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"THE THREAT TO KILL"

A Thesis Submitted for the Degree of Doctor of Medicine
University of Otago

by

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Application for exemption from the examination prescribed in Section 4 of the 1964 regulations for the M.D. degree was approved by the Senate in September 1966
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The physicians, psychologist, psychiatric social worker, nurses and other staff on the "threat to kill" ward willingly cooperated in caring for patients who at times were very demanding. In retrospect it is difficult to assess the extent of their contributions. Formal and informal meetings over the course of a year probably contributed more than the writer realizes to his understanding of these patients. The cooperation of the patients and homicide offenders is appreciated.

Miss Elaine Steffen has typed and retyped this thesis despite the pressure of other duties. It is hoped that the reader will show forbearance regarding the American spelling where it differs from the English.

John M. Macdonald

Denver, Colorado
November 1967
CHAPTER 1

THE PURPOSE AND PLAN OF THIS THESIS

It is considered that the neglected problem of homicidal threats is a subject not only of psychological interest but also of practical importance to the psychiatrist. The purpose of this thesis is to:

1. **Study the relationship between the homicidal threat and homicide.** One hundred persons who made homicidal threats have been followed up after an interval of five to six years.

2. **Assess some potential predictors of homicide.** The incidence of potential predictors of homicide has been examined in three groups - hospital patients who have made threats to kill, convicted homicide offenders, and a control group of hospital patients who have no history of homicidal behavior.

3. **Test the hypothesis** that the incidence of parental brutality, parental seduction and childhood firesetting, cruelty to animals and enuresis is significantly higher in persons who have committed criminal homicide than in persons who have made homicidal threats.

4. **Provide guidance on the emergency assessment of homicidal potentiality.**

5. **Consider briefly those who make homicidal threats and their victims.** One hundred consecutive "threat-to-kill" admissions to a hospital, as well as others who have made threats, have...
been examined. Attention will be given to the role of the victim in provoking threats.

CHAPTER 2

BACKGROUND TO THIS INQUIRY

The shooting of 44 persons by Charles Whitman, a young University of Texas student in Austin, Texas in 1966 focussed public attention on the problem of the recognition and treatment of the potential homicide offender. In March 1966, this 25 year old student of architectural engineering, troubled by his parents' separation, consulted a University staff psychiatrist. In a two hour interview he stated that he had beaten his wife several times and that although he was making intense efforts to control his temper, he was worried that he might explode. He revealed that he was "thinking about going up on the tower with a deer rifle and start shooting people."

The young man did not return for his next appointment with the psychiatrist. Five months later, after killing his mother and wife, he carried three rifles, a shotgun and other firearms to the observation deck of the 307 feet tall University Tower. Before he was killed by police officers, he shot 44 persons, killing 14 and wounding 30. Although multiple homicides involving more than two or three victims seldom occur, there were an estimated 10,920 cases of murder and non-negligent manslaughter in the United States in 1966. There were 5.6 criminal homicide victims per 100,000 population (6). The homicide death rates in Table I have been obtained from the United Nations Demographic Year Book for 1964 (26).
### TABLE I

<table>
<thead>
<tr>
<th>Rate</th>
<th>Countries</th>
<th>Year</th>
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<tbody>
<tr>
<td>4.9</td>
<td>United States</td>
<td>1963</td>
</tr>
<tr>
<td>2.4</td>
<td>Finland</td>
<td>1963</td>
</tr>
<tr>
<td>1.5</td>
<td>Australia, Japan</td>
<td>1963</td>
</tr>
<tr>
<td>1.3</td>
<td>Canada</td>
<td>1963</td>
</tr>
<tr>
<td>1.2</td>
<td>Federal Republic of Germany</td>
<td>1963</td>
</tr>
<tr>
<td>1.2</td>
<td>Poland</td>
<td>1962</td>
</tr>
<tr>
<td>1.1</td>
<td>Czechoslovakia, Italy</td>
<td>1962</td>
</tr>
<tr>
<td>1.1</td>
<td>Greece</td>
<td>1963</td>
</tr>
<tr>
<td>0.9</td>
<td>Austria</td>
<td>1963</td>
</tr>
<tr>
<td>0.8</td>
<td>France</td>
<td>1963</td>
</tr>
<tr>
<td>0.7</td>
<td>England and Wales, Scotland</td>
<td>1963</td>
</tr>
<tr>
<td>0.6</td>
<td>Belgium, Sweden</td>
<td>1962</td>
</tr>
<tr>
<td>0.6</td>
<td>New Zealand</td>
<td>1963</td>
</tr>
<tr>
<td>0.5</td>
<td>Denmark, Norway</td>
<td>1962</td>
</tr>
<tr>
<td>0.4</td>
<td>Netherlands</td>
<td>1963</td>
</tr>
<tr>
<td>0.3</td>
<td>Ireland</td>
<td>1963</td>
</tr>
<tr>
<td>0.2</td>
<td>Spain</td>
<td>1961</td>
</tr>
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In New Zealand (Population 1961 census, 2,414,984) during the years 1960-1965, 51 persons were convicted of murder or manslaughter (11). In Colorado (Population 1960 census 1,753,947) during the same period there were 498 cases of murder and non-negligent manslaughter (5). Differences in definitions of murder and manslaughter and the difference between convictions and reports of criminal homicide weaken the value of this statistical comparison. Nevertheless, criminal homicide is much more frequent in Colorado than in New Zealand.

The incidence of criminal homicide may be even higher than that recorded in official statistics. Mannheim draws attention
to certain weaknesses of the official figures arising from the existence of the "dark figures" of undetected crime and from other deficiencies of police and court statistics. "First, the commission of an offence may remain altogether unknown, for example, the disappearance of the murdered person may not be noticed, which can easily happen in the case of persons living alone and having no relations, neighbors or friends, or of tramps and vagrants or persons traveling abroad... Secondly, the death of a person may be noticed but explained in an innocuous way, for example, murder may be cleverly disguised as death by accident or suicide... Thirdly, the commission of an offence may be known to others or at least suspected by them, but the authorities are not informed and no official action is taken (15)."

Harvard points out that most crimes are brought to light as a result of a complaint being laid by the victim, yet it is precisely in homicide that the victim, except in rare instances, is unable to raise the alarm or give information concerning the circumstances. "For this reason the medico-legal investigation of all violent deaths, and all sudden deaths of unexplained cause is of considerable importance to the community...

"Three points only need to be remembered. First, to kill in such a way that no external marks of violence are left on the body; secondly to make sure that no witnesses are in the vicinity;
and thirdly to ensure that the body is found in just such a place as might have been expected if the person had suddenly dropped dead from a natural disease, e.g. heart failure. In districts showing a low autopsy index there will be a good chance that the crime will be undiscovered and the body disposed of through the normal channels. The chance of detection is, of course, even less if the victim is known to have consulted his own medical attendant for some illness which might conceivably lead to a sudden death, e.g. coronary heart disease.

"It is commonly believed that homicide leaving no obvious external signs of violence is limited to cases of poisoning; but this is very far from the case. Even bullet wounds may pass unnoticed in the superficial examination of persons who have died suddenly, particularly where the wound of entry is concealed by thick hair, and a small calibre bullet has been used. Some extremely bizarre situations may result, and cases have occurred in which victims have been shot through the open mouth or eyes, the wound being later concealed by closure of the lips or eyelids. One such case was discovered only because it was noticed that the lens of the spectacles had been broken. . . .

"Serious and fatal internal injuries may also be sustained from external violence without leaving any obvious evidence. In one such case the victim had sustained a rupture of the liver and diaphragm, part of the liver having been forced up into the chest
cavity through the rent in the diaphragm, yet there were no external signs of violence. In another case the victim was sent away from hospital, because it was not suspected from the absence of external signs that his liver had been ruptured. These cases may well lead to the concealment of homicide." (9)

Harvard believes that the most competent physician, if he attempts to certify the cause of violent or sudden deaths of unexplained cause on the basis of the available clinical history and external examination of the body, is likely to be proved wrong by a medico-legal post mortem in approximately one out of every three cases. He quotes Roche Lynch as stating that of eight of his cases of homicidal poisoning discovered only after exhumation of the body, the attending doctor should have suspected poisoning in only one case. Harvard also notes that as a method of destroying all evidence of homicide, cremation is probably unexcelled.

Wolfgang quotes the claims of a state pathologist in a New England state that only one out of every ten murders in that state is ever discovered, that it is easy to get away with murder in that state and that it is a simple matter to dispose of the body (29). The claim that only one in ten murders is ever discovered may be an exaggeration, nevertheless, it is likely that not a few murders go undiscovered. Small police departments which lack trained investigators, sheriffs who are elected to office
without previous experience of law enforcement and coroners without medical training who are also elected to office, contribute to the problem.

Although criminal homicide arouses great public concern and has stimulated much research, the problem of homicidal threats has received scant attention from psychiatrists, psychologists, sociologists and criminologists. The curiously meagre scientific literature cannot be attributed to lack of opportunity for study as many persons who make homicidal threats either seek psychiatric treatment or are committed to hospitals for psychiatric examination. It is important to know the relationship between homicidal threats and homicide. Are a significant number of homicides preceded over a period of days, weeks or months by homicidal threats? How does one assess the degree of homicidal potentiality among those who threaten homicide? What measures are likely to be effective in reducing the risk of homicide?

Homicidal threats, like those of suicide, are more often made than fulfilled. It would be difficult to determine the number of persons who make homicidal threats. The Uniform Crime Reports of the Federal Bureau of Investigation do not include statistics on homicidal threats. In Denver, Colorado, a city with a population of slightly more than half a million persons, the police department keeps a record of persons who
make threats. Approximately 25 to 30 threats a month are reported to the police, but not all these threats are homicidal in nature.

It is likely that many threats are not reported to the police. Recipients of threats may not attach any significance to the threat, may wish to avoid the inconvenience or publicity which might result from a complaint to the police, or may be reluctant to press charges because of their awareness of the lenient attitudes of many judges toward persons who make these threats. Fear of retaliation or a wish to shield the offender may be other factors. The victim himself may have made homicidal threats and be fearful of police action.

It would also be difficult to determine accurately the number of homicide offenders who make the threat before the fatal act. It is not to the advantage of the offender to reveal that he has made threats to kill. Such an admission might be used by a district attorney to prove premeditation and thus lead to a conviction of first degree murder rather than second degree murder or manslaughter. Even after the offender has been convicted and sentenced, fear of an adverse response from the parole board may discourage him from making any disclosure regarding threats.

Victims of homicide may not survive long enough to report prior threats on their lives. Even if they had told someone beforehand, restrictive rules of evidence may preclude such
testimony. Furthermore, persons who have knowledge of the threats are often unwilling to testify, especially when they themselves have criminal records or when they are related to the accused. Homicide is frequently a family affair in which witness, accused and victim have ties of blood or marriage.

Studies which deal specifically with homicidal threats are difficult to find. A computer bibliographic search at the National Library of Medicine, Bethesda, Maryland, for the period January 1964 to July 1966 resulted in the retrieval of 156 citations on homicide from the 420,080 articles which were searched. Ten of these citations contained references to homicidal threats but only one article focussed primarily on this problem. "Presidential Assassination Syndrome" by Rothstein was based upon a study of ten patients at the U. S. Medical Center for Federal Prisoners, where they had been confined because they had threatened the life of the President (23).

The ten patients in Rothstein's report were all suffering from schizophrenia. Several had also threatened other officials and or relatives at one time or another. Brief histories are given of each patient and the author draws attention to what he considers to be striking similarities between his patients and the fragmentary news media outline of Presidential assassin Lee Harvey Oswald. In his formulation of a typical or prototype case he states that a basic ingredient would seem to be maternal deprivation
which has resulted in severe rage against women.

"A basic ingredient would seem to be maternal deprivation which has resulted in severe rage against women. The presence of this rage shows itself in comments such as patient 3 stating that he did not care if every woman in the United States died. Patient 7 had sold the family's home and furnishings when his wife was hospitalized, an implied death wish to which she reacted by obtaining a divorce. Patient 2 had directed his threat partially toward the President's grandchildren, whom he later tended to identify with his sister's children, at a time when he expressed some incestuous but ambivalent feelings toward her. None of the patients had been able to form stable mature heterosexual relationships, and overt or underlying homosexual difficulties were prominent."

His claim of maternal deprivation would have been more convincing if he had provided more evidence of maternal deprivation rather than deriving, in part, such deprivation from expression of anger at women. He describes the President as a mother figure basically and as a father figure only superficially. He continues "Even the death (of the President) may represent ultimate oceanic reunion with the mother, being only superficially an expected masculine castrative retaliation."

He also states, with reference to the slaying of Oswald by Ruby: "It is, of course, possible for another person to respond at an
unconscious level to the implicit meaning communicated by the act of a psychotic individual, and it would seem that Jack Ruby may have responded to Oswald's invitation for self-destruction." The reader is left with the impression that Rothstein uses Procrustes' bed to fit each of his patients and Lee Harvey Oswald. His psychodynamic speculations are not supported by adequate clinical evidence.

Two other articles primarily concerned with homicidal threats, "The Threat to Kill" and "Homicidal Threats" by the writer were published in 1963 and 1967 (13, 14). The content of these articles will be included in later chapters. De Leon's article "Threatened Homicide" published in 1961 referred to the striking absence of papers specifically directed toward the early recognition of homicidal states and the prevention of murder. His experience that patients, (apart from mothers who have fear of killing their children) almost never present as their chief complaint the fear of committing murder, is not shared by the writer. He notes that the victim of homicide may effect his own suicide by provoking the slayer to homicide, and gave brief details of a female patient who sought help because "that man outside is going to make me kill him and I really don't want to do anything like that." She later killed her paranoid male friend after he started to beat her with a chair leg (4).

Gold describes in more detail another case of apparent victim
precipitated homicide. A 32 year old man with a sociopathic background sought treatment in a State Mental Hospital as he was not making progress in therapy with a local psychiatrist. Although he stated that he was going to kill his wife, he was discharged after ten days. Several months later he shot and killed his ex-wife. During psychiatric treatment for depression following his arrest he made these comments about his crime, for which he was later sentenced to life imprisonment.

"Sometimes I think my wife committed suicide using me as an instrument. Why did she leave the pocketbook open with the boyfriend's letter sticking out? She knew she was pregnant, the abortion pills didn't work, it was the second illegitimate pregnancy, it was by another man, she couldn't get rid of it. She knew it wasn't mine because I was sterile, she wanted no more children and I agreed to have the vasectomy in Springfield. She was suicidal during the first illegitimate pregnancy and I talked her out of it, I told her I was going to marry her."

"When I walked in with that pistol she was very calm and she said 'You are going to kill me anyway so you may as well do it now.' I really wanted her to go outside and talk to me but she said she wasn't going to go. Being killed was her only way out of her terrible situation."

The man emphasized his ex-wife's refusal to talk with him, telling him to go ahead and shoot her, and making no attempt to
dissuade him from giving up the Luger, which he believed she could have done. At the time of the tragedy he was not aware that his ex-wife was pregnant. Gold recognized that his patient's interpretation of the crime may have involved the use of rationalization (8).

In "Homicide after treatment with lysergic acid diethylamide" Knudsen describes the case history of a 25 year old woman who on the third day after treatment with lysergic acid stabbed a male friend to death. Following an earlier treatment with this drug she made a verbal threat to kill this male friend. Her diagnosis was psychopathic personality and depressive psychosis. The author concluded that the lysergic acid treatment activated to an exceptional degree already existing aggressive impulses which weakened the self-control of the patient (12).

Usually references to homicidal threats in journal articles and books are confined to mention of the fact that a patient made such a threat prior to committing homicide or homicidal assault. The focus of the writer is often on some aspect of criminal homicide or the homicide offender, for example, toxicological analyses, psychopathology or treatment, rather than upon the threat itself. Contributions of this kind include those of Easson and Steinhilber (5), Hudgens (10), Matthew and Constan (16), Neustatter (17), Revitch (21), Shenken (24), Solomon (25), Van Hecke (27) and Wertham (28).
Although the problem of homicidal threats has been neglected in the scientific literature, there have been many books and articles on criminal homicide and aggression. Although no attempt will be made to survey the very extensive literature on these subjects, selected quotations will be made in subsequent chapters. One aspect of homicide will be considered in this chapter, namely the incidence of this offense among former mental patients.

It is widely believed that mental patients are likely to be dangerous. Many psychiatrists, disputing this viewpoint, have quoted a series of studies published between 1922 and 1962. These surveys have compared the arrests rates of former mental patients with those of the local population (1, 2, 3, 18). The general conclusion from this work has been that the rate of crime as measured by arrest rates is, if anything, lower among formerly hospitalized mental patients than it is in the general population (7).

Brill and Malzberg, for example, studied 10,247 male patients, age 16 or over, who were released from the New York State Mental Hospitals during the year 1947. Of these patients, 5,354 had been fingerprinted and it was possible to study their subsequent arrest record through the New York State central fingerprint file. The arrest rate for the remaining 4,893 was calculated. The period of observation was five years, six months. It was found that the
The annual arrest rate for patients was far lower than that of the general population (122 per 10,000 as compared with 491).

A major conclusion was that arrest rates among patients are inversely related to severity of mental symptoms. The more outspoken are the evidences of mental illness during hospitalization, the lower is the rate of arrest after release. Thus patients "disturbed" on admission had an arrest rate two and a half times smaller than that of those immediately in condition to occupy themselves in hospital. Patients with no record of prior arrest have a strikingly low rate of arrest after release. These ex-patients show two-thirds of the felony arrest rate and one-tenth of the total arrest rate for the general adult male population.

