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Is Schizoid Personality a Forerunner of Homicidal or Suicidal Behavior?

A Case Study

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The authors believe that a relationship exists between schizoid personality disorder and violent acts. The following case study is presented to contemplate such a possible relationship. There is a paucity of research on this topic. The authors suggest that further research closely examine the relationship between violent behavior and those character traits associated with schizoid personality disorder. If such a relationship is found, these character traits could be integrated with other risk factors known to predict violence.

Keywords: *schizoid personality; homicidal; suicidal; behavior*

Introduction

Mental illness is recognized as prevalent among incarcerated offenders. For example, the results of a survey of offenders incarcerated in the Canadian federal correctional system completed by Motuik and Porporino (1991) indicated that these offenders suffered from the following diagnoses: organic brain syndrome (4.3%), psychosis (0.4%), depression (29.8%), anxiety (55.6%), psychosexual disorders (24.5%), antisocial personality disorder (74.9%), substance abuse (52.9%), and alcohol abuse dependence (69.8%). Similarly, Hodgins and Cote (1990) reported that offenders in their sample from the Canadian province of Quebec were diagnosed with schizophre-

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nia (6.3%), depression (8.1%), anti-social personality disorder (46.4%), alcohol abuse dependency (33.1%), drug abuse dependency (18.6%), and any disorder (96.3%). Another set of research indicates alarming figures for the prevalence of mental illness among offenders. Teplin (1990) reported on the prevalence of severe mental disorders among men in an urban jail in the Chicago area. She found that the percentages of major depression, mania, schizophrenias, and severe mental disorders were significantly higher among detainees than among the nonjail population. She also presented 18 studies indicating that the prevalence of mental disorders in jails was extremely high. Some studies reported as that high as 49.0% were diagnosed as psychotic, 75.0% were diagnosed with schizophrenia, 35.0% were diagnosed with affective disorders, and 63.0% were diagnosed with any psychiatric diagnosis. Another study indicated an average of three prior psychiatric hospitalizations for the male offenders involved.

Similarly, a study on women pretrial detainees in the Chicago area (Teplin, Abram, & McClelland, 1996) found that 80.0% of these women met criteria for one or more lifetime psychiatric disorders, and 70.0% were symptomatic within the past 6 months. Although major depressive episode was the most prevalent major mental disorder, other common disorders included drug abuse or dependence, alcohol abuse or dependence, and post-traumatic stress disorder. Abram and Teplin (1991) reported that the co-occurring disorders among mentally ill jail detainees diagnosed with schizophrenia, major depression, mania, or any severe mental disorders were 84.9%, 81.0%, 86.7%, and 84.8%, respectively, for alcohol abusers; 60.9%, 59.5%, 46.9%, and 57.9%, respectively, for drug abuse or dependence; and 67.8%, 67.7%, 81.9%, and 68.7%, respectively, for antisocial personality disorders.

The link between mental illness and violent behavior has been investigated, and although some studies report a relationship between violent behavior and mental illness, others found no relationship between the two. Among researchers who suggested that such a relationship exists, Link and Stueve (1994) reported a higher rate of violent behavior among psychiatric patients than among nonpsychiatric patients. They found that although the percentage of police arrests for committing criminal acts and weapon- or fighting-related convictions were 22.5%, 12.9%, and 28.6%, respectively, for psychiatric patients, they were 9.9%, 2.7%, and 15.1%, respectively, for nonpsychiatric patients. Link and Stueve also reported that acute psychotic symptoms have greater predictive validity for violent acts than do lifetime diagnoses of schizophrenia. Motuik and Porporino (1991) reported that of the offenders in their study who committed homicides, 59.9% suffered from anxiety, 40.4% from depression, 13.1% from psychotic episodes, 3.0% from organic brain syndrome, 29.1% from psychosis, 43.6% from substance abuse, and 68.8% from alcohol dependency. Villeneuve, Oliver, and Loza (2002) reported that 32.65% of mentally ill offenders in their study who were released to the community recidivated violently, whereas the percentage was only 14.84% for the non-mentally ill offenders. In another study, Adams (1983) also found evidence for a link between mental illness and violence. Menuck (1985) reported studies that found a relationship between mental illness and aggressiveness in epileptics, temporal lobe epilepsy psychotic disturbances (in particular paranoid psychoses, and violent behavior), and a relationship between affective disturbances

