Homicide-Suicide in Older People

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- Mr. M, age 67, shot his 65-year-old wife before killing himself. The couple, who had been married for over 20 years, had a history of marital problems. The morning of the homicide-suicide, the couple had a heated argument. Mrs. M locked herself in the bedroom, but her husband pried the door open with a pipe and killed her with a semi-automatic pistol. About eight weeks prior to the homicide-suicide, Mrs. M discovered the existence of her husband's young illegitimate child in Cuba and, the day before the homicide-suicide, told her husband she would see a lawyer about a divorce.
- Mr. B, age 87, shot his 84-year-old wife in the head with a rifle before killing himself. He had taken Mrs. B for a walk in her wheelchair outside the nursing home where she had been a resident for over a year. Mrs. B had Alzheimer's disease, and her husband had visited her daily, spending most of the day caring for her. Mr. B left three suicide notes, one in his truck, one at home and one in his wife's wheelchair. He had just been diagnosed with liver cancer. The notes said that he was too sick to go on.
- Mr. W, age 78, killed his 73-year-old wife while she slept in the living room and then killed himself in the bedroom. Married for over 50 years, Mr. W was devoted to meeting all of his wife's needs. Mr. W, who was in good health, had cared for his wife since her stroke five years prior. Both of them had been incapacitated with a virulent flu for two weeks before the homicide-suicide. Mrs. W was probably going to be placed in a nursing home, and Mr. W was worried that he would not be able to care for her.

These three cases illustrate the diversity and drama of homicide-suicides in older people, the population with the highest rates of homicide-suicide (Cohen et al., in press). Until recently, it was believed that homicide-suicides occurred most frequently in the young where a jealous, angry man would commit suicide after killing a wife or girlfriend when he believed the relationship was threatened with dissolution. Homicide-suicides in older people were considered to be suicide pacts, mercy killings or altruistic homicide-suicides where both partners were old and sick (McIntosh et al., 1995).

Overview of Homicide-Suicide

Homicide-suicides are human tragedies in which a perpetrator, usually a man, kills one or more victims, usually a wife or intimate, and then commits suicide within minutes or hours. Almost all occur in the context of the family and while they may involve children, most involve only one victim. The most common form, occurring in 80% to 90% of cases, is spousal/consortial homicide-suicide (Berman, 1979; Currens et al., 1991; Nock and Marzuk, 1999).

An estimated 1,000 to 1,500 homicide-suicides occur in the United States each year, a mortality comparable to meningitis, viral hepatitis or pulmonary tuberculosis (Marzuk et al., 1992). Although homicide-suicides are relatively rare compared to homicides and suicides, they have a dramatic, enduring impact on surviving family members and the communities in which they occur.

Reports of the annual rates for homicide-suicide have been remarkably constant in the United States and other countries, ranging from 0.2 per 100,000 person-years to 0.3 per 100,000 person-years (Coid, 1983; Milroy, 1995). A few investigators have reported higher incidence rates: 0.46 per 100,000 in Fulton County, Ga., for 1988 to 1991 (Hanzlick and Koponen, 1994), and 0.38 per 100,000 in central Virginia for 1990 to 1994 (Hannah et al., 1998).

Homicide-suicides, reported in terms of the percentage of total homicides, vary regionally in the United States from 1% to 20%, but average 5%. The percentages have been reported to vary from 3% to 60% in other countries (Marzuk et al., 1992). In Canada, the only country with a national surveillance system for homicide-suicide, Gillespie and colleagues (1998) reported that about 10% of homicide offenders committed suicide. The variation in homicide-suicide rates is related to homicide rates, i.e., the higher the homicide rate in a region, the lower the percentage of homicide-suicides (Coid, 1983).

Rates and Clinical Typologies

There are no national or international data for homicide-suicide rates by age. This is likely due to the low base rates for all ages as well as the lack of operational definitions and surveillance systems. Our team conducted the first descriptive epidemiological study of the incidence, patterns and clinical characteristics of homicide-suicide in older persons (Cohen et al., 1998a). Cases were ascertained from four medical examiner districts covering seven counties in west central and southeastern Florida (about 4.5 million people) from 1988 to 1994.