The annual homicide rate following release per 10,000 male patients, age 16 or over, was 0.73 compared with 0.65 annual homicide arrest rate per 10,000 New York State males 16 years of age and over (2).

In contrast to earlier reports, Rappeport and Lassen found the arrest rate of former patients in Maryland Psychiatric hospitals, was equal to or greater than that of the general population of Maryland (19). The arrest records of all male patients over 16 years of age, discharged from all Maryland psychiatric hospitals, except one private institution, during the fiscal years 1947 and 1957 were checked for the five years preceding and for
the five years subsequent to hospitalization. In fiscal 1947, 708 patients were discharged and in fiscal 1957, 2,152 patients were discharged.

The arrests referred to in the study are only for the five serious offenses of murder, negligent manslaughter, rape, robbery and aggravated assault. These offenses were selected because they are felonies and represent danger to persons. The writers assumed on statistical grounds that the occurrence of one murder by a former patient happened by chance and that it was probably not related to mental illness. There was a significantly higher arrest rate for robbery, in both groups of patients than in the general population. Aggravated assault arrests were about equivalent in the discharged patients and in the general population. The data suggest that the incidence of arrests for rape was higher in the pre-hospitalization population than in the general population.

The arrest records of all female patients discharged from all hospitals in Maryland in the fiscal years 1947 and 1957 were similarly examined. Comparison of their arrest rates with those of the general population indicates that these female psychiatric populations have a significantly higher arrest rate for aggravated assault than the general population (20).

Giovannoni and Gurel, in a follow-up study of 1,142 functional psychotics who had been released from 12 Veterans Administration
Hospitals found higher rates of ex-patient criminal activity than those reported in most published studies, particularly for crimes against persons. These patients were followed for four years from admission to ascertain extent of socially disruptive behavior. Three patients were arrested for homicide and seven for aggravated assault. The incidence of homicide among these patients was estimated to be 98.2 per 100,000 compared with a homicide rate of 4.7 per 100,000 in the general population. The arrest rate for aggravated assault was 229.1 compared with 86.0 in the general population.

No patients over 60 years of age on admission were included in this study. The lower age limit was not stated, however, as the patients were all veterans it is unlikely that any of them were under 16 years of age. Thus the incidence of homicide in a population between the ages of 18 and 64 is compared with the incidence of homicide in a population with no age restrictions. Nevertheless, the incidence of homicide among these patients gives rise to concern.

These authors believe that the low rates of ex-patient arrests in the New York data in part reflect cautious release policies. They consider that their findings, which are fairly consistent with those of Rappeport and Lassen, but discrepant with those of earlier investigators, reflect a change in the community utilization of mental hospitals. The police and the community more
frequently are turning to the mental hospital for assistance

in dealing with persons who have committed a criminal act (7).

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CHAPTER 3

FOLLOW-UP STUDY OF 100 PERSONS WHO MADE HOMICIDAL THREATS

A guide to the relationship between the threat to kill and homicide can be determined by follow-up study of persons who have made homicidal threats. One hundred patients admitted to the 78 bed Colorado Psychiatric Hospital, specifically because they had made homicidal threats, provided the opportunity for follow-up study. This group of consecutive "threat to kill" admissions was described by the writer in an article entitled "The Threat to Kill" which was published in the American Journal of Psychiatry in 1963 (2).

Eighty-one patients made a verbal threat to kill and in some cases combined words with physical assault. The remaining 19 patients made an undoubted non-verbal threat to kill in the form of physical assault or discharge of firearms. Three of these patients, who were psychotic, denied homicidal intent, but the homicidal nature of their actions was not in question. A chronic paranoid schizophrenic who threatened that she would cut out the tongues of her neighbors with an axe was not included, although such actions might well be deadly.

These 100 patients (one in every 16 admissions) were admitted to the hospital during a fifteen month period in 1961 and 1962. This group of 95 Caucasians (no Spanish-Americans) and five
members of other racial groups included 55 males and 45 females. Fifty-four patients were admitted on civil court order and 46 were admitted voluntarily. Although no patient was committed by a criminal court, several sought admission as an alternative to the filing of criminal charges. Their ages ranged from 11 to 83 years; 52 were between the ages of 20 and 40, and the mean age was 43\frac{1}{2} years.

Forty-eight patients were psychotic and all but ten of these psychotic patients had schizophrenia or organic brain disease. The majority of patients with chronic organic brain syndrome had cerebrovascular disease or senility. One young woman was found to have an inoperable cerebral tumor. Paranoid delusions, an important factor in the threat to kill in this group, were present in 35 patients. As will be seen from Table 2, only three patients showed mania or psychotic depression.

TABLE 2

<table>
<thead>
<tr>
<th>Diagnostic Classification</th>
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<tbody>
<tr>
<td><strong>Psychotic Group</strong></td>
</tr>
<tr>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Paranoid state and paranoia</td>
</tr>
<tr>
<td>Chronic brain syndrome</td>
</tr>
<tr>
<td>Acute brain syndrome</td>
</tr>
<tr>
<td>Mania</td>
</tr>
<tr>
<td>Psychotic depression</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>
In the non-psychotic group of 52 patients, the primary diagnosis was character disorder, except in two patients with mental retardation and two patients with neurotic behavior disorder. Frequently features of more than one form of character disorder were present and some patients also had acute neurosis or alcoholism. Among the 100 patients, alcohol or drugs facilitated expression of the threat to kill in 26 cases. A record of criminal behavior was not common. One psychotic patient had previously been convicted of criminal homicide and had accidentally killed a child in an automobile accident.

Six months after the end of the 15-month period during which these 100 patients were admitted to the hospital specifically because they had made homicidal threats, it was known that one patient had killed deliberately and one had killed accidentally. In contrast none of the 1528 other patients admitted during the same period was known to have killed either deliberately or accidentally. The Fisher Exact Probability Test (4) was used to analyze the data. The findings reject the hypothesis of no difference in the incidence of killing in the two groups at the .0037 level of significance.

Five to Six Year Follow-Up

These patients were followed up after an interval of five to six years from the date of their admission to Colorado
Psychiatric Hospital. As a formal letter of inquiry might go unanswered, every effort was made to speak to the patient on the telephone. It was explained that the writer was checking on the progress of former patients. This responsibility was not delegated as clues to additional information might have been overlooked by someone untrained in psychiatric interviewing techniques. Hospital records showed the telephone number at the time of admission. A reply "this number is no longer in service" or an answer by a new client of the telephone company would lead to a search of the hospital chart for the names of any possible informants: parents, relatives, employers, general practitioner, mental health clinic, state hospital, Veterans Administration hospital, or private mental hospital, sheriff and so on.

Direct telephone contact with the patient eliminated any need for inquiry as to death by suicide. Inquiry as to whether the patient had committed homicide, however desirable from the viewpoint of research, was contraindicated. Such a question could be interpreted as an expectation on the part of the physician and might well have undesirable consequences. If the patient had committed criminal homicide, it is possible that he might have been released from imprisonment within five to six years. The possibility of criminal homicide which was either not detected or not regarded as criminal homicide by the police or courts cannot be eliminated.
Telephone conversations whether with patients, their relatives, or others, were continued for some minutes in the hope that discrete general inquiries would lead to significant information. Failure of telephone inquiry was followed by inquiry by mail. Twenty-three patients have not yet been traced. It was found that three patients had taken the lives of others and that four patients had taken their own lives.

Patients Who Committed Homicide

The three patients who took the lives of others were under the age of 30 at the times of the tragedies. Two patients, a male sociopath and a male paranoid personality had previously threatened to kill their victims - one before and one after hospitalization. The third patient, a paranoid schizophrenic woman who killed her son, had previously threatened to kill her husband and had expressed fears that someone would kidnap her son. The reports should be regarded as confidential and should not be quoted by any reader of this thesis.

Case 1 - A fifteen year old youth was admitted to Colorado Psychiatric Hospital after he had made six threatening telephone calls to a married woman. (He was interviewed by the writer on this admission) He made obscene remarks to her and threatened to kill her and her children if she did not agree to have sexual relations with him. He reminded her of the recent brutal murder of a woman and her child by a youth about his own age and said that the same thing
would happen to her and her children. The telephone calls were traced by the police and he was arrested but criminal charges were not filed against him. Instead he was admitted to the hospital on civil court order.

His parents reported that he did not have any friends as he would attempt to hurt the neighborhood children when he had arguments with them. He was large for his age and in this respect his parents described him as being "practically a monster." At school his grades were poor and sometimes he did not attend classes. He was discharged from one school within five weeks after he was found exploring another boy's locker. There was a history of impulsive behavior and an interest in fires, rockets and explosions. He admitted firesetting and voyeurism was suspected. The records include reference to sadistic acts regarding animals but details were not given and when re-examined by the writer in 1967 he denied cruelty to animals.

His father was able to set firm limits but directly and indirectly encouraged aggression. In contrast his mother was more lenient but frequently punished him for responding to his father's encouragement of aggressive behavior. Father once struck him with a closed fist and his whippings sometimes caused bruises. While in the hospital the youth smashed a phonograph record on the floor when asked not to play the same record again and again.

Psychological testing showed that he was of average intelligence.
On a sentence completion test he completed the sentences as follows: "Sometimes I wonder...what I'd do if I was mad enough to kill." "Under certain conditions, almost any girl...would defend herself from a murder." He was not seen as a good candidate for psychotherapy because of his strong avoidance of meaningful relationships.

As it was considered that this patient was potentially dangerous and unlikely to respond to psychotherapy, he was transferred on court order to a state hospital. Within two years he was discharged from that hospital. It is reported that shortly prior to his release he made threats to kill another patient and that he stole a revolver while on leave from the hospital. It was also reported that another patient who overheard him making threats to kill hid his bullets so that he could not use them.

Just over two years after his release from the State Hospital and over five years after his admission to Colorado Psychiatric Hospital, he shot and killed a younger brother. He had asked this brother to visit him in an apartment where he was staying. While talking to his brother, he picked up a gun "I just took it out and laid it across my arm, and I just told him - 'Hey, look.' And I didn't squeeze the trigger or nothing, it just went off." He said that it was his intention to scare his brother. According to the State Hospital, to which he was returned on the recommendation
of the jury, his mother stated that it could have been worse, that he could have killed the whole family. The diagnosis is sociopathic personality.

Case 2 - A 29 year old paranoid personality was admitted to Colorado Psychiatric Hospital after he had threatened to kill his wife and children. He was interviewed by the writer at this time. He had long been a shy, self-conscious, suspicious person with feelings of being discriminated against. He was quick to misunderstand the intentions of others and during the two and a half years prior to admission had become pathologically jealous of his wife. Frequently he accused her of infidelity and while she was at work he would call her fifteen to twenty times a day to make sure she was actually at work. He was himself unfaithful and recently had become very upset because of impotence during an attempt to have sexual relations with a girl friend.

When he was a child his father used to beat him with such severity as to cause bleeding. On occasions his father beat him with his fist, and once knocked him unconscious. Another time his father choked him and he believed that his life was saved by the intervention of his brother. His mother told him that his father had said he was the illegitimate child of a man whom the patient remembered visiting the home in his father's absence. As a child he slept in the same room as his parents. There was no history of firesetting, cruelty to animals or attempted suicide.
He was discharged from hospital after twelve days but was readmitted four months later after shooting one of his children. Three days prior to the shooting his wife told him she had a premonition ever since the birth of this child that the child would never have a full life. She felt that something was going to happen to the child in the near future. That day her husband told her that he was going to sell his guns as he was in debt. "She didn't want me to, she wouldn't let me." On the evening of the tragedy the patient decided to show his pistol to a friend. Although he said he was careful never to keep a loaded weapon in his home, he stated that his wife unknown to him had loaded the gun at the time of his previous admission to hospital, allegedly for her own protection. "It was sitting on the floor, loaded and hammer cocked back. When I took it out (of the closet) I pointed it toward the floor, I didn't know it was cocked. I pulled the top back to see if it was loaded, it went off."

Although the shooting was considered by the police to be an accident, the patient blamed himself and wondered whether the shooting was really accidental. He was reluctant to be interviewed by the writer and expressed the fear that he might find out the truth that he really wanted to kill his son. He was upset over his wife's lack of distress. "My wife feels he was cut out for this, that he was meant for God not us, she broke down at first but she was relieved." His wife was interviewed by the writer. She was firmly convinced
that the tragedy was God's will. She stated that when her husband's friend asked to see the pistol "I thought to whisper in (her son's) ear to ask him (her husband) to take him along." She added "I felt uneasy."

Case 3 - A 25 year old married woman was admitted to Colorado Psychiatric Hospital after she had threatened to kill herself, her husband and her sister-in-law. She believed that her husband was going to kill her and that her sister-in-law was trying to take her children from her. She was brought to hospital from her home by the police as she was violent and combative. One month before admission she had complained of increasing fatigue and it was noted that she was anxious and irritable. Ten days before admission she had a tonsillectomy, adenoidectomy and cervical conization at a general hospital. Within three days of these operations she returned home and shortly afterwards she became delusional.

Review of her personal history showed no evidence of parental brutality. She slept in the same room as her parents till the age of five. There was no history of cruelty to animals but as a child she used to play with matches and once when she set some weeds on fire she thinks that a chicken coop might have been burned. There was no history of alcoholism or prior arrests.

At eighteen, three months after the birth of her first child, she expressed delusional ideas that her husband was trying to kill
her. She felt that her house was burning and claimed that she could hear the flames and smell the smoke. During her seven weeks in hospital she received electroshock therapy and she was given tranquilizing drugs which were continued for two months following her discharge from hospital. Two years later, two months after the birth of her second child, she became acutely agitated and delusional. She believed that her husband intended to poison her, that someone wanted to kidnap her children. She was treated with electroshock therapy, tranquilizing drugs and insulin therapy. She remained in the State Hospital for sixteen months. The diagnosis on all admissions was paranoid schizophrenia.

She was discharged from Colorado Psychiatric Hospital after one month against medical advice. Arrangements were made for her to continue on tranquilizing drugs and to see her therapist as an outpatient. Four weeks later she gave her two sons barbiturate drugs as she thought they would be better off dead. She had also planned to take her own life but became frightened and notified the sheriff of her actions. One child died and the other survived. At a subsequent trial she was found not guilty of murder by reason of insanity and was committed to the Colorado State Hospital where she was interviewed by the writer in 1967.

Patients Who Committed Suicide

Four patients committed suicide within five to six years
of their admission to hospital. Two were schizophrenic patients under 25 years of age and two were men over 65 years of age with organic brain disease. Hospital records show that 37 of the 100 patients either threatened or contemplated suicide at the time of the threat to kill but it is not known how many had a history of suicidal behavior.

Comment

In contrast to the three per cent incidence of homicide within five to six years of the admission of the 100 "threat to kill" patients to hospital, a study in Pennsylvania of 2,568 criminal homicide parolees over a twenty year period showed that only 13 or 0.5 per cent repeated this crime (1).

In contrast to the four per cent incidence of suicide within five to six years of admission to hospital, Pokorny, who followed up 615 suicidal Veterans Administration Hospital patients for a period of one month to 14\(\frac{1}{2}\) years averaging 4.6 years, found that 3.4 per cent had committed suicide (3).

Thus, seven per cent of the 100 patients admitted to hospital following homicidal threats are known to have taken their own lives or those of others in a five to six year period and the incidence may be higher as 23 patients have not yet been traced.

It should be noted that three of the four patients who later committed suicide and none of the three patients who later killed others, had made suicide attempts prior to admission to Colorado Psychiatric Hospital.
References


Addendum

Considerable difficulty was encountered in tracing some patients. One man was found with the aid of his minister of religion, to be serving with the U. S. Armed Forces in Viet Nam. Another man was finally located in a State Prison where he was serving a sentence under an assumed name.
CHAPTER 4

THE HOMICIDAL THREAT

The homicidal threat may be uttered succinctly or bombastically, seriously or in jest, in the heat of anger or in deceptive calm. A young soldier calmly informed another soldier that he was going to kill a non-commissioned officer. That day he shot and killed the N.C.O. He then returned to his barracks, where he related the full story after remarking "Mission accomplished, mind at ease." He told one soldier to notify his commanding officer and asked another to play the tune, "In the Jailhouse Now."

Another soldier, when informed that he was to be transferred to a mountain camp, where the living conditions were more rigorous, announced that he would kill himself or someone else first. He stated that he did not care about the consequences of such an action. Arrangements were being made to discharge him from the army when he shot and killed a man while stealing a car in which he had planned to go absent without leave.

In both these examples, the calm statement of intended murder was deceptive. In contrast the threat of murder in the heat of anger arouses a greater sense of alarm and urgency. This alarm may disappear quickly upon expression of remorse and reassurance that no harm was intended. These threats, however, should not be dismissed lightly.
Although the threat may be made in a quiet tone of voice, it may be uttered with such conviction that there is immediate apprehension. Concern is heightened when the threat made in this manner includes statements such as "I've developed a severe malicious killer hatred towards people" or "I know deep down someday I'm going to kill somebody like that guy in Texas." (The reference was to Whitman, the university student who killed 16 persons).

Criminals may resort to threats of bodily injury or death in order to obtain payment of illegal gambling debts or to enforce compliance with other demands. A sociopathic university student, who was admitted to hospital after he had threatened to kill his wife, was questioned about prior threats. He revealed that he had threatened to kill two former girl friends and also another student who had started to sell marihuana on the college campus, without taking much effort to avoid detection.

