a parent and a sense of professional loss. According to Stukan and Staszak, in the case of this type of perpetrators, one should rather talk about “extremely intense egocentrism” [21], which does not fit the classic definition of “extended suicide”.

In “extended suicide” there are usually no pre-murder acts of aggression towards the victim, especially if the victim is a child. The respondent’s husband’s account showed that she repeatedly showed anger and vulgarity towards her son. The mechanism of such behaviours was explained in the psychological assessment – the behaviours

were not a consequence of disease disorders, but they resulted from the structure of her personality.

Considering the description of the perpetrator's behaviour during the act and taking into account the cited definitions in the literature, it seems that the image of the crime is closest to "dyadic death", which is a broader term than "extended suicide" [21]. While her intrapsychic motivation could result from the presence of depressive symptoms, modified only by personality traits [33], the manner in which the crime was committed (its phenomenology) was associated primarily with the disturbed personality of the perpetrator. This position was supported by, among others, the fact that Zofia K. was in a public place with her son, probably surrounded by other people, she talked for hours with several family members (she was looking for help, support, attention), and she did not remember the moment of throwing the child into the water. After being arrested, she gave a false account of the event, which should be interpreted as an expression of her deliberate defensive attitude. Descriptions of her behaviour *tempore criminis* corresponded to the characteristics of the histrionic personality provided by Kępiński – "suicide is primarily a cry for help in their case" [31, p. 80]. The method of killing the child is also ambiguous – although there is no bloodshed, it is difficult to conclude that throwing a helpless child into the water is not brutal.

The subject of forensic psychiatric judgments is situations in which the perpetrator of the murder survived the suicide. One of the key responsibilities of experts in a criminal investigation is the assessment of the perpetrator's sanity concerning the alleged offence, that is, the extent to which potential mental disorders could influence the perpetrator's ability to consciously take action and to recognise the implications of their actions. The answer to this question should be determined by an analysis of the perpetrator's mental state and health, assessment of their motivations and additional circumstances of the act. On the contrary, the incriminating behaviour should not be determined by the criteria of murder-suicide constructs alone. Despite the fact that in the discussed case the perpetrator only considered suicide, the first team of experts, based on her reports, began to suspect "extended suicide", and the second confirmed it. Perhaps, in order to determine whether a specific case can really be analysed in terms of "extended suicide" or "dyadic death", one should first consult not expert psychiatrists and psychologists, but forensic experts who will comment on the degree of threat to the perpetrator's life as a result of attempted suicide. This would make it possible to objectify the circumstances of the critical event, and thus eliminate doubtful cases.

In the discussed case, there are certain elements common to both constructs, especially those related to environmental factors: the suicidal death of a depressed father and the psychological burden resulting from this fact; fear of losing a job, which increased the perpetrator's self-esteem; protracted difficulties in interpersonal relations (with the husband, mother-in-law, mother) as well as typical therapeutic problems (discontinuation of treatment, negating the need for therapy, premature leaving the hospital).

The act performed by Zofia K., no matter how we classify it, can be considered in relation to her clinical condition and here another issue appears – namely, the occurrence of symptoms of the so-called presuicidal syndrome [1, 19, 34] in the form of anxiety, limitation of interpersonal relationships, lack of established hierarchies of

values, presence of fantasies about death and being dead with the son. It seems that this aspect was not clearly noticed by the psychiatrists and psychologists who examined her, which could have possibly reduced the risk of dangerous behaviour on her part.

Criminologists use a clinical fact, which is primarily the subject of psychological and psychiatric analyses, while psychiatrists make assessments within their competence, drawing on criminal phenomenology. They analyse information from the description of the course of the crime, they look for elements that can be used in a reconstruction of the mental state of the perpetrator *tempore criminis*. Criminologists use the perpetrator's clinical assessment to explain the aetiology of the crime. The interaction between the clinical sphere and criminological phenomena is two-sided and complementary. So what is the practical value of the terms "dyadic death" or "extended suicide"?

Causes of a homicide-suicide should be analysed from a multidimensional perspective, taking into account the possible pathological basis and even specific disease states. At the same time, environmental determinants should not be overlooked [13, 35], including real problems that cannot be solved from the perpetrator's point of view [32].

The complications of judgment are favoured by the lack of clear definitions of the quoted terms, their diversity, mutual interpenetration of the criteria, and possibility of their wide application, which may lead to over-interpretation and overuse. As indicated by the analysed case, there is no simple translation between the pathology of mental life and motivation, motivation and behaviour, the mode of action and the image of the criminal act. Both criminology and psychiatry draw from different sources, have different assumptions and goals, and a different view of the crime. The value of cooperation between specialists in these fields lies precisely in their distinctiveness. While in criminology the use of the discussed constructs may be significant in the sense of a certain concept, a mental shortcut, which hides the phenomenological meaning of the act, a certain external interaction between the perpetrator and the victim, or the nature of the crime, in forensic psychiatric judgments the practical possibility of their use seems to be questionable and may even be the cause of errors. Adopting a priori of a construct explaining the crime at the phenomenological level may lead to erroneous conclusions regarding the aetiology of the act.

Conclusions

The use of one of the discussed constructs to describe the situation of the murder and then the perpetrator's suicide should be limited only to special cases where the results of meticulous research in the field of forensic medicine, criminology, psychiatry and forensic psychology leave no doubt as to the course of the critical event, nature of the relationship between the perpetrator and the victim, the course of possible mental disorders in the perpetrator as well as his motivation. The discussed case shows that the usefulness of their application in forensic psychiatric and psychological practice is very limited. Their overuse may result in overly simplified judicial conclusions.

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