Of the 171 homicides that occurred over the seven-year period, 58 (34%) occurred in the population 55 years and older and 113 (66%) occurred in the population under 55 years of age. The clinical typology by age was ascertained and interpreted. In the older population, we found that 48 (83%) homicide-suicides were spousal/consortial, seven (12%) were familial, and three (5%) were nonfamilial. In the younger population, 89 (79%) were spousal/consortial, seven (6%) were familial, 11 (10%) were nonfamilial, and six (5%) were filicide-suicide (i.e., involving children).

The annual rates for all ages were higher than the 0.2 to 0.3 per 100,000 person-years reported in other studies, and those 55 years and older had homicide-suicide rates about two times higher than those younger than 55 years of age. Annual incidence rates ranged from 0.4 to 0.9 per 100,000 for the population 55 years and older, and homicide-suicides accounted for 12% of homicides and 2.4% of suicides. Although West (1965) did not report incidence rates by age in his classic study, he did report the number of homicide-suicide cases classified as old and sick, and they were 2% of all suicides.

Applying Florida rates to 1998 U.S. census population projections, we estimate that about 500 homicide-suicides occurred in the population 55 years and older, and about 1,000 occurred in the younger population (Cohen et al., in press). The total of 1,500 events is consistent with the estimates of Marzuk and associates (1992). Since most homicide-suicides involve couples, at

least 1,000 older people die each year, or 19 people per week, and 2,000 younger people die each year, or 38 people per week.

Preliminary results from an ongoing study of homicide-suicides in Florida suggest that homicide-suicide rates may be increasing (Eisdorfer and Cohen, 1999). Homicide-suicide rates were ascertained for an 11-year period (1988 to 1998) for two medical examiner districts in west central Florida (about 2.1 million people). Homicide-suicide rates doubled in the population 55 years and older but stayed about the same for the younger population. The prevalence for the older population over the 11-year period was 0.62 per 100,000 person-years compared to 0.34 per 100,000 for the young.

Clinical Characteristics

Homicide-suicides in older people are not acts of love or altruism. They are acts of depression and desperation. Approximately 40% of the perpetrators in west central Florida had depression or other psychiatric problems, 11% were abusing alcohol or drugs, 15% had talked about suicide and 4% had attempted suicide. About 20% of couples in southeastern Florida were depressed, 10% had other mental problems and 24% had talked about suicide. Only one of the perpetrators tested positive for antidepressants, and none tested positive for other psychotropic medications at autopsy. Most had seen a physician within weeks or a month prior to the act (Cohen et al., 1998a).

Analyses of the medical examiner and law enforcement reports, including photographs, suggest that the perpetrators, always men, had made a unilateral decision to commit the act. The perpetrator appeared to have thought about a homicide-suicide for months or even years, and the wife/lover probably was not a knowing or willing participant. The wife was usually shot in the back of the head or torso while sleeping. When domestic violence occurred, the attack was aggressive and violent with multiple wounds to the victim.

Cultural differences emerged in the older spousal homicide-suicides. All cases in west central Florida were white, older couples who were almost always married. The mean ages of the perpetrators and victims were 78 and 74, respectively. By contrast, in southeastern Florida more than two-thirds of the older couples were Hispanic and significantly younger. The mean ages of the perpetrators and victims were 68 and 50, respectively. Less than half lived together or were married. In west central Florida, half of the perpetrators and victims were sick, whereas health was not a prominent issue in the couples of southeastern Florida. Physical violence, verbal discord and lawsuits were prominent in the older southeastern couples.

Profile of Perpetrators

What motivates an older married man to commit a homicide-suicide rather than to kill only himself? Our team compared the characteristics of the 24 cases of spousal homicide-suicides perpetrated by husbands 55 years and older in the three medical examiner districts of west

central Florida from 1988 to 1994 with 36 randomly selected age-matched married men who committed suicide in the same area over the same period (Cohen et al., in press).