The patient was one of many students who smoked marihuana and used narcotic drugs. These students were concerned that the open sale of marihuana would quickly lead to an arrest with the risk of further arrests and a police "crackdown" on drug users. The patient was selected to play the role of enforcer. The drug "pusher" was kidnapped, taken to an artificial lake in an old quarry, where he was warned that if he did not leave town immediately, he would be thrown in the lake wearing "concrete shoes."
The patient had no intention whatever of fulfilling this threat which achieved its purpose.

The melodramatic threat by an hysterical personality conveys no message of doom, yet persons with this character disorder have been known to commit criminal homicide. An agitated but histrionic adolescent girl was brought to the hospital by her family who reported with considerable distress that she had pointed a loaded rifle at her father and threatened his life. Neither the girl nor her father mentioned the fact that the bolt was not in the rifle as father always kept the rifle bolt in a locked cabinet separate from the rifle.

The dramatic statement may be followed by tragedy. A young woman who talked about shooting her boy friend between the eyes and not "batting an eyelid," two months later shot him five times with fatal outcome.

The nature of the threat may provide a clue to the clinical diagnosis. A young paranoid schizophrenic man, while being held down, after making an unprovoked assault on his brother-in-law said to him "I need to kiss you Jesus. If I can get up I'll kill you."

Conditional threats may have lethal consequences. "If you ever leave me, I'll kill you" may lead to "If I can't have you I'll make sure no one else does." As promiscuous wives tend to remain promiscuous, the threat "If you ever step out on me again . . ."
may foreshadow tragedy. The husband who can neither live with his wife nor without her may resolve his dilemma through homicide.

Girls who spurn their suitors and wives who leave their husbands may be kidnapped and held at gun point under threat of death for many hours or even days. Police are often unable to rescue the victim because of the danger of the kidnapper fulfilling his threat before he can be disarmed.

Comments intended as jokes may have serious consequences for the joker. Airline employees, especially airline stewardesses, are inclined to take very seriously any comments about bombs by passengers. "Watch out, there's a bomb in this briefcase" said jokingly by a passenger who has had one or two drinks before boarding the plane may lead to cancellation of the flight, thorough search of the aircraft and arrest of the passenger by agents of the Federal Bureau of Investigation.

The threat may be made over the telephone and if the caller is a stranger, who does not identify himself, detection may be very difficult. When telephone calls are repeated frequently, it is possible for the telephone company to trace the source. Persons who telephone married women to make obscene remarks and demands for sexual intercourse under threat of death to the woman or their children, are usually, in the writer's experience, adolescent youths or young men, who live in the neighborhood of their victims.
The threat may be made directly to the intended victim or it may be made outside his hearing or presence. Frequently the person who makes the threat will deny ever having made it or will claim no recollection of the threat, adding perhaps "If my wife says I did, then I must have." A patient may have genuine amnesia for threats made while in a drunken state. It is important to record the actual words used. As time passes there is often a tendency on the part of those present at the time of the threat to deny its significance. This is especially true when threats are made in the family circle.

Threats may be readily acknowledged and indeed voiced once again in the presence of the physician. Threats repeated over many years tend to lose their ominous significance but the danger may remain. The threat to kill may occur in the form of physical assault or discharge of firearms. Not infrequently verbal threats are accompanied by physical assault.

The threat which is expressed in gesture, the hand drawn across the throat or clasped to some weapon has a melodramatic quality which may be misleading. A change in facial expression, "if looks could kill," sometimes conveys greater menace than the spoken word. The threat may be made in writing, stated clearly in an extortion note or perhaps disguised in the phantasy of a classroom essay. When a teacher asked the class to write a theme on a book, a 15 year old student wrote,
This book does not have a title, but it is the story of a boy who was fed up of living. His name, that doesn't matter. It's what he will do will shock you. One night when his parents went to bed, he got up from his bed, took his shotgun, loaded it and went quietly into their bedroom.

His mother and father were sleeping, he took aim, shot his father first, his mother screamed, he shot her. His smaller brother came running out of his room to see what was the matter, he fired again. What was the reason for this gruesome murder? What made him do it? He hated them. His life ambition was to get a car. They promised him one, but always fell down on their promises. This story is not fiction, although it sounds fantastic, it happened in my family.

That night the student went to his parents' room and wounded both with two shots.

Symbolic expression of the homicidal threat includes burning, firing bullets at, or sticking a pin in a picture of the intended victim. The husband who rips or burns clothing belonging to his wife or stabs her pillow repeatedly with a knife may be warning her of his homicidal anger toward her. A mother who stabbed a favorite childhood doll later attempted to kill her infant daughter. False confessions of murder may also betray homicidal inclinations. Clifford Allen pointed out the need for psychiatric examination after a young man made such a confession. His warning was disregarded. A few days later the young man stabbed a girl to death on Dartford Heath (1).

A person may be falsely accused of having made a serious threat to kill in order to secure his commitment to a mental hospital, as in the case of a mother who claimed that her son
threatened to kill her with a baseball bat. A home visit revealed that the baseball bat was a small light plastic child's bat which could serve no lethal purpose. Occasionally a patient will falsely claim that he made the threat with the sole purpose of ensuring his admission to hospital.

Reference

It would be difficult to obtain a group fully representative of persons who have committed criminal homicide. This crime is probably investigated with more thoroughness than lesser crimes. The Uniform Crime Reports for 1966 noted that police in the United States were successful in clearing by arrest a higher percentage of the criminal homicide cases than any other Crime Index offense.

However, the Reports also noted that 89 per cent of the criminal homicides in that year were solved (1). Some of the remaining 11 per cent of homicides may be solved later. Wolfgang, in a report on 6,435 criminal homicides in 18 U. S. cities with a population of over 250,000 during the years 1948-1952, found that 9.9 per cent of the homicides were not cleared by arrests (7). It is likely that some deaths are not recognized as being the result of criminal homicide, furthermore some homicide offenders commit suicide.

The difficulties in obtaining a representative group of persons who have threatened to kill are even greater. Although patients admitted to the Colorado Psychiatric Hospital following homicidal threats may not be representative of the threat to kill population, yet there may be some value in reviewing this segment of the threat-to-kill population.
Two groups of 100 consecutive "threat to kill" admissions to the Colorado Psychiatric Hospital have been studied. The first group, admitted in 1961 and 1962, not all of whom were examined by the writer, is described in Chapter 3. The second group was admitted between July 1, 1966 and June 30, 1967 and all members of this group were interviewed by the writer. With one exception all these patients made verbal homicidal threats within one month prior to their admission. One patient made the threat three months before his admission to the hospital.

Six patients denied having made any homicidal threats but in each case there was clear evidence to the contrary. In one case, the police perhaps anticipating an uncooperative attitude, brought with the patient, affidavits which had been made by witnesses of the homicidal threats. One of the six patients stated "I don't remember saying it. If my wife says I did, I must have said it."

Some patients initially admitted having made the homicidal threat but later denied having made any such threats. A woman who said she was going to feed her children carbon tetrachloride later said she was going to give them turpentine with sugar which she claimed was an old fashioned remedy that her mother used. Another patient, an intelligent non-psychotic man who made repeated verbal threats to kill his wife and who held at various times a loaded rifle and a knife at her, in the course of treatment casually
mentioned that he had never threatened his wife. Yet
previously he had described his threats at great length.

Stengel and Cook in their study of attempted suicide did
not aim at a statistical analysis of the data collected and
pointed out the doubtful value of an analysis of unrepresentative
samples. Nevertheless, these authors presented numerical
data to illustrate the character of the groups studied, but
kept the use of percentages to a minimum to avoid giving an impression
of scientific exactitude (6). The writer, in presenting statistics
on the two groups of 100 threat to kill patients, shares the
above viewpoint. Round figures will be given for subgroups.

These 100 patients, 87 males and 13 females included 95
Caucasians (13 Spanish Americans) and 5 Negroes. Seven patients
were admitted on civil court order and 93 were admitted
voluntarily. Although no patient was committed by a criminal
court, several sought admission as an alternative to the filing
of criminal charges. Their ages ranged from 12 to 58 years;
65 were between the ages of 20 and 40, and the mean age was 29.

Twenty-three of the 100 patients who threatened to kill
were psychotic and with two exceptions suffered from schizophrenia.
In the non-psychotic group of 77 patients the primary diagnosis
in the majority of the cases was character disorder. Frequently
features of more than one form of character disorder was present,
and some patients also had acute neurosis or alcoholism. The
diagnoses are listed in Table 3.
There are fewer psychotic patients, particularly patients with chronic organic brain syndrome, more voluntary admissions, more patients between 20 and 40 years of age, and more patients with character disorders, particularly sociopathic personalities than in the 1961-1962 group. The reduction in number of elderly patients with organic brain disease and the increase in voluntary admissions between 1962 and 1966 was not confined to threat-to-kill admissions. In the fiscal year 1961-1962, 38 per cent of all patients were admitted on court order in comparison with eight per cent in the fiscal year 1966-1967. The increase in patients with severe character disorders may reflect the availability in 1966 and 1967 of beds on the special "threat to kill" ward. Patients with severe character disorders are often referred to the outpatient department or other hospitals when there are few beds available for the many patients seeking admission to the hospital.
Social Class

Hollingshead's Two Factor Index of Social Position (occupation and education) was used to determine the social position of those who threatened to kill and their parents (3). The parents resided in many parts of the United States and the patients lived in Colorado with few exceptions. Samples of these populations are not available for comparison. Hollingshead and Redlich in their study Social Class and Mental Illness utilized ecological area of residence as well as occupation and education to determine the social class status of samples of persons living in the urbanized community of New Haven, Connecticut (4). This area probably includes a larger number of persons in social classes 4 and 5 than Colorado. Use of their figures for comparison has obvious limitations.

TABLE 4

Social Class (Population per cent)

<table>
<thead>
<tr>
<th>Class</th>
<th>Psychiatric Patients New Haven</th>
<th>Non-patients New Haven</th>
<th>Threat to Kill Patients</th>
<th>Their Parents</th>
</tr>
</thead>
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<td>Class I</td>
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<td>3.0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Class II</td>
<td>7.0</td>
<td>8.4</td>
<td>3</td>
<td>3</td>
</tr>
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<td>Class III</td>
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<td>20.4</td>
<td>14</td>
<td>18</td>
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<td>Class IV</td>
<td>40.1</td>
<td>49.8</td>
<td>37</td>
<td>31</td>
</tr>
<tr>
<td>Class V</td>
<td>38.2</td>
<td>18.4</td>
<td>43</td>
<td>45</td>
</tr>
</tbody>
</table>

n= 1891 236,940 100 100
Recent Stresses

All patients were questioned regarding recent deaths of relatives or close friends, separation from marital partners or threat of separation, marital infidelity or suspicion of infidelity, and job loss or business failure. One in two of the 38 non-psychotic husbands, who had threatened to kill their wives, reported that their wives had left them or had threatened to leave them. Four out of ten of these husbands reported or suspected infidelity on the part of their wives.

Only six patients reported deaths of close friends or relatives. More than four out of ten of the 74 adult males had either lost their jobs or suffered business failure. Less than half the men who reported job loss or business failure had a poor work record.

Alcohol and Alcoholism

Six out of ten adult non-psychotic males and six out of ten adult non-psychotic females had been drinking alcohol prior to making the threat to kill. None of the 17 adult psychotic males and four of the five adult psychotic females had been drinking alcohol prior to the threat to kill.

One out of two adult non-psychotic patients had a history of excessive drinking which interfered with his social life or work record. Almost one out of four adult psychotic patients had such a history. (Patients 18 years of age and over have been classified as adults.)
Plans for Homicide

More than one in four of the patients stated that they had not considered what method they might have used if they had proceeded with their threats. Approximately one in four patients mentioned firearms. Another one in four of the patients had contemplated using knives. Other methods which had been considered included physical assault (14) automobile (3) poison (2) and acid (1). One patient said that he had thought of hiring "junkies" (drug addicts) to carry out his homicidal threats.

Fifty-one patients owned a total of 88 firearms. According to the Harris Survey, 27 million white Americans, representing 54 per cent of the nation's homes, own guns. In the Western region of the United States, 59 per cent of the homes were represented (2).

Danger of Homicide

The majority of patients were confident that there was no danger of their having fulfilled their homicidal threats. "I would never have carried it out." "I didn't mean it, I just wanted to scare her." "I could never do it." One patient who had prepared a drink containing carbon tetrachloride for his wife said that his verbal threat to kill was "just an empty threat."

Two patients stated emphatically that homicide was only prevented by the intervention of others. Others gave indefinite
answers such as "yes and no", "I definitely had malice toward her at the time," "There might have been a danger". Several patients expressed concern about the danger of committing homicide in the future. "I'm afraid someday I will kill someone," "There's always the danger under the right circumstances." "If I catch her with some man, I don't know what I'd do." One patient thought there was a danger of future homicide but added that he was not concerned about this.

Some of these evaluations were considered to be very unreliable guides to dangerousness. Thus an adolescent youth stated "If I'd choked her a little more, I would have done the job," yet the attempt was not very effective and was made in the presence of other family members. Although he was somewhat impulsive the clinical examination suggested very slight danger of homicide. A patient with obsessional personality was much concerned about the risk of homicide yet clinical examination suggested slight risk.

Coping Behavior

The patients were questioned regarding their behavior when they wished to avoid quarrels or fights. More than one in two patients said they would "walk away, just get out, take off." Some would stay away from people until their anger had subsided. They would seclude themselves in a room and watch television, or read a book, go for a drive in the car, or take a walk. One patient used to walk as much as five miles. Physical activity included working in the
garden or hobby room. One man would pray. Others sought company, usually in a tavern. Food, alcohol and drugs were used to relieve tension.

Some patients would meekly give in to avoid arguments. "I usually agree with a person, say he was right, I was wrong, apologize." "I like you, what's wrong, let's be friends, I know I'm wrong." One patient turned his anger from his wife on to himself by putting his arm through a window. "I took a swing at it rather than hit her." Another patient said that he used to get out of fights by carrying some kind of weapon. However, one time he shot a man in the hand during an argument. "So then I shot myself through the hand as a way of saying I'm sorry."

Other forms of coping behavior included some of the coping devices described by Menninger (5): - Laughing, crying and cursing - "I would crack jokes": Talking out - "I get a hold of friends and talk", "I talk it out: Thinking through - "First thing I ask myself why? I try to understand it from more dimensions." "I pull a Ben Franklin shot, the pros and cons. I try to be as rational as possible."

Coping behavior in response to hostile impulses included the use of mechanisms of defense such as repression, denial, displacement, reaction formation, rationalization, introjection, isolation, projection and sublimation. It is of interest that one patient who had very sadistic phantasies was employed as a mortician and formerly had studied theology.
Prior to the threat to kill there would be horrifying dreams or nightmares in which a beloved relative would be killed or injured. Fears would be expressed regarding the risk of a husband dying in a train or aeroplane disaster. Other persons might be accused of planning to murder, kidnap or otherwise harm the very person who would later be threatened with death by the patient. Unexpected kindness or lavish gifts occasionally preceded the homicidal threat. A psychotic patient shortly before threatening to kill his neighbor, cut down a tree in his property as he feared it might be blown over in a storm and damage the neighbor's home. Yet the tree was a considerable distance from the home.

In the description of the 1961-1962 group of 100 patients who had made homicidal threats the writer reported that problems in expression of hostility were prominent in both psychotic and non-psychotic patients. Some patients showed sadistic behavior throughout their lives and the threat to kill seemed to be an inevitable part of the total clinical picture. They boasted of their sadistic exploits and took pleasure in describing their hunting triumphs and their skill in karate or judo. One man derived satisfaction from telling his wife again and again of an incident in which he assisted in the birth of a calf by hitching the cow to a post and tying a rope from the presenting legs of the calf to his tractor. He gunned the motor and eviscerated the cow.
Other patients showed free expression of hostile impulses yet their behavior could not be described as sadistic. Sensitive to criticism and quick to anger they would not hesitate to respond verbally or physically when provoked. At the opposite end of the aggressive spectrum were passive-aggressive and passive-dependent personalities who had difficulty in directly expressing their hostility. In these patients, threats to kill and physical violence stood in contrast to their usual behavior. Sadistic impulses found infrequent expression and the defenses against these impulses were conspicuous.

Thus persons capable of sadistic acts would speak of their abhorrence of blood and war, their distress over war time atrocities and their aversion to TV programs of murderous violence. In this group were two nurses, a former missionary, a minister of religion, and a member of a humane society. Some gave up hunting because of their distress over the kill. The juxtaposition of great solicitude for the welfare of others and threats of homicide was not confined to any single diagnostic category but the contrast in those patients with hysterical character traits was heightened by the dramatic expression of feeling in either direction. Such threats were sometimes acknowledged to be appeals for help.

In the 1961-1962 study four of the 25 married women under the age of 40 were pregnant when they threatened to kill and a fifth had recently delivered a child. The pregnant mothers all threatened
to kill their husbands and three of them also threatened to kill their children. Strong negative feelings over the pregnancy were either freely admitted or suggested by depression in previous pregnancies or attempted abortion. Two mothers who were not pregnant threatened to kill persons who had made disparaging remarks about one of their children and a third threatened to kill her husband because he showed little concern over the illness of his stepson. In each case the mother herself, despite protestations to the contrary, showed evidence of great hostility toward her child.

Prior Homicidal Threats

Fifty-two patients had made prior homicidal threats. Twenty-seven of these patients had previously threatened the same person that they threatened prior to admission to hospital. Thirteen patients, on separate occasions, had made five or more homicidal threats. One wife who was threatened by her husband said that he had also threatened to kill her 22 years earlier.

Prior Homicides

Two patients stated that they had been responsible for the deaths of others. Both these patients were sociopathic personalities and if these statements are true, their acts were regarded as justifiable homicide by the legal authorities. One, while in the armed services, shot and killed a civilian who attempted to break into an overseas service base. The other,
as the leader of a prison camp guard search patrol, discovered five prisoners, who had escaped, hiding in a cave. When he asked them to come out, they refused with obscene comments, and he threw a grenade into the cave, killing all the prisoners. He claimed that at a court martial he was "cleared but advised that it would have been better to use handarms."

**Parental Threats to Kill**

Ten patients had overheard a parent making homicidal threats and five of these patients were threatened with death by a parent. One patient stated that his stepfather when drunk would threaten to kill all his family and he would try to shoot the heels off his wife's shoes. Another patient reported "Oh, my father went berserk down in the basement, shooting high powered rifles when she (stepmother) threatened to leave him. She got tired of his beating her. He was threatening to shoot everyone. The cops took him to jail. When my biggest sister was 16, he tried to rape her, tried to kill her with a pillow, hit her, broke her jaw." A third patient recalled being taken by her mother to a police station after her father escaped from a mental hospital and telephoned to say that he was going to kill his wife and children.

**Arrests and Assaultive Behavior**

Fifty-six patients had a history of arrests by the police and 20 had been arrested for assaultive behavior. Twenty-three
assaulted their victims at the time of the threat to kill. Another 13 patients had previously assaulted persons they had threatened to kill. These assaults included forcible abduction, choking, beating with a rubber hose, striking the victim with a closed fist and cutting a person on the face with a knife. One patient attempted to force his wife's car off the road. Two patients fired rifles at their victims but did not injure them. One of these patients was charged with a misdemeanor—discharging a firearm within the city limits. The other patient, who fired at a State Highway patrolman as well as at his wife, whom he had threatened to kill was not charged with these offenses. No victim was seriously injured although one wife, who was badly beaten, suffered a broken nose and other injuries which required treatment in hospital.

**Attempted Suicide**

Forty-six patients gave a history of attempted suicide. Eight patients attempted suicide at the time of the homicidal threats. Five patients took drugs, one cut his wrist, one walked in front of a car and one shot himself in the face. A ninth patient shot himself in the abdomen, four days after the homicidal threat. He had threatened to shoot his brother if the brother told his parents that he had been thinking of shooting himself after an argument with his girl friend. Another patient drank "by mistake" carbon tetrachloride, which he had placed in a drink which he had prepared for his wife.
Treatment in an intensive therapy unit in a general hospital resulted in recovery but with evidence of liver damage. This was probably a suicide attempt but has not been so classified.

Twenty-one patients either made suicidal threats or had suicidal ideas at the time of the homicidal threat. Thus thirty patients either had suicidal ideas, expressed suicidal threats or attempted suicide at the time of or shortly after the homicidal threats. Another patient refused to answer a question regarding suicidal ideas at the time of the threat.

References


CHAPTER 6

THOSE WHO WERE THREATENED

The victim of criminal homicide is often a relative or friend of the slayer. Svalastoga, in a study of 172 Danish murderers, found that of every ten murderers, six selected victims among members of their own family, three selected victims among acquaintances and one selected as victim a stranger (4). In this study, of every ten patients, eight threatened members of their own families, and two threatened friends or acquaintances. The only strangers threatened were police officers called to the scene of the original threat and the relatives of one acquaintance.

In contrast, in the United States in 1966, killings within the family made up 29 per cent of all criminal homicides. (In the Western States which include Colorado, killings within the family made up 34 per cent of all criminal homicides in 1966). In the United States in 1966 other killings included romantic triangles and lover's quarrels eight per cent, arguments (most frequently involving acquaintances) 41 per cent, felony or suspected felony homicide 22 per cent. Felony homicide is defined as those killings resulting from robberies, sex motives, gangland slayings and other felonious activities (2).

The 20 patients in the present study who did not threaten family members threatened sex rivals (6), girl friends (4),
acquaintances (4), guardians (2), homosexual partners (2), strangers (1) and friends (1). Policemen called to the scene were also threatened by one patient. The other 80 patients also threatened police officers (1) and a sex rival (1).

Family Members as Victims

In Wolfgang's study of 588 criminal homicides in Philadelphia, 126 victims had a familial relationship to their slayers. There were 100 marital partners, 17 children, four siblings, three mothers and two fathers (5). McKnight and associates studied 100 male patients in a maximum security hospital in Ontario, Canada, who had killed 110 victims and wounded a further 26. They found that 67 victims had a family relationship to the offender (3).

In 1966 in the United States over one half of killings within the family involved spouse killing spouse and 15 per cent parents killing their children (2). In the two threat-to-kill groups, marital partners and children were the most frequent victims of homicidal threats within the family.

TABLE 5
Family Members as Victims

<table>
<thead>
<tr>
<th>Victims</th>
<th>Threat to Kill Patients</th>
<th>Homicide Offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Marital partners</td>
<td>51</td>
<td>52</td>
</tr>
<tr>
<td>2. Children</td>
<td>36</td>
<td>15</td>
</tr>
<tr>
<td>3. Mothers</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>4. Siblings</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>5. Fathers</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>6. Other relatives</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Total Victims</td>
<td>116</td>
<td>104</td>
</tr>
</tbody>
</table>
The Role of the Victim

A victim of criminal homicide may contribute in large measure to his own death. In 26 per cent of the 588 criminal homicides reported by Wolfgang, the victim was the first to show and use a deadly weapon, to strike a blow in an altercation— in short the first to commence the interplay of resort to physical violence (5). The incidence of these victim-precipitated homicides, as defined above, was even higher in a more recent study in Baltimore. Thirty-two per cent, 187 of 578 criminal homicides, were victim precipitated (1).

None of the victims (recipients of homicidal threats) in the 1966-67 group were the first to show and use a deadly weapon or strike a blow at the time of the threat. Four victims had, however, previously threatened to kill the patients who later threatened them. A man telephoned one of the patients in this study saying "If you don't come out right away, I'm going to take your wife from you. I'm going to take her if you don't do something tonight. But you'd better come careful. I've got a 45 (pistol) over here. I'll put a slug right between your eyes." The patient later threatened to kill this man. Three wives had previously threatened to kill their husbands. Another wife, two years before she was threatened by her husband, told him twice during arguments that it took all she could do to keep from picking up a gun and shooting him and then herself.
Another patient, a miner, was convinced that the sex rival he threatened to kill had previously attempted to kill him. Some days after he had seen this man alongside his car, he discovered under his car seat 25 blasting caps, which could be set off by changes in temperature such as might result from use of the car heater.

Three victims had assaulted patients on some occasion prior to the homicidal threat. One victim assaulted his homosexual partner, fracturing his nose and cutting his finger. A female victim gave her boyfriend a black eye during an argument. Another female victim, who suspected her husband of infidelity, burned him on the arm and forearm with a hot iron. "She was jealous, thought I took off with another woman. I went to a friend's house, then went home to bed. She got home an hour later. She heated up the iron, wasn't going to iron no clothes. I guess she figured there'd be an argument." This wife, during a temporary separation, telephoned her husband to say that she had bought a gun to kill him and that she would hire detectives to find him. Another time she threatened him with a butcher knife.

Other patients were assaulted by the victims following the homicidal threat. A youth was badly beaten by his father, and one husband described an assault by his wife. "She scratched me quite a bit and broke a broom handle over my head. I was a
mess. She half scared me to death." A wife pointed a loaded gun at her husband after he had threatened her. When her husband attempted to take the gun from her, the gun discharged but no one was injured. Further clinical examples will not be confined to the 1966-1967 group of patients who made homicidal threats.

Words and looks can wound as well as blows and bullets. Some of the victims acted in a very provocative manner indeed. Harsh, unmerciful comments would be continued long after they had aroused very great distress or anger. Who should be labelled as the aggressor in these circumstances? Some persons seem drawn to death by violence, not merely by an injudicious word or gesture at an inopportune moment but rather through a persisting pattern of sado-masochistic behavior. They may be homicide-victim prone as others are accident prone.

A thirty-one year old man asked his girl friend if she loved him. When she replied, "If you don't know now, you never will," he struck her on the back of her head, knocking her down, then he shot her in the head, in each hand and in the right shoulder. He then dragged her into the bathroom and tried to drown her. She fought her way out of the bathroom and he pulled her into the bedroom where he tried to smother her. Charges of assault to murder were withdrawn after his girl friend married him and refused to testify against him. One month prior to the assault a brother of the assailant had murdered his wife.
Some wives provoked their husbands by their domineering and rejecting behavior. One wife persuaded her reluctant husband to undergo vasectomy and shortly after sued for divorce. Other wives provoked their husbands by refusing to speak to them. Some wives of dependent alcoholic husbands would reveal that a previous marriage or marriages had also been to brutal alcoholic husbands. Beatings would be tolerated with surprising lack of complaint. One wife left her husband and obtained color photographs of her bodily injuries to aid in her suit for divorce, only to rejoin her husband after a brief separation. After a particularly severe beating, the wife may take legal action against her husband, but within a short time assault charges are withdrawn.

Many husbands acted in a very provocative manner themselves by excessive drinking, irresponsible behavior, and infidelity. Yet it was striking to see during visits to the ward, frank demonstration by the wives of behavior which could only cause further trouble. One wife on leaving the ward at the end of a visit, in a voice that could be heard throughout the day room said "I may come up tomorrow, I may not, don't count on it." The tone of her voice added a peculiarly insulting quality to the remark.

One wife complained that she wanted to be a wife and not a mother, yet she and some other wives seemed to prefer dependent men as husbands. Another wife sent her husband a "get well" card
while he was in hospital. On the outside of the card was the picture of a baby with a bandage around his jaw as if he had a painful tooth. On the inside of the card under the caption "Back to your old tricks" was the picture of a grown man leaning on a bar with a drink in his hand.

Some wives provoked their husbands by flirtatious or promiscuous behavior. Wives of jealous husbands would dress in a very revealing manner and flirt openly with casual acquaintances. The wife of one patient had sexual relations with another threat to kill patient she had met on a visit to the ward. She quickly revealed this fact to her husband. Another wife would provoke her husband by telling him about men she had slept with. One young woman during a separation from her husband charged to his drug store account the purchase of birth control pills.

Some wives sought employment in taverns as cocktail waitresses despite strenuous objections by their husbands. One such wife was instructed by the tavern owner to be "extra friendly" to customers and not to reveal that she was married. She further enraged her husband by wearing a very immodest uniform. On her first night she returned home two hours after the tavern closed and when he called her a whore an argument followed which was terminated by his attempting to smother her, then knocking her unconscious with a blow on the chin.
A wife who had suffered repeated beatings and homicidal threats, kept on display in her living room a gift from a man she had lived with while separated from her husband. This incensed her husband, yet it was only on the writer's insistence that she agreed to get rid of the gift. On their next visit to her mother, the husband discovered the gift on the mantelpiece. Following one threat with a loaded shotgun his wife said "Go ahead, you might just as well kill me." Whenever the husband announced his intention of selling the shotgun, his wife would insist on his keeping it.

Other wives responded to production of firearms during an argument with provocative comments such as "What are you going to do, big man, kill me?" and "You haven't got the guts to kill me." A man who was threatened by his homosexual partner who held a knife at his throat said "I dare you, I think you're chicken." A very vain girl friend did not say "Don't shoot me," but "Don't shoot me in the face." Her boy friend altered his aim and shot her in the chest. She died as her boy friend was driving her to a hospital.

How different the response of a child when his severely depressed mother said she was going to kill him, "Oh no, momma, I know you wouldn't do that." A daughter overhearing father beating mother, came between her parents. Her mother said, "Never mind, honey, let him kill me." After she left the home to seek help, her
father obtained his revolver from another room and killed his wife. A mother threatened by her daughter responded angrily, "We'll see who kills who first."

Wives were not the only victims who provoked the patients. A mother who had placed her home on sale, insisted that her two sons leave the home all afternoon while the realtor waited in it for prospective purchasers. It was a cold windy afternoon and she offered to take one son with her in the car for a drive but refused to take her other son. Another mother told her son "Go around in front of the car" after he threatened to commit suicide. Later that evening her son took some pills in a suicide attempt. When he told his parents, he was instructed to go to bed. His parents continued to watch television. Yet another mother refused to allow her son to bring his fiance into the house.

A youth told another youth that his girl friend was a whore. An employer constantly criticized a young man in the hearing of customers. In some cases the provocation was slight, as for example, argument over the use of bathroom or kitchen facilities. Usually in such instances there was evidence of long continued underlying resentment.

Reluctance of Victims to Seek Help

The reluctance of some relatives to seek advice or protection was remarkable. A police report which accompanied one young
man to the hospital noted that the man had told a casual girl friend that he wanted to kill someone. She thought he needed help and decided to try to help him. Even though he informed her that he could kill her and enjoy doing it, she continued to see him. She did not seek help until after he had assaulted her by choking her. Shortly before she filed charges against him, he had threatened to kill another girl with a broken bottle.

The following examples are drawn from the 1961-62 study. A man with many bizarre paranoid delusions repeatedly threatened to kill his wife and over a two week period spent much time sharpening three knives. His wife revealed this information only after her husband threatened to kill his surgeon. Another wife, who always slept with "one eye open" because of her husband's homicidal threats, agreed to obtain a court order for psychiatric examination only because the police threatened to jail her husband if she did not do so. The police were concerned over the welfare of two young daughters who had been sleeping at night in the family station wagon because of fear of their father.

An elderly man with chronic brain syndrome and paranoid delusions that his life was in danger had for two years been sleeping at night in his barn with a dog and two loaded weapons at his side. He threatened to kill a neighbor and during the two years made many threats to kill his family. One night he hit his wife in the face and pulled her around the barnyard by her hair. No effort was
made to admit him to the hospital until he attacked his wife with a fence post. The family were reluctant to agree to continued hospital care and following his discharge from another hospital, they wrote requesting that he should be allowed to have his guns back.

A young paranoid schizophrenic, who had previously been treated with electroshock therapy, beat his father unconscious following an argument. After the assault his behavior was bizarre and he told his mother he had a castration complex. Several months later when his mother asked him to mow the lawn he said, "Do you want to die, because you are going to die?" He then choked his mother till she fell to the floor. She did not reveal this attack to her husband as she wanted to "preserve the peace." A month later he again attacked his mother and was choking her when someone intervened. Following this incident he was admitted to the hospital.

Delay in seeking help was not confined to relatives. A demented old man who lived in a shack with 26 dogs and 58 cats threatened health officials with a loaded shotgun several times during a three month period. Another senile, not in this series, called at a police station with a loaded shotgun and stated that he intended to shoot his imagined persecutors. The police removed the shotgun shells, returned his shotgun to him and sent him on his way. He was arrested shortly afterwards following a threat to kill.
Relatives who recognized their danger were often at a loss to explain their failure to seek help. One wife calmly remarked, "Some day he'll kill me." Several wives were reluctant to seek divorce because of their fear of homicide. They lacked confidence in the protection provided by society. Court orders restraining a husband from visiting his wife can be violated and police are seldom able to provide adequate protection. Newspapers contain frequent accounts of murder by husbands under restraining orders. Commitment to jail or mental hospital may provide only temporary security because of the risk of early release. Paranoid patients are often skilled at concealing their symptoms and they may avoid commitment by impressing a lay jury or they may obtain premature release from a hospital.

The reluctance of persons to take action through fear of retaliation is not surprising. However, many recipients of threats to kill do not appreciate their danger. The reaction of denial extends to physicians and others who are consulted. Review of the case records in the present study revealed that some threats to kill were not mentioned in the summary of the medical record. In not a few cases the only reference to the threat was contained in the notes recorded by the physician on admission duty. In other cases the threat was mentioned but discounted and in one case little credence was given to the statement of reliable informants.
References


CHAPTER 7

RESEARCH ON SOME POTENTIAL PREDICTORS OF HOMICIDE

Contributions by psychiatrists on prediction of homicide have been based upon clinical impressions and anecdotal material rather than upon statistically controlled clinical studies. Predictive factors which have been suggested include the intensity of the aggressive drive, assaultive behavior, sadism, alcoholism, latent homosexuality and paranoid delusions. The writer had the clinical impression, derived from psychiatric examination of criminal homicide offenders, that parental brutality, parental seduction, childhood firesetting and cruelty to animals were unfavorable prognostic factors in those who threaten homicide (10, 11). Firesetting and cruelty to animals are sometimes accompanied by the third member of the triad, enuresis.

In order to test the hypothesis that the incidence of parental brutality, parental seduction and childhood firesetting, cruelty to animals and enuresis is significantly higher in persons who have committed criminal homicide than in persons who have made homicidal threats, three groups of persons were selected for study. The incidence of these and four other potential predictors of homicide was examined among three groups--hospital patients who had made homicidal threats, convicted criminal homicide offenders, and a control group of hospital patients who...
had no history of homicidal behavior. The nine factors will be reviewed briefly.

1. Parental Brutality

Parental brutality not only generates aggression in the child but also provides a model for future behavior. Satten and associates in a study of murder without apparent motive examined four men convicted of bizarre, apparently senseless murders. In the historical background of all cases was the occurrence of extreme parental violence during childhood (15). Duncan and associates found that among six prisoners convicted of first degree murder, remorseless physical brutality at the hands of the parents had been a constant experience for four of them. Brutality far beyond all the excuses of discipline had been perpetrated on them; often, it was so extreme as to compel neighbors to intercede for the boy.