The average ages of the homicide-suicide and suicide perpetrators were similar, 79 and 80, respectively. Whereas about half of the men who committed homicide-suicide were caregivers, only 13% of the men who committed suicide filled this role. The men who committed suicide had significantly more health problems, but more than one-third of homicide-suicide perpetrators had a recent significant decline in health prior to the act. Indications of depression were high for both groups, but postmortem toxicology results were negative for antidepressants for both groups. Older men who committed suicide threatened suicide more frequently than homicide-suicide perpetrators.

The nature and quality of the marital relationship is probably a more important factor in the chain of events leading to homicide-suicide, rather than a suicide (Berman, 1996). Unfortunately, there were no data in the medical examiner files about the wives of the men who only committed suicide, making comparisons between groups of the couples' dynamics not feasible.

Subtypes of Homicide-Suicide

Clinical homicide-suicide typologies other than the spousal/consortial type are rare in older people, accounting for about 15% of all homicide-suicides. Familial homicide-suicides, usually involving older brothers and sisters, are the most common. Older perpetrators do not kill children in a pedicide- or filicide-suicide, which is more common in the young. They rarely kill nonrelative victims (e.g., employees, police) in nonfamilicide-suicides and, when they do, the victims are usually friends.

There appear to be at least three types of spousal/consortial homicide-suicide involving older couples: dependent-protective, aggressive and symbiotic. One common feature of all three that precipitates the act is a perception by the older man of an unacceptable threat to the integrity of the relationship (such as a pending institutionalization), a real or perceived change in the perpetrator's health, or marital conflict and domestic violence.

About 50% of spousal/consortial homicide-suicides are dependent-protective. In these instances, the couple has been married a long time and they are highly dependent on each other. The man, who has been dominant in the relationship, fears losing control of his ability to care for or protect his wife. Even if the woman is not sick, a real or perceived change in the man's health, coupled with depression and multiple stressors, can precipitate the process. A common variant is the caregiver-dependent homicide-suicide, where serious depression from years of caregiving, coupled with increasing isolation, produces hopelessness in the male caregiver and triggers the act.

The second type is an aggressive homicide-suicide, occurring in 30% of cases, where there is marital conflict or domestic violence. This is more common in young-old couples, ages 55 to 65 years, but it does occur among older couples. The perpetrator is usually much older than the

victim. Pending or actual separation, issuance of a restraining order, and threatening behavior are common precipitants.

A third type is a symbiotic homicide-suicide, occurring in 20% of couples. This is characterized by extreme interdependency in an older couple. One or (usually) both are very sick, leading the husband to a mercy killing and suicide. The husband and wife are so enmeshed in each other that their individual characteristics are blurred. The male perpetrator is often the dominant personality and the female victim is often submissive.

Unsuccessful Attempts

A number of unsuccessful homicide-suicides have been widely publicized in the media, yet almost nothing is known about how often homicide-suicides are unsuccessful, i.e., the perpetrator or the victim does not die. In our review of files from 1988 to 1994 in the Florida epidemiological study, we found 12 older cases where the homicide-suicide was unsuccessful, but these were excluded from the analysis.

Unsuccessful homicide-suicides are complex clinical and legal issues. The older perpetrator faces arrest and time in jail; criminal charges; and a prison sentence if convicted of murder, manslaughter or assisted suicide. There is significant prosecutorial and judicial discretion in charging and sentencing (Cohen and Wareham, 1998). Cohen et al. (1998b) reported a case study of a 63-year-old woman with Alzheimer's disease and multi-infarct dementia who shot and killed her healthy 93-year-old mother. She then shot herself in the chest. Although not expected to live, the daughter recovered. She was charged with second-degree murder and then released by a judge to her family on $50,000 bail. Because of declining health, including multiple small strokes, the judge sentenced her to probation so that her family could continue to care for her. The increasing number of well-publicized homicide-suicides and homicides involving older couples highlight the lethal consequences of overwhelming hopelessness and depression. It is well-documented that depression often goes unrecognized and untreated in older people (Hirschfeld et al., 1997).