One father held up his nude little boy by the heels, belted him, then dropped him on his head to the floor. Recurrently some prisoners, when children, had been flung bodily across the room. Only by chance were some of them not fatally injured. The authors state that although such violence was a common factor in the four cases, it should not be concluded that violence is the major factor in the etiology of murder. Imitation and identification with violent parents, however, constituted the commonest pattern found (3).
The findings of extreme parental brutality in these two studies were not corroborated by the data of Weiss and associates in their examination of 13 "sudden murderers." The "sudden murderer" was defined as a person who, without having been involved in any previous serious aggressive antisocial acts, suddenly, unlawfully, and intentionally kills (or makes a serious attempt to kill) another human being (20).

2. Parental Seduction

Parental seduction may arouse in the child of the opposite sex great anxiety and hostility which may find later expression in murderous attacks on the parent or substitute victim. Parental behavior may have a seductive effect even though it is not intended. Infantilization of the child, for example, may involve continuation of bathing by the mother into late adolescence.

Eason and Steinhilber reported that among seven children and adolescents who showed murderous aggression, lack of privacy, physical overcloseness and, at times, the grossest seduction were repeatedly found. The mother of one thirteen year old boy, for five or six years had been in the habit of getting into bed with the boy and, face to face with him, massaging his back. The grandmother of a sixteen year old boy continued to sleep with him. The mother of another thirteen year old boy gave him details of her first intercourse and her feelings during the intercourse when his sister was conceived. Whenever he asked if he could have
intercourse with her, her standard answer was "Yes, but it would be horrible" (4).

3. **Firesetting**

Fire is universally linked with aggression (the angry man "smoulders", "breathes fire", or shoots his adversary "down in flames"), excited ambition ("setting the world on fire"), and sexual readiness (the loved one "fans the flames of passion" and sets one "afire with desire") (13). Fenichel has commented on the sadistic drives and vindictive impulses of firesetters (5).

Bender noted compulsive fire setting as a feature of children and adolescents who have killed. Death was caused by fires set by six children. These were all evidently unintentional deaths. Among the 27 children who caused death by some other means than fire, there were eight who were compulsive firesetters (1).

4. **Cruelty to Animals**

In childhood, sadism often shows itself in cruelty to animals. Some Murderers give a history of great cruelty to animals. Margaret Mead has discussed the tabus about killing and torturing living creatures. In her opinion in many parts of the present day world these tabus are no longer reliable. Parents no longer can teach, without conscious thought, by their admonitions, looks of horror or repulsion, quick slaps and retaliations, the difference between murder and permitted self-
protection or patriotic defense. She believes that all child therapists should watch for any record of killing or torturing a living thing. Such children, in her opinion, could be helped instead of being allowed to embark on a long career of episodic violence and murder. (12).

5. **Enuresis**

Hellman and Blackman compared the incidence of enuresis, firesetting and cruelty to animals in two groups of prisoners, all consecutive admissions to a Social Maladjustment Unit. The first group consisted of persons charged with aggressive violent crimes against the person. These crimes included murder, serious assaults, armed robbery and forcible rape. The second group consisted of persons charged with misdemeanors and relatively non-aggressive felonies such as burglary, child molestation, stealing, car theft and forgery.

Twenty-one of 31 patients charged with aggressive crimes and 15 of the 53 charged with non-aggressive crimes had a history of enuresis. The authors postulate that the presence of the triad of enuresis, firesetting and cruelty to animals in the child may be of pathognomonic importance in predicting violent and antisocial behavior (8).

6. **Police Arrest Record**

The general impression that persons who commit criminal homicide are usually first offenders has been questioned by
Wolfgang who found that 64.4 per cent of 621 homicide offenders had a previous arrest record. Fifty-three per cent of his 154 white homicide offenders had a previous arrest record (22).

7. Arrests for Assault

Poorly controlled anger with assaultive behavior may well be an unfavorable factor in those who threaten to kill. Sixty-six per cent of the 400 homicide offenders with a previous arrest record in Wolfgang's study had been arrested for offenses against the person (aggravated assault).

8. Alcoholism

Alcohol impairs self-control and homicide is commonly associated with drinking. Fifty-eight per cent of 449 male homicide offenders in Philadelphia had been drinking prior to the offense (22). Although Shupe's study is based upon only 30 persons arrested for murder in Columbus, Ohio, the urine alcohol concentration was measured in all cases immediately after commission of the crime. It was found that only 17 per cent of the offenders had no alcohol in their urine (17).

9. Attempted Suicide

Freud stated that no neurotic has thoughts of suicide who has not turned back towards himself murderous impulses against others (6). The intimate relationship between murder and suicide is illustrated by the finding in England that between 1952 and 1960 one-third of all murderers committed suicide (7). Suicide
following criminal homicide is less frequent in the United States. A study of criminal homicide in Baltimore for the years 1960 to 1964 showed that less than three per cent of 626 homicide offenders committed suicide after the homicide (2).

Wolfgang found that in Philadelphia less than four per cent of those who commit criminal homicide kill themselves. Although whites are one-fourth of all his offenders, they significantly make up half of the homicide-suicides. Less than eight per cent of his white homicide offenders committed suicide (22). It will be recalled that four per cent of the first threat to kill group later committed suicide. None of the three patients who later committed homicide had attempted suicide prior to hospitalization.

The Three Groups

The first group, psychiatric hospital patients who had made homicidal threats, was drawn from 80 consecutive threat-to-kill admissions to the Colorado Psychiatric Hospital. All these patients had been admitted after July 1, 1966 and all had made verbal threats within the month preceding their admission.

The second group, convicted criminal homicide offenders, was drawn from 192 homicide offenders in the Colorado State Penitentiary at Canon City, Colorado. This is the only penitentiary in Colorado and it includes a building outside the walls for female offenders.
The third group, the control group, was drawn from psychiatric patients admitted to the psychiatric wards of a Veterans Administration Hospital for reasons other than suicidal or homicidal ideas, threats or attempts. No V.A. patient had a history of threatening or attempting homicide. The original intention was to draw the control group from patients admitted to the Colorado Psychiatric Hospital but difficulty was encountered in obtaining a sufficient number of patients who met the necessary criteria.

Homicide threat-homicide offender pairs were matched according to race, sex, age within a decade of the age at the time of the homicide, freedom from psychosis, and social class of the parents on the Hollingshead two factor index of social position (9). Occupation and education are the two factors utilized to determine social position. Because of differences in the incidence of criminal homicide and in child rearing practices among various social classes, parental social class was chosen as one of the criteria. The same offender-victim relationship was required although no distinction was made between marital partners and heterosexual friends as victims. Patients and offenders examined by the writer prior to this study were excluded.

It was possible to match 20 homicide threat-homicide offender pairs according to these criteria. As the majority of the patients were non-Spanish-American Caucasians and as many of the
homicide offenders were Negroes or Spanish-Americans, a substantial number of homicide offenders were ineligible on this criterion alone.

The control group patients were matched with the threat-to-kill patients on race, sex, freedom from psychosis and parental social class. Their age at the time of admission to hospital was within a decade of the matching threat to kill patient. When a choice had to be made in matching subjects (i.e. more than one matching subject available) the one closer in age was chosen.

The mean age in the threat-to-kill group was 31 years, six months, in the homicide-offender group 32 years, and in the control group 37 years, nine months. Each group included three Spanish-Americans, one Negro and one female. Use of the Hollingshead two factor index of social position places a subject in one of five social classes ranging from I, the highest, to V, the lowest. In each group of 20 subjects, two were in Class III, three in Class IV, and 15 in Class V.

Character disorders and alcoholism were prominent in all three groups, but the control group included more patients with psychoneurosis.

**Design of the Interview**

The writer interviewed all the persons in this study, and was aware prior to the interview whether the person was a threat-to-kill patient, a homicide offender or a control group patient.
In order to avoid possibility of bias, it would have been preferable for the interviewer to have had no such prior knowledge. Spontaneous comments by the subject might have made "blind study" difficult. This could have been avoided by prior instructions to the subject and the use of a highly structured formal interview. This procedure would have had the disadvantage of possible failure to elicit information because of reduced rapport resulting from the formal structure of the interview.

Furthermore, it would have been prohibitively expensive, if not impossible, to arrange the transfer under guard of homicide offenders from the penitentiary at Canon City to Denver, a distance of 110 miles. There was some structure to the interviews. At the beginning of the interview its purpose was explained briefly and an opportunity was provided for the subject to ask questions. During this preliminary stage and throughout the interview effort was made to establish rapport.

Threat-to-kill patients were informed that the writer had the permission of their physicians to talk to them and that he was making a study of persons who made threats. It was explained that many patients made such threats. Control group patients were also informed the writer had the permission of their physicians to interview them. It was explained that for research purposes it was necessary to interview a group of patients in a Veterans Administration Hospital in order to complete a study on a group of patients in the Colorado Psychiatric Hospital.
In both hospitals the writer was introduced to the patient either by a nurse or physician and the interviews were conducted in an office without anyone else present. All eligible patients agreed to be interviewed. One control group patient who refused interview was later found to be ineligible for matching purposes. Reassurance was given regarding confidentiality.

More difficulty was anticipated at the Colorado State Penitentiary. Homicide offenders were requested without prior explanation to report to the desk sergeant's office. The writer either introduced himself or was introduced to the offender by the associate warden's clerk, who was also a homicide offender. Some offenders appeared to have no knowledge of the writer's presence at the penitentiary, others had been informed over the prison "grapevine". Interviews were conducted in an office without anyone else present and none of the offenders were under any form of physical restraint.

Subjects were informed that the writer had the permission of the warden to speak to them but that the content of the interviews would not be revealed to penitentiary officials, the parole board or others. Any information which might be published, would be mainly in the form of statistics and no names and no information which could identify the subject would be used without his specific permission. It was also explained that the writer
was interviewing patients at Colorado Psychiatric Hospital who had made threats to kill and one of the purposes of the study was to help persons who made such threats.

One offender refused to respond without the written consent of his attorney. This consent was obtained without difficulty. Three offenders refused to participate. Later when the group of 80 threat to kill patients had been completed, it was found that none of these three offenders and none of the offenders awaiting execution could be matched with threat-to-kill patients.

All the offenders interviewed appeared to cooperate on examination. One offender was irritable and evasive when questioned on the extent of his father's income. These questions were asked in connection with ascertainment of social class. On gentle confrontation it was discovered that disclosures to the Internal Revenue (income tax) department were not entirely accurate. Further discussion quickly elicited his cooperation.

Following introduction, explanation of the purpose of the interview and replies to any questions by the subject, all subjects were questioned regarding age, education, occupation, marital status and other identifying data. Information was obtained regarding father's occupation and education in order to record the father's social class. Ascertainment of information regarding the family background was followed by questions on childhood discipline and punishment and the other eight potential predictors
above described. In the latter part of the interview information was obtained regarding the threat to kill or act of homicide.

Some subjects were interviewed more than once but statistics and clinical examples in this chapter refer only to information obtained during the initial interview, which was from 45 to 60 minutes, except for most of the control patients who were not subjected to the same range of inquiry. In general broad questions were followed by very specific direct questions. For example, "How were you disciplined by your parents?" and "How were you punished by your parents?" would be followed by direct questions regarding bruises, welts, blood loss or use of a closed fist by the parents.

"Were you ever in any trouble with the law" was followed by "Were you ever arrested by the police?" "Did you play with matches as a child?" would lead to inquiry regarding property damage. "Did you have any pets as a child? Did you tease them?" and "Were there any animals you particularly disliked?" would be followed by questions regarding injury and cruelty to animals. Clear answers were sought to enable statistical documentation regarding the nine predictors, as follows:

1. Parental brutality was recorded when whippings or other
punishment caused bruises, welts or blood loss or when the child was struck with a closed fist.

2. Parental seduction was recorded when the parent of the opposite sex slept in the same room or bed with a child to the age of five or beyond; exposed breasts or genitals; had sexual relations with marital partner or lovers in the presence of the child; discussed sex in a pathological manner or sexually assaulted the child.

3. Firesetting was recorded whenever there was destruction of property (e.g. chair or garage) whether or not this was attributed to an accident while playing with matches. Pleasure in lighting matches and burning weeds were not classified as firesetting.

4. Cruelty to animals was recorded when a child caused deliberate injury or death to animals or birds in a sadistic manner. Thus shooting rabbits and birds was not included but setting a cat on fire with gasoline and disembowelling a pet rabbit were included.

5. Enuresis was recorded when it persisted to the age of five years or beyond.

6. Police arrest record

7. Arrests for assault

8. Alcoholism was recorded when the subject reported a drinking problem or when his drinking interfered with his social life or work record.
9. Attempted suicide was recorded when the patient acknowledged that he had made a suicide attempt. Some workers classify suicide attempt resulting in only slight injury with no danger to life as suicidal threats or gestures, but the writer agrees with Stengel and Cook that the degree of self-inflicted injury is no reliable measure of suicidal intent (18).

**Results**

As two-sample tests of differences among three samples may lead to false significant findings if there are no over-all differences among the three samples, the Cochran Q test was used to test for over-all differences (16). This test for related samples provides a method of testing whether the frequency of occurrence of some characteristic differs among three or more matched samples. The data, matched sets of tallies (one for presence, zero for absence) on each potential predictor studied, was arranged in 20 rows (one row for each member of the three groups) and three columns (one column for the threat to kill group, one for the convicted homicide offender group and one column for the control group). The formula used for computation was

\[
Q = \frac{(k - 1) \left[ \sum_{j=1}^{k} G_j - \left( \sum_{j=1}^{k} G_j \right)^2 \right]}{\sum_{i=1}^{N} L_i - \sum_{i=1}^{N} L_i^2}
\]

Where
- \(N\) = number of subjects
- \(k\) = number of matched groups or samples
- \(G_j\) = total number of positive findings in the 3 columns
- \(L_i\) = total number of positive findings in the 20 rows

The particular significance level was obtained from a table.
It was found that there were significant differences for attempted suicide (p < .01) and for firesetting (p < .02) within the three groups. There were no significant differences among the three groups with respect to parental brutality, parental seduction, childhood cruelty to animals, enuresis, alcoholism, a police arrest record, and arrest for assault.

There was a narrow range of incidence of five factors within the three groups of 20 persons. The range between highest and lowest incidence in the three groups was: alcoholism, 11 to 13; police arrest record, 12 to 16; arrest for assault, five to six; enuresis, five to eight; and parental brutality, five to seven persons.

The incidence of any of the four following factors (parental brutality and seduction, childhood firesetting and cruelty to animals) when considered together, was higher in the homicide-threat group (p < .01) than in the control group. The same trend toward higher incidence was noted in the criminal homicide group. The Index of Associations (19), a measure of correlations, showed no evidence of reliable correlation among these four factors. The presence of any one factor did not affect the likelihood of another factor also being present.

The McNemar test (16) was then applied in an attempt to localize the differences between the three samples with regard to attempted suicide and firesetting. Although firesetting was more
frequent in the homicide-threat group than in the other two groups, the statistical significance of the differences was not convincing. This test showed a significantly higher incidence of attempted suicide in the homicide-threat group than in the criminal homicide offender group (p < .05) and in the control group (p < .01). Twelve of the homicide-threat group had attempted suicide in comparison with four in the criminal homicide group.

In the earlier follow-up study of 100 homicide threat admissions to Colorado Psychiatric Hospital, three of the four patients who later committed suicide and none of the three patients who later killed others, had made suicide attempts prior to hospitalization.

Conclusions

This study does not support the hypothesis that the incidence of parental brutality, parental seduction and childhood firesetting, cruelty to animals and enuresis to the age of five or beyond, is significantly higher in persons who have committed criminal homicide than in persons who have made homicidal threats.

The absence of any significant differences in the incidence of these factors, as well as of alcoholism, a police arrest record and arrest for assault, within the three groups studied throws doubt on their usefulness as predictors of homicide.
The combined data from this study and the follow-up study suggest the following conclusions regarding persons who threaten homicide: absence of suicide attempts indicates a higher risk of homicide. Prior suicide attempts indicate that the person is more likely to kill himself than to kill others.

The one distinguishing factor noted between the homicide-threat and homicide-offender groups was the incidence of attempted suicide. This factor may help distinguish those homicide-threat patients with a low homicide potentiality from those with a high homicide potentiality.

The occurrence of homicide may depend on many factors, including factors unrelated to homicide potentiality, thus adding to the difficulty of predicting this event. Defective ammunition, the misfiring of a rifle, or the fortuitous arrival of a third person may be life-saving. A slight difference in aim may avoid injury to a major artery. Ready availability of skilled surgical care may save the assailant from a charge of criminal homicide. An accumulation of life stresses such as death of a close relative, physical illness, and job loss coincidental with extreme provocation by the victim may add up to tragedy.

**Research Evaluation**

The threat-to-kill patients were not drawn from a representative sample of persons who make homicidal threats.
The convicted homicide offender group did not include any offenders who committed suicide after the homicide. As West has emphasized murders followed by suicide constitute numerically so substantial a section of the murder statistics that the special characteristics of this group must have a profound effect upon any criminological analysis of English murder as a whole (21). In the United States between two and nine per cent of homicide offenders commit suicide according to Wolfgang's review of studies on this subject (22).

Different results might have been obtained if the criminal homicide-offender group had included offenders who killed strangers. A group of 20 was selected from over 200 homicide offenders examined by the writer. Ten members of the group had taken more than one life and together the ten had taken 65 lives. The remaining ten had been selected because of the sadistic nature of the crime or the callousness of the offender.

Eleven of these 20 offenders committed homicide during the commission of another felony such as armed robbery and only six offenders killed relatives. The incidence of only one factor, cruelty to animals, exceeded the higher incidence of the various factors in the homicide-threat and matched homicide-offender groups. The higher incidence of cruelty to animals might be expected in a group which included more sadistic offenders.

The control group patients were drawn from a Veterans
Administration Hospital which admits only those persons who have served in the Armed Services of the United States. It is likely that criminal homicide is related to many factors. Additional matching requirements might have produced different results.

The conclusions regarding a history of attempted suicide were based upon a follow-up study of a group which included psychotic and non-psychotic males and females, and upon the controlled study which included only one female in each group and no psychotic patients. (Unfortunately it was possible to match only nine of the 23 psychotic threat-to-kill patients in the 100 consecutive threat-to-kill admissions with nine of the 86 patients in the Colorado State Hospital who had committed homicide while in a psychotic state).

More reliable information might have been obtained as a result of several interviews. It is possible that the concealment of information might have varied among the three groups. Possibly the incidence of the various factors in the homicide-offender group may be higher than the interviews revealed. Penitentiary inmates are traditionally reticent in talking to outsiders. One homicide offender, despite prior reassurance, asked at the end of the interview whether there would be a report to the parole board. However, another inmate confided significant information about his homicide which he had not revealed to anyone else.
Several inmates stated that they continued to keep in close touch with their parents. However, answers to questions on the date of the last parental visit and whether they had received a card at Christmas time suggested otherwise. Their tendency to idealize their relationship with their parents may have resulted in their concealing acts of parental brutality or seduction.

Fortunately, a further eight of the threat-to-kill patients could be matched with eight homicide offenders with the single exception that the homicide offenders had been evaluated by the writer prior to their conviction. These evaluations, in response to a plea of insanity, ranged from five to 11 hours, with an average of eight hours. Information was also obtained from relatives and others to aid in the evaluations. At that time the homicide offenders were acutely aware of the possible advantages which might accrue from disclosure of psychopathology, particularly attempted suicide.

A similar incidence of all factors except attempted suicide was noted in the two groups. Five of the patients who threatened homicide had a history of attempted suicide in contrast to one offender in the matched homicide-offender group.

Robins in her 30 year follow-up study of deviant children found that a history of attempted suicide was particularly likely to be concealed by the subjects. However, she also noted that
honesty appeared to be seriously impaired by the presence of relatives during the interview (14). In this thesis study all subjects were interviewed alone.

It should be noted that Robins, after comparing answers to structured interviews with results obtained from a search of police, hospital, social agency, credit bureau, school and other records, questions the belief that valid life history data is obtainable only in the privileged, long enduring relationship between doctor and patient (14).

One check was made on the reliability of information provided by the three groups. Police records were requested on all subjects. It was found that in each group one person concealed a history of arrest by the police.

Further studies by others are needed to confirm or refute the tentative conclusions reached in this research.

References


In making an emergency assessment of homicidal potentiality, it is important to seize the opportunity provided by the initial interview to obtain full information on the nature and circumstances of the threat. Police officers and others who accompany the patient to hospital may not be readily available for interview at a later date. Anxious relatives, a distraught victim and an angry or remorseful patient will often reveal information which they might not disclose under less stressful circumstances. As time passes, conscious suppression of information and unconscious denial of homicidal behavior hamper inquiry. Homicidal threats in the heat of anger soon become minor family arguments or vague statements made in jest.

Even at the initial interview relatives, friends and the victim may minimize the seriousness of the occasion. Quick reassurance that the patient will be admitted to hospital may discourage frank disclosure. The most vocal relative may not be the best informant. Police officers may assume that their verbal report to an emergency room attendant will be passed on to the physician. As important messages may go astray in the hustle and bustle of an emergency room, the physician should always interview the police.
Information obtained should be recorded at length, otherwise the physician to whom the patient is assigned for treatment may overlook the significance of the occasion. A note that the patient attacked a policeman is surely an inadequate description of an attempt to cut the officer's throat with the result that his tie was slashed in two beneath the knot and sutures were required for a knife wound on his face.

Not rarely the only reference to a homicidal threat in a thick hospital record is a single brief sentence in the admission note. This sentence can easily be overlooked by those who do not wish to see, or seeing, too readily accept the patient's protestations to the contrary. Denial is not confined to the patient and his family.

The following items, derived partly from clinical experience, may provide a guide to the need for immediate admission to hospital for further evaluation. Hospitalization, whether voluntary or involuntary, should not be recommended lightly for reasons which will be considered later.

1. **Sex, Age and Race**

Criminal homicide is usually committed by men between the ages of 18 and 40. The risk of homicide, unlike that of suicide, decreases with advancing years. Negroes, both male and female, have a higher homicide rate than Caucasians.
In Philadelphia between 1948 and 1952, 512 males (82.4 per cent) and 109 females (17.6 per cent) were arrested on charges of criminal homicide. Wolfgang points out that since males are but 48 per cent of the Philadelphia population, their share of homicides is plainly excessive (6).

Verkko's laws regarding homicide offenders deserve mention:

1. "In countries of high frequency of crimes against life the participation of women in these crimes is small; and vice versa: in countries of low frequencies of crimes against life the participation of women in these crimes is perceptibly larger than in countries of high frequencies of crimes against life."

2. "If the frequency of crimes against life in a country tends to increase, the increase primarily affects the number of male criminals, and vice versa: if the frequency of crimes against life in a certain country is on the decline, the decline primarily affects the number of male criminals" (5).

Wolfgang noted that in Philadelphia the association between race and homicide was statistically more significant than that between sex and homicide (6). The rate per 100,000 population by race and sex of offenders reveals the following rank order of magnitude: Negro males (41.7), Negro females (9.3), white males (3.4), and white females (.4). Thus the Negro female rate is almost three times the white male criminal homicide rate.

Among 626 homicide offenders in Baltimore, more offenders
were between the ages of 25 and 29 than between the ages of 45 years and over. More than 72 per cent of these offenders were more frequently under the age of 40 (1). Although males of both races commit criminal homicide during their twenties than during any other period of life, Negro males in their early sixties kill as frequently as white males in their early twenties (6).

2. Clinical Diagnosis

Patients with psychotic depression should be admitted to hospital because of the risk of suicide. Patients with acute schizophrenic reactions or delirium who make homicidal threats should also be admitted to hospital. Mania seldom leads to homicide but there may be other indications for hospitalization. Patients with chronic organic brain syndrome, chronic paranoid states or chronic schizophrenia present a difficult problem, when, apart from the homicidal threats, there is no indication for hospital care. Persistence of paranoid delusions over many years does not preclude violence. Thirty-nine male murderers examined by Mowatt had been delusional for a mean of four and a half years before committing murder (4).

Passive dependent and hysterical personalities who have no history of assaultive behavior give less reason for concern than those sociopathic and passive-aggressive personalities who show poor impulse control. If the latter patients are unlikely to follow advice to obtain outpatient therapy, admission to
hospital may provide an opportunity for development of motivation for therapy. Even though the immediate risk of homicide may be negligible, the danger of homicidal behavior in the future may justify admission to hospital. Diagnostic labels alone do not provide an answer and each patient should be considered in the background of the total situation.

It may not be possible in an emergency evaluation to elucidate the psychodynamic picture. Clues to the patient's psychological conflicts and their activation by recent stresses may aid in the evaluation. The usefulness of alcoholism as a predictor is reduced by the fact that indulgence in alcohol is very common, but it does not commonly lead to homicide. Evaluation of the drunken patient may be difficult and overnight beds in the emergency room of a general hospital permit adequate examination the next morning.

3. The Homicidal Threat

Whether the threat is uttered briefly or bombastically, seriously or in jest, in anger or in deceptive calm, as an offhand comment or accompanied by assault, the outcome may be tragedy. The melodramatic threat of the hysterical personality carries no message of doom. In contrast "I know deep down someday I'm going to kill somebody like that guy in Texas" and "I've developed a severe malicious killer hatred toward people" uttered quietly but with conviction by a sociopathic personality convey a warning which should not be lightly disregarded.
A conservative attitude is recommended when the patient continues to voice his homicidal threats. Threats repeated over many years tend to lose their ominous significance but the danger may remain. Expression of remorse is favorable but does not preclude risk. Conditional threats may have lethal consequences. "If you ever leave me, I'll kill you" may lead to "If I can't have you, I'll make sure no one else does." As promiscuous wives tend to remain promiscuous, the threat "If you ever step out on me again..." may foreshadow tragedy. The husband who can neither live with his wife nor live without her may resolve his dilemma through homicide.

4. Method

If the patient has purchased a gun, poison or other aids for the express purpose of homicide or has made careful plans to this end, hospitalization is indicated. Inquiry should always be made regarding possession of firearms. One patient arrived at the hospital with three rifles, an automatic pistol, and 150 rounds of ammunition in his car. Patients should be requested to arrange for sale of their firearms, even if the weapons are in the custody of the police, as it is a frequent police policy to return firearms on request. Although it is easy to purchase another pistol, the fact that one is not immediately available in the moment of rage may be life saving. Shakespeare's comment in King John is pertinent "How oft the sight of means to do ill deeds, makes ill deeds done."
5. **Previous Homicides**

The question "Have you ever caused loss of life?" is unlikely to be included in a routine psychiatric examination. Patients may not volunteer information of this nature yet will reveal it on direct questioning. Two patients in the 100 consecutive threat to kill admissions reported homicides. One had killed a civilian at a Navy base in a foreign country and the other while a prison camp guard had killed four men. Review of previous homicides provides a guide to dangerousness.

6. **Assaults**

Inquiry should also be made whether the patient has ever caused bodily injury or tied anyone up with rope. The latter question revealed that one of the 100 homicide-threat admissions had followed three women to their homes, tied them to their beds with baling wire, threatened to kill them and raped them. He had fantasies of cutting off their breasts with the knife which he used to cut their nightgowns. This patient wished to become a professional killer and mentioned the difficulties in seeking such employment. Recent assaultive behavior may indicate failure of coping devices and the need for hospitalization.

7. **Suicide Attempts**

Absence of suicide attempts by a non-psychotic patient suggests greater risk of homicide. Previous suicide attempts suggests the need to evaluate the risk of suicide. Emergency assessment of
self-destructive potentiality has been reviewed by Litman and Farberow (3).

8. Recent Stresses

Death of a relative or friend, loss of a job, illness, infidelity or threatened separation by a marital partner, or a pregnant wife may reduce the patient's self-control temporarily and brief hospital care may be helpful.

9. Resources

The patient's family may, or may not, be a source of strength. A wife, who had been threatened, sent for her father-in-law who told her in her husband's presence "If my son had killed you tonight, I wouldn't have blamed him." The sister of one patient gave him his revolver while he was still in the hospital. This patient later shot himself in the abdomen. One mother compared her son with the man who killed so many persons in Texas, another gave her son a derringer after he threatened to kill his father.

10. The Victim

Homicidal threats without provocation suggest greater risk than threats in response to extreme provocation. Continued provocation by the victim increases the risk of homicide. Special care should be taken when children are threatened as they are less able to defend themselves or seek help. The important role of the victim has been considered in Chapter 6.
Admission to Hospital

Admission to hospital, whether voluntary or involuntary, should not be recommended lightly for the following reasons:

1. It may cause considerable loss of self-esteem.

2. It may discourage the patient from seeking psychiatric help in the future when his need may be greater.

3. It may be very expensive, especially if the patient does not have hospital insurance to contribute to the cost. Hospital care may cost up to $40 a day or more and for persons already in debt or with small financial reserves, a hospital bill of several hundred dollars provides an additional stress for the patient.

4. It may result in termination of employment.

Availability of psychiatric outpatient care may be an important factor in the determination of whether to admit the patient to hospital. If the patient comes from a rural area, far distant from the nearest psychiatrist or mental health clinic, admission to a psychiatric hospital may be the only means of providing psychiatric treatment. On the other hand, immediate psychiatric outpatient intervention may eliminate the need for inpatient care. The Bureau of Mental Hygiene in Amsterdam has had success in providing emergency outpatient care for dangerous patients. The following case illustrates the work of the Bureau:

"The Bureau received an emergency call about a young man who had to be forcibly held by four policemen because he wanted to
murder his employer. His name was recognized by the Bureau, which had a record about him in its files. He was known as an epileptic who worked at a knitting machine and supported his mother who had been deserted by her husband many years before. Immediate investigation by the Bureau revealed that because of a slump in the industry, the patient recently had been assigned to two machines in order to cut down on labor costs. He was unable to cope with the additional work and after some failures he was dismissed from the job.

"The patient had just bought a new suit on installments and also had been loaned money to buy a bicycle. (A bicycle is practically a social necessity in Amsterdam.) His bicycle had been repossessed as a result of his discharge. Accordingly, he flew into a rage and wanted to murder his employer as the cause of all his troubles. As a result of the Bureau's efforts, the young man, when he had quieted down, was returned to his mother and a social worker paid for the suit and the bicycle out of emergency funds available for such purposes. Subsequently, she found him another job. The entire process took a week and the patient continued satisfactorily at work" (2).

References


CHAPTER 9

MEDICO-LEGAL ASPECTS OF HOMICIDAL THREATS

The Law on Threats

Formerly it was well settled that threatening language cannot of itself amount to an assault (3). A widely quoted legal citation reads: "Notwithstanding many ancient opinions to the contrary, it seems agreed at this day that no words whatsoever can amount to an assault" (1 Hawkins, Pleas of the Crown C. 15.). Some courts have even held that a menacing act, for example pointing a gun at another person, is not a criminal assault "if done without any intention to proceed to a battery, though the act may apparently be accompanied by such an intent and though it may be calculated to terrify the other party and put him on the defensive and may in fact have such effect" (3).

The better opinion, however, according to Wingersky, is against this view, and to the effect that if a person presents a gun at another, or threatens him with a stick or other weapon, and thereby reasonably puts him in fear and causes him to act on the defensive, or to retreat, there is an assault, whether there is any actual intention to injure or not (Com. v. White, 110 Mass. 407 (1872)). Under Colorado State Law a person who makes a threat with a deadly weapon can be charged with
assault with a deadly weapon. Punishment for this offense is confinement in the penitentiary for a term of not less than one year and not more than five years.

It is a crime in Federal jurisdictions to threaten the lives of the President and Vice-President of the United States, and to threaten a Federal officer or a juror or witness in a Federal Court trial. Threats sent by mail, or threats in which interstate communication or travel can be proved, are also Federal offenses.

Under Colorado State Law it is not a criminal offense to make verbal homicidal threats unless these threats are made by means or use of the telephone. It is unlawful to use a telephone to threaten any physical violence or harm to any person or family. Violation of this statute is a misdemeanor punishable by a fine of not more than $300 or by imprisonment for not more than 90 days in the county jail, or by both fine and imprisonment. (Colorado Revised Statutes 40-4-23, 1963).

Although it is not a criminal offense under Colorado State Law to make verbal homicidal threats, apart from threats by telephone, some local governmental agencies within Colorado have ordinances against threats. In Denver, for example, an ordinance states that "It shall be unlawful for any person knowingly to convey or cause to be imparted or conveyed in any manner or by any means any threat...to kill any person" (The Revised
Municipal Code of the City and County of Denver, Section 847, 4-6.
The penalty upon conviction is a fine of not more than $300 and or 90 days in jail.

A person who has received homicidal threats may file a complaint in court alleging that the defendant has threatened the life of the plaintiff or threatened to do seriously bodily harm to the plaintiff. The judge may issue a temporary restraining order and require the defendant to appear in court to show cause, if any, why the restraining order should not be made permanent. Violation of the restraining order constitutes contempt of court and subjects the defendant for each such violation to a term of imprisonment in the county jail not to exceed six months (Colorado Revised Statutes 40-2-48).

Restraining orders are sometimes used in a manner never intended by the courts. One day a husband is welcomed in the home and invited to stay overnight. On his next visit his wife will refuse to allow him in and notify the sheriff's office. A wife telephones her husband and tells him his son is ill and has had a convulsion. He hurries to his wife's home only to have his wife call the sheriff to have him arrested for violation of the restraining order.

Restraining orders may discourage some persons who make homicidal threats from continuing to make these threats. However, they provide no protection against homicide. The police can take
no action until the restraining order is violated. By that time it may be too late. Police departments do not have sufficient personnel to provide police protection in anticipation of violation of a restraining order, nor can they provide police guards, except in special circumstances for persons who have received homicidal threats.

Mrs. L. S. was warned that her former husband intended to come to Denver to kill her. She tried to get help from the authorities, but was told that nothing could be done until S. actually came to Denver and started bothering her. S. arrived by plane from New York at 4 p.m. on a Monday afternoon. Early Tuesday morning he called at his ex-wife's home and, in the presence of their son, he killed her before shooting himself. Four months earlier S. had been released from a Colorado mental hospital to the care of his mother in New York. She had promised to keep him under close supervision and to place him under private psychiatric care.

The Police and Homicidal Threats

Police officers who come to the aid of victims of homicidal threats may themselves be threatened. Nine patients in the 1961-1962 homicidal threat group threatened to kill police officers. In the United States between 1960 and 1965, 58 of the 278 law enforcement officers murdered in the line of duty were killed when they responded to disturbance calls (family quarrels, man with a gun,
but not robberies and not investigation of suspicious persons or circumstances). An additional 17 officers were killed by "berserk or deranged" persons (1).