The case of *The State of Florida v Walter Opp* highlights the importance of developing guidelines for the consideration of mental health issues in legal proceedings against older perpetrators. Walter Opp, age 86 and driven by depression, desperation and feelings of hopelessness, intended to carry out a homicide-suicide. His health was failing, several close relatives had died, his brother and sister were chronically ill, and his two daughters had serious problems and were estranged from Mr. Opp and his wife. When Mr. Opp developed more health problems, he saw no other option. On an early October morning in 1997, he picked up a gun in despair and fired two shots at his wife's head as she lay sleeping. Fortunately, one bullet missed completely and the second only grazed her head.

Mr. Opp was arrested and charged with attempted first-degree murder, and he spent just over 100 days in jail before his sentencing hearing. He could have faced 15 years in prison under Florida law. After hearing the arguments of the prosecution and defense, the circuit court judge asked

Mrs. Opp what she wanted. She replied, "I love my husband and want him with me in our home so I may take care of him. He must have me with him, and I am dependent on him as well." Judge Ben Bryan sentenced Mr. Opp to time served, 15 years probation, and mental health evaluation and treatment. He summarized that imprisonment would not serve the goals of punishment, deterrence or rehabilitation. The judge recognized that a cascading series of life stressors and social isolation, coupled with a severe depression developing over a two-year period, were critical to Mr. Opp's actions. He also recognized that there was no history of domestic violence, and that Mrs. Opp would also be punished if her husband were sent to prison.

Intervention and Prevention

The long-term objective is to prevent homicide-suicides (Cohen, 1999). Although these acts appear to be a surprise when they occur, our research suggests that perpetrators have thought about it for a long time. In fact, there are often many warning signs of the pending violence. Predisposing risk factors include advanced age and a long-lived marriage where one or both members of the couple have real or perceived multiple health problems, as well as depression and other psychiatric problems in the perpetrator. Potentiating factors include a perpetrator with a controlling or dominant personality, the perpetrator is a caregiver, marital conflict, domestic violence, and family discord. Precipitating risk factors may include a real or perceived change in the perpetrator or victim's health, pending move to a nursing home, social isolation (staying home and rarely leaving the house), talk of divorce, pending separation, and increased use of alcohol.

These predisposing, potentiating and precipitating risk factors have important implications. Although homicide-suicides have complex motivations, the common theme is an intense attachment of the older perpetrator to a relationship that, when threatened by separation or loss, leads to violent, lethal action. Clinicians should assess the risk for homicide-suicide in all older patients where the following exist: 1) a history of ideation about suicide or violence; or 2) older couples who have been married a long time and one or both have health problems or evidence of domestic strife or discord. Assessment can be complicated for many reasons, especially since the victim, rather than the perpetrator, may be the patient. The perpetrator may also resist evaluation. The strong evidence of undetected and untreated depression in older perpetrators and the existence of domestic violence in about one-third of older homicide-suicides underscores the importance of careful interviews when one or both members of an older couple present for medical appointments. Since the de facto mental health care system for older people consists of primary care physicians, substantial efforts are needed to increase their knowledge in recognizing and treating depression as well as ways to combat hopelessness in older people and their caregivers.

Interventions should include intensive treatment of depression and other psychiatric problems when appropriate, removal of guns or other lethal weapons, social support for spouses and families in caregiving situations and appropriate interventions to deal with marital conflict-especially where the older woman is a potential victim of aggressive, lethal behavior. Intervention is complicated and should be done on a case by case basis. Separating the

perpetrator and victim may be appropriate to diffuse the tension and protect the victim. A careful clinical plan is essential, however, since separation is often the trigger for violence.

Homicide-suicides are traumatic events that change the lives of family members in many ways and for a long time. Short- and long-term reactions are influenced by many factors, including the history of family relationships, the nature and level of family members' involvement with the perpetrator and the victim, personal coping styles, religious beliefs of family, culture, and influence of friends. Similarly, contact with law enforcement, medical examiners and journalists in the investigative phases of the incident can affect outcomes. Spungen (1998) has created a traumatic grief assessment instrument that is useful for evaluating survivors' needs and guiding traumatic grief intervention. Supportive or counseling services should be made available to survivors.

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