In the writer's experience, police officers called to the scene of a homicidal threat will usually try to handle the situation without making an arrest. It is possible that many "family disturbance" calls follow homicidal threats which are not reported to the police. Even when mention is made of homicidal threats, no official record may be made of this fact. Police officers are well aware of the reluctance of friends and relatives, who have been threatened, to sign a written complaint or to testify in court. Often the police will help to resolve a family crisis through discussion of grievances. They may encourage a husband who has threatened his wife to stay with relatives overnight or they may drive him to a motel.

Even when the police officers, who respond to the disturbance call, are themselves threatened they will often take the offender to a psychiatric hospital rather than to a jail. This is true not only in rural areas where the officer is more likely to know the offender, but also in urban areas. If the officer feels that the quarrel has not been resolved and that there is a danger of further threats or assaultive behavior, he may give the offender the choice of going to jail or to hospital as a "voluntary" patient.

In Denver, Colorado, a city of just over half a million population, when police officers file a formal report of a threat,
the report is investigated further by detectives. Twenty-five to 30 formal reports are filed each month but not all these reports involve homicidal threats. Although each report is carefully checked, prosecution is difficult. The majority of these threats are made to wives by their husbands. On completion of the investigation, the wives are often unwilling to file a complaint that would permit prosecution. Some wives report the threat simply to intimidate their husbands. An interview with a police officer, without any further action, may indeed discourage the husband from making further threats.

The husband may claim that the threat was not intended seriously or that he threatened to kill his wife "if she continued to sleep with every man in town." Such conditional threats are difficult to prosecute in court. Even if the threat was not made in this form, the court may have difficulty in deciding who is telling the truth. Proof is particularly difficult when threats are made over the telephone.

Denver Police Department records were made available for the month of September 1966. Twenty-seven threats were reported to the police. Eight reports were classified as "Inactive - not cleared." In these cases the department planned no further action. Eleven reports were classified as "Exceptionally cleared." In these cases the recipients of the threats refused to prosecute or the police considered that there was no "bona fide" threat.
Eight reports were classified as "Cleared by Arrest." These eight reports involved five offenders. Their police records were checked after an interval of one year. One offender was released on bond and did not appear for his trial. A warrant was issued for his arrest but the police have been unable to find him. The charges against one man were dismissed. The three other men were convicted of making threats. One man received a 30 day jail sentence, and two men received sentences, which were suspended, of 90 days in jail.

Experienced police officers in Denver, Los Angeles and other cities have expressed the opinion to the writer that homicidal threats which are reported to the police, seldom lead to homicide. All officers admitted the absence of a careful follow-up study and that a homicide might have been committed in another state without their knowledge. The Denver detectives, who investigate reports of threats, could recall only one such case, that of a wife who considered that her husband might kill her, yet was unwilling to file charges against him.

This woman, who had been repeatedly beaten by her husband and threatened with death over a period of several years, finally complained to the police after he attempted to run her down with his car. Although she told the police officers "Someday this man will kill me," she refused to sign a complaint against him as "it might damage his reputation." Later she had him arrested
because she stated that he attempted to have sexual relations with his daughter. At his trial she refused to testify against him and he was released. His wife did take out a court order for his admission to a psychiatric hospital after he threatened to kill himself. A diagnosis was made of paranoid personality with sociopathic features and reactive depression. He did not respond to psychiatric treatment and he was discharged after the court had been notified that he was potentially dangerous. Less than a year later he shot and killed his wife.

Persons who complain to the police are not always reliable informants. One wife who accused her husband of threatening her with a gun, later shot at him with a rifle, killing a small child who was riding a tricycle on the sidewalk. Her husband did not have any firearms. Even when there is sufficient evidence to justify prosecution, the maximum penalty may be slight as such threats are often regarded as misdemeanors at common law. Threats on the President's life, especially since the assassination of President Kennedy, are treated more seriously by the courts.

Even when husbands or boy friends assault or shoot their wives or girl friends, prosecution may be difficult when death does not result and the victim is unwilling to prosecute. The following report from the Denver Post on June 5, 1967 illustrates this point.

A 34 year old Denver woman shot her boy friend in the shoulder Sunday morning near the Police Department substation at 2607 Welton St. while a surprised police officer watched.
Patrolman J. C. Sewell said he was just leaving the station when he heard a crash and saw Robert Brown, 33, of 2703 California St., run out onto the second floor landing of an outside stairway at 607 26th St.

Sewell said he heard a shot, saw Brown grab his shoulder and then heard the man say, "Don't shoot, baby, don't do it."

At that point a woman in a salmon colored housecoat appeared and fired two more shots at Brown, both of which apparently missed, Sewell said.

Sewell said he and Patrolman Gerald M. Frazzini, with guns drawn, hid behind a police cruiser and yelled at the woman to drop her weapon.

The woman backed into the apartment and police officers then charged up the stairway. Inside the apartment Patrolman Steve Kern found the weapon in the woman's purse and she was arrested after being advised of her rights by a fourth officer, Patrolman Carl Scavo.

Detective Clarence Nelson said the woman, Dolly Gamble, of the 26th St. address, was jailed overnight for investigation of aggravated assault but was released Monday morning when Brown refused to press charges. The detective said, however, that she would be charged with firing a weapon inside the city limits.

Brown was treated at Denver General Hospital for a gunshot wound in the left shoulder, then released.

The Physician and Homicidal Threats

When a patient informs his physician that he intends to kill someone, and there is evidence that he may do so, it is the physician's duty to take immediate steps to prevent homicide. If the patient refuses to be admitted to a hospital, it may be necessary to reveal his threats, either to secure his involuntary admission to hospital or to protect the intended victim. The problem is that it is not always possible to assess with confidence the risk of homicide. One has to exercise clinical judgment with the
knowledge that error may result. Every effort should be made to preserve physician-patient confidentiality.

A depressed young woman with a personality disorder telephoned her therapist and stated that she had beaten her child and that there was blood all over the place. The police were notified immediately but on arrival they discovered the child sleeping peacefully without any sign of injury.

Another young woman, who had been treated for paranoid schizophrenia, telephoned the emergency room of the University of Colorado General Hospital, during this study, and informed the physician on duty that she had killed one of her children and that she was going to shoot her other child. However, her gun had jammed and she wanted someone to "unjam it." The physician made arrangements for notification of the police but kept her in conversation until the police officers arrived. The child's body was found on the living room couch with four bullet wounds in the head. The revolver was on the telephone book and three live and four spent shells were in the chamber.

When there does not appear to be any immediate danger and when the patient is unwilling to come to the clinic or hospital for an interview, it may be possible to arrange for a home visit by an experienced psychiatric social worker or public health nurse. The patient who rings the hospital and states that he is going to kill someone may have been under the care of another psychiatric
hospital or clinic. Consultation often provides additional useful information or offers of help for the patient.

The homicidal voluntary patient who insists on leaving the hospital and cannot be persuaded to remain may have to be kept on a civil court order. When relatives are unwilling to request a court order for involuntary hospitalization, the judge may issue an order on his own motion, if the psychiatrist reports that the patient has made threats to kill and is considered dangerous.

A young man who was admitted to the hospital as a voluntary patient revealed that he had raped and threatened to kill three women. He had also telephoned another woman and threatened to kill her husband and children if she did not agree to have sexual relations with him. Indeed he had fired his rifle several times at the door of her home. His family had previously discouraged him from seeking psychiatric help. In view of his sadistic attacks on three women and his homicidal behavior, the court was requested to commit him to another hospital for long term care.

Involuntary commitment should not be lightly requested. The patient may be very resentful, especially if the basis for the request is information confided to the physician by the patient. Whenever involuntary commitment is contemplated, the opinion of a consultant physician should be obtained. This serves to protect the best interests of the patient and may also protect the physician if the patient should later sue him in court.
A middle aged man requested psychiatric treatment as he was concerned about his ability to control his anger. On several occasions he threatened to kill his girlfriend and himself. He said that he would carry out these threats if his girlfriend ever decided to leave him. He wondered whether psychiatrists could help him and mentioned the failure of psychiatry to help another man who later killed seven or eight people. During outpatient treatment he asked whether an insurance company could subpoena his psychiatric records if he and his girlfriend died in an automobile "accident."

After an incident in which he tied up his girlfriend and held a recently acquired gun to her head, his physician requested the court to have him committed to the Colorado Psychiatric Hospital on an involuntary basis, as he refused to enter the hospital voluntarily. Shortly after admission he was transferred to another hospital for long term care. However, he was discharged from that hospital within three weeks as it was not considered that he presented "sufficient danger to himself or others to justify further retention under court order in the hospital especially since he denied any need or interest in receiving help with his problems."

Following his discharge from hospital he sued three physicians on the staff of the Colorado Psychiatric Hospital for $200,000 each for "falsely and fraudently causing a hold and treat order
to be issued. . . . in committing said acts the defendants violated a confidential relationship which existed between them and the plaintiff."

Six months after the complaint for damages was filed, and before the trial date, the man's girl friend complained to police that he had slapped her across the wrist with a revolver and that he had threatened to kill her and her children if she did not agree to continue her relationship with him. The man was arrested but was released as his girl friend refused to file charges against him. Ten days later she jumped out of his car as he was driving down a city street. He chased her and dragged her in front of an apartment house. She cried out to bystanders "Please help me, he's going to kill me." He shot and killed her and then killed himself.

The Physician and Civil Suit in Case of Homicide

A recent U. S. Federal District Court decision may have far reaching consequences in the question of a psychiatrist's responsibility for the behavior of patients under their care. The court ruled that two psychiatrists and a psychologist at the Veterans Administration Hospital at Fort Meade, South Dakota had been negligent in failing to control a patient who subsequently murdered his wife.

"Testimony in the case indicated that Mr. William B. Newgard was committed to a state mental hospital in January 1965 and later transferred to the Veterans Administration Hospital. Authorities permitted him to leave the hospital on one occasion to attend a
funeral despite objections by the patient's wife, who feared harm from him. She had him seized and returned to the hospital.

"Subsequently, hospital authorities decided to find work for the patient outside the hospital in preparation for his release. Again his wife objected, in a telephone conversation with a staff psychiatrist, contending that the patient was dangerous. However, the hospital completed the arrangements for outside work, although it claimed that it had restricted the patient's movement so that he could not see his wife. Shortly after beginning work, the patient drove to his former home and shot his wife to death.

"Suit was brought in federal court by the administrators of the wife's estate on behalf of her children, charging the hospital with negligence. The court, sitting without a jury, awarded $200,000 to the estate.

"U. S. District Judge Ronald N. Davies ruled that hospital authorities were negligent in a number of actions and omissions. A psychologist was found to have failed to exercise reasonable care by not making certain that the outside employer was aware of the circumstances and the need for restrictions on the patient's travel and activities. The employer had testified that he had assumed that the patient was free to come and go as he chose.

"The psychiatrist who had spoken with the wife when she telephoned to object to the patient's impending release was found negligent for having failed to make notation of the call and for having failed to pursue the matter further.

"Another psychiatrist, who had treated the patient and conferred with his wife on several occasions, was found to have "ignored and rejected every warning signal" that the patient was dangerous and that the patient's wife "had every reason to be in mortal fear of her husband." The court commented that "had (the psychiatrist) devoted more of his time and talents to Newgard and less of them to diagnosing Newgard's wife, conceivably she would never have met so tragic and untimely a death." (2)

References


CHAPTER 10

PSYCHIATRIC TREATMENT

The follow-up study of the 1961-1962 group of 100 patients who had made homicidal threats showed that within five to six years seven patients had either taken their own lives or those of others. Although this group was not representative of the threat-to-kill population, this study suggests that patients admitted to hospital following homicidal threats have a high risk of homicide or suicide. The need for thorough psychiatric examination and treatment of these patients should be emphasized. The importance of obtaining at the first interview a full account of the circumstances of the homicidal threat from the patient and from persons who accompany the patient to the hospital has been noted in Chapter 8. Every effort should be made to persuade these patients to dispose of their firearms. It may be necessary to secure the cooperation of those who have been threatened, as all too often the victims encourage the patients to keep their firearms.

Selection of the type of psychiatric treatment for the patient who has made a homicidal threat will depend on many factors, including the clinical diagnosis and the personal preference of the physician. Some psychiatrists confine themselves to one form of therapy such as psychoanalysis, family therapy or the
therapeutic community approach while others do not restrict themselves in this manner. Thus they may use supportive psychotherapy, brief analytically oriented psychotherapy, hypnosis or group therapy depending on the clinical picture and other factors. Tranquilizing drugs and electroshock may also be used when indicated.

The Physician and the Patient who Threatens to Kill

Psychiatric evaluation and treatment demand objectivity and a certain calm detachment. Osler in his essay "Aequanimitas" claims that in the physician or surgeon no quality takes rank with imperturbability. Equanimity is a virtue more easily recommended than attained. During psychiatric examination of a man who murdered his bound victims one by one, the writer's distress on hearing the detailed account of the triple slaying was evidently reflected in his facial expression. The patient gently remonstrated "You shouldn't let yourself be emotionally involved. You should be cool, detached and clinical. A good psychiatrist should cultivate that ability" (2).

Imperturbability is particularly important when interviewing a patient who has made homicidal threats. A few physicians show undue alarm when confronted with patients who have made threats of physical violence, and are inclined to make a quick decision that the patient is not a suitable candidate for psychotherapy or that he should be treated in another clinic or hospital. Patients
are not slow to recognize a negative response on the part of the physician and may themselves respond in a similar manner. This may lead the physician to conclude, perhaps erroneously, that there is slight motivation for treatment. The mental mechanism of denial in regard to homicidal threats is not confined to the patient and his family. Even physicians may show this response.

A Special Ward for Threat-To-Kill Patients

In order to facilitate this study, beds on a nine bed male ward in the Colorado Psychiatric Hospital were reserved for threat to kill patients. During the first eight and a half months five beds were reserved, and for the remainder of the fiscal year 1966-67, all beds were reserved for these patients. During the year 60 patients who made homicidal threats were admitted to the ward. Most of the patients were treated by the second year psychiatric resident in charge of the ward.

Initially there was some apprehension among the nurses and attendants regarding the possible dangerousness of these patients. Although staff on all wards were accustomed to treating patients with homicidal behavior, the consensus was that concentration of several threat-to-kill patients on one small ward might lead to major problems in acting out. The first 15 non-psychotic, threat to kill admissions included many patients with severe character disorders and much antisocial behavior.
One in three of these patients had been charged with committing a felony and two in three had been arrested by the police. The following brief comments on five of the first six such admissions suggest that the initial concern of the staff was not without basis.

Case 1. Prior to admission this patient sadistically assaulted his girl friend. After tying her hands and feet together, he taped her mouth shut with adhesive tape and then he beat her with a rubber hose. He also pulled out her pubic hair. Finally he threatened to kill her unless she agreed to have sexual relations with him. Within a month of discharge from hospital he robbed a man of his car at gunpoint and fired at the man but did not wound him. He was arrested after a State Highway Patrolman detected him driving at 105 miles per hour in a 60 mile per hour zone. At present he is serving a sentence of five years imprisonment for armed robbery and auto theft.

Case 2. This patient threatened to kill and attempted to smother his wife and then rendered her unconscious with a blow on the jaw. He claimed that he had previously attempted to choke her to death and that he had once pinned a fellow worker to the floor and held a knife at his throat. Previously he had been placed on probation for one year for robbery and he had been jailed three times for fighting and theft.

Case 3. This patient had no history of assaultive behavior and no criminal record. His sister-in-law was awaiting trial on a charge of murdering her husband.

Case 4. This man, who threatened to kill his wife, had a history of eight arrests by the police on charges of assault, burglary, forgery and possession of narcotics. Shortly after his discharge from hospital he was arrested for possession of narcotics while on probation and he was sentenced to an indefinite term in the Colorado State Reformatory.

Case 5. This man was brought to the hospital after he attempted to shoot his wife and a police officer. As a youth he had threatened to kill his father with a loaded shotgun. His police record included five arrests for drunkenness and a sentence to a Federal Penitentiary for check forgery.
During the year there was only one major untoward incident in which a patient kicked a physician from another ward who was on night duty for the hospital. This physician showed poor judgment in disregarding a request that he should telephone the patient's physician and then threatening to seclude the patient and give him an intramuscular injection of a tranquilizing drug. The patient complained the next day "I was trapped, there was no way out. I knew I couldn't talk him out of the shot." On the ward the policy was to encourage patients to talk out rather than act out.

Many of these patients have very poor self-esteem, although this might not always be immediately apparent from their conversation. They are very sensitive to any reflection on their manliness and are quick to respond with physical assault when they feel challenged. The staff tried to avoid placing them in a situation which provided only complete and immediate capitulation to staff orders. The measures which were taken to prevent acting out have been described by the writer in an article entitled "Acting Out" (1).

A more sympathetic attitude toward the patients appeared as the staff gained greater understanding of their behavior. It became apparent that sometimes the aggressive, outspoken, independent behavior masked deep dependent longings and fear that emotional involvement with the staff might be followed by the trauma of subsequent rejection.
The great provocation and rejection shown by some wives and parents on their visits to the ward contributed to staff toleration, but not approval, of deviant behavior. When acting out behavior occurred, it usually followed a series of setbacks for the patient. The stress which sparked the acting out was often trivial. At first sight, the response to minor stress suggests that the patient has very slight self-control. At times these patients showed remarkable self-control. The fact that acting out is usually in response to an accumulation of stressful situations, not just the precipitating stress, suggests that even minor remedial measures in a crisis may be sufficient to reduce significantly the risk of assaultive behavior.

At group therapy meetings an attempt was made to help patients recognize the manner in which they provoked others to act unfavorably toward themselves. There was much emphasis on self-destructive behavior. At family group meetings, effort was made to resolve destructive patterns of interaction within the home. Treatment was short term, one to three months, and patients were encouraged either to seek outpatient therapy or to return to see the ward physician at times of crisis or impending crisis.

Treatment of the Homicidal Sociopath

"A perverse temper . . . with an intellect in the most unhappy of all states, too much disordered for liberty and not sufficiently disordered for Bedlam" Lord Macaulay, The History of England
Macaulay's trenchant comment epitomizes the problem posed by the sociopathic personality, who figures so prominently among those who threaten homicide. Involuntary commitment to a State Hospital, often distant from his home, is difficult to achieve and seldom prolonged. As these patients disrupt the therapeutic ward milieu and show little apparent motivation for treatment, rapid discharge from hospital frequently occurs. Involuntary commitment often provides only brief protection for society. It may further undermine the patient's self-respect as well as cause resentment toward the relatives, who participated in his court commitment, and toward the psychiatrist who was unwilling to treat him in a local hospital or clinic.

As fear of recommitment to the State Hospital may discourage the patient from seeking psychiatric help when the next crisis occurs, the risk of homicide may be increased. Every effort should be made to provide treatment at the local hospital or clinic. There will always be a few patients who are so dangerous that long term confinement is imperative. The majority of these sociopaths can benefit from help even if that help is confined to crisis therapy as the need arises, or treatment of the wife who provokes the threats she fears. Acting out, slight apparent motivation for treatment, and refusal to acknowledge illness are too often regarded as portents of therapeutic failure rather than as a therapeutic challenge (1).
The Victims and Psychiatric Treatment

As eight out of ten patients threatened members of their family, it was possible to involve many of the victims in the treatment situation. Wives who have been threatened may refuse to come to the hospital for interview because of their firm decision to obtain a divorce. It was found that many of these wives later returned to their husbands. For this reason continued effort was always made to seek the cooperation of those wives who refused to participate in the evaluation and treatment.

The Family Treatment Unit of the University of Colorado, on a random selection basis, accepts for outpatient treatment, voluntary patients from the Denver area who have been approved for admission to the hospital.

"When the team takes the case, the identified patient and whatever family members are present or available by telephone, are seen together immediately. The first interview usually takes one to two hours. Individual sessions are avoided. During this first session, the family history is taken focusing on the events which led to the decision to hospitalize one member. An evaluation is made of the identified patient's symptomatology and the family's tolerance of it. Attention is paid to failures of functioning and tolerance of such failure. The team also concerns itself with the cohesiveness of the family, the capacity
for change, and the motivation for holding the family together. Referral sources and previously involved community agencies are contacted. In a few instances they have been able to participate in the first session. With this preliminary understanding, a treatment plan is worked out with the family. A home visit is scheduled within twenty-four hours; psychoactive drugs may be prescribed for various family members as indicated (not just the identified patient); the family is informed of its responsibility for resolving the crisis" (3).

"A typical example of the work of the Unit is illustrated by their treatment of a patient who made homicidal threats: The nominal patient was Mr. D., a 34 year old unemployed house painter. He had been referred to Colorado Psychiatric Hospital by the social worker who had seen him and his driving and capable wife, in regard to the school failure of one of their six children. The admitting physician recommended admission because of his 'paranoid jealousy bordering on the delusional', homicidal threats, and severe depression.

"At the time Mr. D. was seen in the Admission Office, he was tearful, retarded in thought, reported sleeplessness, anorexia, inability to work and was requesting hospitalization out of fears that he would kill his wife, his family and himself. Mrs. D. had already left him after a violent fight at the cafe where she worked. A divorce was planned. The family difficulties were intensified the year before, during the sixth pregnancy, when Mrs. D. refused her husband sexual intercourse and he had an affair which he then told her about. She retaliated by moving the family into the house formerly occupied by the other woman, then taking a job as a nighttime waitress, something which her husband had always forbidden her to do.

"Within a few weeks, Mr. D. lost his job and was having jealous rages; the 14 year old daughter, who was left with the care of her siblings, had attempted suicide and was contemplating marriage; the 10 year old boy began bedwetting; the nine year old son was suddenly failing in school; the five year old girl was also bedwetting; the three year old girl was becoming very withdrawn; and the year old baby ceased attempts at ambulation.
"All eight were seen at once and then the attention was focused on the couple. They were encouraged to live together again. Mr. D. was placed on Thorazine. He confessed his guilt over the affair and the entire family was made aware that his difficulties were in part a response to other factors in the family. Mrs. D. recognized her involvement and the family began begging her to make adjustments for the common good.

"When her strong need to socialize through her work was discussed, she became anxious and was also placed on medications. After a week of vigorous wrangling, she recognized that she had punished him long enough. Compromises were worked out between the adults, and a reasonable family equilibrium was reached. She quit her job, he went back to work, plans were made to move, and her needs for more social outlets were respected. Therapy was terminated after seven visits in two weeks. At the six months follow-up, all eight were symptom free and the family functioned as well as it had before the crisis" (3).

**Protection of Children**

Fifteen patients in this study, and 36 in the earlier study, threatened to kill their children. Even when the children have not been threatened there may be risk to their lives. One of the patients in the earlier study who had threatened to kill her husband and sister-in-law later killed one of her children and attempted to kill her other child. A wife, in the present study, who had been threatened by her husband, reported that one of her children of an earlier marriage had suffered permanent kidney damage, because of beatings given by her husband for bedwetting.

Brutal alcoholic husbands are complemented by long suffering masochistic wives who patiently endure not only homicidal threats but also repeated physical assault. Children of these marriages may be exposed to repeated brutality and sometimes homicidal threats. Rather than risk separation through divorce or commitment
of their husbands to jail or mental hospitals, these women sacrifice their children to preserve the marriage. As children tend to grow up in the image of their parents, the pattern of family violence may pass from one generation to the next.

It is particularly important for the physician to see that steps are taken to protect the children. These families may move from one county to another when welfare agencies or courts show concern, and too often the cases are lost in the files of bureaucracy. Alternatively judges and lawyers, with an overscrupulous regard for due process, or an inability to believe that a man who presents a good appearance in court can yet seriously mistreat his children, contribute to society’s failure to protect these child victims. The children are either too young to voice complaint or are terrorized into withholding information from court and welfare officials.

A 35 year old alcoholic (1961-1962 study) often threatened to kill his wife and frequently beat her and the children. After one such threat and a severe beating he put her in his car and drove around with the stated intention of looking for a mine shaft in which to bury her. Once while he was beating one of his children, his wife went to load a shotgun, but he took the gun away from her and clubbed her with the butt. She would turn white according to a neighbor, when she heard her husband’s car in the driveway and the children would fearfully scurry
around the house picking up their toys and putting things straight in the living room. One child had mild deafness from blows on the head. The wife made no effort to seek help and when her mother notified the court, she opposed the efforts of the court to protect the children from further mistreatment.

Steele and Pollock have studied intensively 60 families in which significant abuse of infants or small children had occurred. They make the following observations regarding this problem.

"Too often in the past, severe abuse of children has been managed by separation of child from the parent and placing it in a foster home and the problem considered to be solved. While separation is useful and often an absolutely necessary intervention, it does not in any way deal with the basic issues involved. Sooner or later will arise the question of whether the child can be returned to parental custody. Also, the abusing parents already have or may have in the future other children who can be mistreated. Therefore, effort must be directed not only to handling the immediate situation so as to protect an infant from further abuse, but also toward investigating the total pattern of parent-child interaction in a family and instituting remedial measures.

"In a similar vein, we are very doubtful of any value in 'treating' an abusing parent in the context of criminal law with determination of guilt and the imposition of punishment. If the
prosecutor fails to get a conviction, which can easily happen, the parent feels exonerated in his behavior and goes on his way and is highly resistant to treatment. On the other hand, conviction followed by punishment does nothing to really change the parent's character structure and behavior; rather, it is one more reinforcing repetition of the experience of being disregarded, attacked, and demanded to do better, the very things which led him to be an abuser in the first place. As one of our patients put it, 'as soon as I get out of the penitentiary, we're going to get out of this state to where we aren't known. Then we'll have some kids and raise them the way we want to'" (4).

References

CHAPTER 11

CONCLUSIONS

In 1965 there were 5.3 victims of homicide and 11.6 victims of suicide per 100,000 population in the United States (1). Although the homicide rate is almost half the suicide rate, psychiatric research on preventive measures has been focused almost exclusively on the problem of suicide. This focus on suicide is not confined to research. It is reflected in textbooks of psychiatry, in undergraduate and postgraduate education, and in clinical practice.

Those who threaten or attempt suicide are regarded as the responsibility of the healing professions. Those who attempt homicide may find themselves in the courts and penitentiaries. Psychiatric services in the former are usually confined to the determination of criminal responsibility and in the latter are often woefully inadequate. Psychiatric aid is more readily available for those who threaten homicide as these persons seldom appear in court, unless they threaten the President of the United States.

Yet persons who seek psychiatric help following a homicidal threat may minimize the significance of the threat, avoid reference to it or even deny ever having made the threat. The incidence of homicidal threats is probably much higher than might appear from perusal of hospital or clinic records. Within one year 100 patients (one in every eight admissions) were admitted to the 78
bed Colorado Psychiatric Hospital after they had made homicidal threats. Other patients who had made these threats were treated as outpatients or were referred to other clinics or hospitals.

The five to six year follow-up study of 100 patients admitted to the hospital because of homicidal threats showed that seven had either taken their own lives or those of others. Four committed suicide and three committed suicide. The incidence of homicide or suicide may be more than seven per cent, since 23 patients have not yet been traced.

This study suggests that patients admitted to hospital because of homicidal threats have much higher homicide and suicide rates than the general population.

The incidence of nine potential predictors of homicide was examined among three groups--hospital patients who had made homicidal threats, convicted homicide offenders, and a control group of hospital patients who had no history of homicidal behavior.

The hypothesis, that the incidence of parental brutality, parental seduction and childhood firesetting, cruelty to animals and enuresis is significantly higher in persons who have committed criminal homicide, than in persons who have made homicidal threats was tested. This study did not support the hypothesis.

Statistical analysis showed no significant differences among the three groups in the incidence of the following factors: parental brutality, parental seduction, childhood firesetting, cruelty to
animals and enuresis, a police arrest record, arrest for assault and alcoholism. This study throws doubt on the usefulness of these factors as predictors of homicide.

The study showed a significantly higher incidence of attempted suicide in the homicide-threat group than in the homicide-offender group ($p < .05$) and in the control group ($p < .01$). In the follow-up study of 100 homicide-threat admissions to Colorado Psychiatric Hospital, three of the four patients who later committed suicide, but none of the three patients who later committed homicide, had made suicide attempts prior to hospitalization.

These data suggest the following conclusions regarding non-psychotic persons who threaten homicide: The risk of homicide is higher in the absence of attempted suicide. Those who have attempted suicide are more likely to kill themselves than to commit homicide.

Attempted suicide was the one distinguishing factor noted between the homicide-threat and matched homicide-offender groups. This factor may help distinguish those homicide threat patients with a low homicide potentiality from those with a high homicide potentiality.

Further studies are required to confirm or refute these conclusions.

The emergency evaluation of the patient who makes homicidal threats, the role of the victim, medico-legal aspects and treatment have been reviewed.
Suggestions for Future Research

It might be helpful to study a number of factors which may have some bearing on the origins and prevention of homicidal behavior.

1. The Aggressive Drive

   Aggression has been regarded as a learned response, a response to frustration and as an instinct. Bychowski, among others, has suggested that acting out of antisocial impulses is related to instinctual drives and that in some individuals the general intensity of the drives exceeds the average norm (2). Unfortunately he provides no suggestions for measurement of these drives. Glover points out "Isolation of pure aggressive impulses is a classroom device adopted for convenience in presentation. There is invariably some degree of overlap or fusion with libidinal impulse. For this reason it is impossible to disentangle the problems of unmodified or primary aggression, which is difficult enough to distinguish from sadism, from the problems of anxiety, hate and reactive aggression" (3).

2. Capacity for Object Relationships

   A person who has a poor capacity for relating to others might well have less compunction in taking another person's life. A 30 year old white laborer was examined by the writer after he had been sentenced to death for the murder of a taxi driver.
He gave the following account of his crime. "I was walking across the street, this taxi cab come by, I just flagged him down. I told him to take me to the airport. As we went by the bus station he says 'Is it okay if we pick up another passenger?' I said 'All right.' He got out. We started toward the airport.

That's when I told him to stop. He did. I fired a shot in the floor. I asked him for his money. Then he gave me his money. I told him to drive on. We came to a road. I told him to turn in there and turn around. We stopped there and we talked about three or four minutes. He said 'Are you going to shoot me?' I said 'No.' He said his driver's license was in his billfold. He asked me if I would give it back to him. So I give it back to him. I started to get out of the cab, that's when I shot him. I don't know why. It's like I really didn't do it. You've got to hate somebody to shoot a man. It's like a bad dream."

He showed little feeling as he talked about his crime and he expressed no remorse. In the discussion of his personal life it became apparent that he had formed no deep personal attachments to anyone. He had not seen his parents for several years and did not write to them. His first wife left him after eight months and his second wife after four months. There was one indication of some attachment to his family, he had in his suitcase which he
took with him as he hitchhiked across the United States, a few photos of his family. However, two or three days before the crime while walking along the highway he became tired of carrying the suitcase and threw it away. He did not bother to remove any of the contents and had no intention of recovering the suitcase later.

Research on object relationships would require study in depth and under varying conditions (significant stressful situations) of the subject's relationship, not only with the physician but also with others, particularly members of his family.

3. Latent Homosexuality

Rappeport claims that the homosexual panic would appear to account for a large number of murders. He did not quote statistics in support of this claim which may be an overstatement. He notes that underlying or latent homosexuality is very hard to recognize clearly (9). Halleck believes that homosexual panic occurs with more frequency than is generally acknowledged and that it plays an important role in many crimes of violence. He describes homosexual panic, which is not listed as a formal diagnostic category in official nomenclature, and describes a case of murder which he attributes to this syndrome (4).

4. Epilepsy and Electroencephalographic Abnormality

Hill and Pond noted a very high incidence of abnormal EEG's among prisoners charged with murder whose crimes were apparently motiveless or with very slight motive. A diagnosis of epilepsy was made in 18 of 105 persons charged with murder. Thirteen of these 18 cases were known to have had epileptic seizures of some sort during their lives. This incidence of epilepsy is 32 times that
in the general population. This group did not constitute a
cross section of the murderer population as there was a greater
concentration within the group of persons suspected of epilepsy
or brain disease. Even allowing for the selection, the incidence
of epilepsy is undoubtedly very great (5).

The EEG pattern of 14 and six per second spike discharges,
sometimes referred to as the positive spike phenomenon, may
be associated with a history of explosive outbursts of rage.
Some patients with this EEG pattern have a history of emotional
deprivation and it is difficult to assess the relative importance
of psychological and neurophysiological factors in determining
the clinical picture (7, 10).

5. The Subculture of Violence

Wolfgang has stated that his analysis of homicide in
Philadelphia "implies that there may be a subculture of violence
which does not define personal assaults as wrong or antisocial;
in which quick resort to physical aggression is a socially
approved and expected concomitant of certain stimuli; and in which
violence has become a familiar but often deadly partner in life's
struggles. . . When an insult or argument is defined as trivial
and petty by the prevailing culture norms, but as signals for physical
attack by a subcultural tradition, culture conflict exists. When
a blow of the fist is casually accepted as normal response to certain
stimuli, when knives are commonly carried for personal defense,
and a homicidal stabbing is as frequent as Saturday night, then social control against violence is weak" (11).

Wolfgang and Ferracuti in their recent study "The Subculture of Violence" have tried to define and describe the meaning of subculture in general and have formulated hypotheses for further research (12).

6. Paranoid Delusions

One of the criteria in determining dangerousness, reported by Rappeport, is the presence of paranoid delusions or hallucinations (9). Although many paranoid patients have committed homicide, the great majority of these patients do not kill others. It is difficult to predict rare events such as murder. Prediction of even rarer events, such as homicide by a paranoid patient, presents even greater difficulties.

Prevention of Homicide

Research on the motivation and behavior of the victims of homicidal threats, and research on sublimation and other defenses against the expression of homicidal aggression may lead to a reduction in the number of criminal homicides. Lorenz has described the ways in which various animals have controlled aggression and applies his theories on animal behavior to man (8).

Since the assassination of President Kennedy with a rifle purchased through the mail, there has been revival of interest in the control of firearms in the United States. J. Edgar Hoover,
Director of the Federal Bureau of Investigation, has recommended that mail-order firearm purchases should be banned, interstate transportation of firearms controlled, and local registration of weapons required and enforced (6). Ready availability of firearms may be a factor in the relatively high homicide rate in the United States. In Colorado firearms, including pistols, may be purchased without a permit.

Suicide prevention centers have been established to reduce the incidence of suicide. Expansion of their function and an increase in the number of mental health clinics, especially in impoverished neighborhoods would provide a better opportunity for resolution of conflicts within the family. Police called in an emergency to handle a disturbance call, usually a family quarrel, should be encouraged to refer the participants to the local mental health center for aftercare.

The problem of homicidal threats deserves greater attention in textbooks, in teaching programs and in mental health centers. The homicidal threat may be an appeal for help. It should not be regarded lightly.

References