and violent behavior. Krakowski, Volavka, and Brizer (1986) found that paranoid schizophrenics are more violent than are nonparanoid patients and that schizophrenics as a group tend to be more violent than other patients, followed by patients with personality disorders and organic brain syndrome. Other researchers, such as Monahan (1981), Rabkin (1979), and Taylor (1982), reported that mental illness alone is not a reliable predictor of violent behavior. Monahan (1981) cited researchers who found that a record of past violence is the best predictor of future violence among psychiatric patients, similar to that reported about the prediction of violent acts for the nonpsychiatric criminal population. Monahan (1992) and Wessely and Taylor (1991) reported that mental illness results in only a slightly elevated risk for violence. Gardner, Lidz, Mulvey, and Shaw (1996a) note that thought-disordered patients were less violent than were other patients. Similarly, Hodgins and Cote (1993) found no relationship between thought disorder and violence. In the same vein, several studies have found the rates of violence to be lower among patients with schizophrenia than among patients with diagnoses of other personality disorders (Gardner, Lidz, Mulvey, & Shaw, 1996b). Bonta, Law, and Hanson's (1996) meta-analysis indicated that mental illness was negatively related to the prediction of violence among offenders.

To our knowledge, there is a paucity of research on the relationship between schizoid personality disorder and violence. The following case study is presented to contemplate such a possible relationship. The case is of a man with a history of schizoid personality disorder who made a first unsuccessful attempt to murder his wife and who, a few years later, after several years of marriage, did kill her. Both the attempt and the actual killing were by strangulation. He had served 9 years of his prison term for the killing and was on his way to being released when he committed suicide. Though coming from an affluent family, Mark's (pseudonym) family history included mental illness on both paternal and maternal sides. Mark himself contemplated suicide in his late 30s, thinking that he would rather kill himself than become chronically ill with a disease he thought he may have had. He and his wife both had postgraduate educations with respectable professional careers.

Prior to the violence against his wife, Mark had never been involved with the law and had no history of violence, incarceration, or mental hospitalization. He began dating his wife in his early 20s, never dating anyone prior to that. After a decade of courtship, they married; they never had children. About 4 months into their marriage, Mark discovered that his wife had had a sexual encounter with another man, after she and Mark were married. Approximately a decade after marriage, he began to have platonic relationships with women, meeting them by placing newspaper advertisements. They would meet once every few weeks and go to movies and restaurants. Mark was an excellent listener to these women and gave them money and expensive gifts. Although the women openly encouraged him to have sexual relationships with them, he declined the offers and was very uncomfortable when they initiated any physical contact.

Almost 20 years in his marriage, at a time when he was terminating one of his relationships, a colleague criticized Mark about a professional report he completed. This resulted in his acting bizarrely at work, becoming delusional and depressed, and then contemplating suicide. He worried excessively that he would lose his job and be finan-

cially ruined. To avoid humiliation for himself and his wife, he decided to kill her and then himself. However, as he attempted to kill her, others intervened. No charges were laid, but he was hospitalized for 2 months. He was treated with antidepressants and discharged with a diagnosis of major depression with psychotic features and obsessive compulsive traits. He resumed his work and continued follow-up with a psychiatrist. Two years later, following a conflict with another colleague, he again feared losing his job and enduring financial problems. Moreover, he was convinced he had a serious physical illness. Thoughts of murder-suicide with his wife, to avoid humiliation, began again. Three days before murdering his wife, Mark bought her wine and strawberries. The next day he bought a rope—with which to hang himself—and went out with his wife for dinner. The night before the murder, he watched TV with her. This time, he succeeded in murdering his wife, but police intervened as he was attempting to hang himself.

Mark was diagnosed with major depressive disorder and personality disorder with schizoid and obsessive traits. On admission to the prison system, he was treated with an antidepressant, which was discontinued a year later. His depression disappeared. Nine years later, although he was functioning very well and revealed no indication of a mental illness or suicidal tendencies, Mark committed suicide. While incarcerated, he had no close relationships with friends or family members. However, shortly after he began his incarceration, he began to have biweekly visits with a woman, and they were planning to live together when he was released. Despite being eligible for conjugal visits with her, he did not apply for such visits. This relationship continued until he killed himself.

Discussion

Mark was described by people who knew him prior to and after incarceration as hypochondriac, introverted, odd, and aloof. He was a loner with no close relationships, never even starting a conversation, instead choosing solitary activities. He was a very private person who lived in the office. He became easily distressed if anyone questioned his opinion and could not tolerate anyone being upset with him. Yet he never showed outward anger. He seldom smiled. He was very rigid and meticulous and a perfectionist who set extremely high standards for himself and felt very guilty if he did not meet them. He was vulnerable, defenseless, and very private and had difficulty expressing his emotions. Yet, he also presented as sincere, thoughtful, honest, cordial, articulate, respectful, intelligent, very quiet, and shy and was respected by others. He maintained the same demeanor while in prison until his suicide, but occasionally he had mood swings and was extremely compulsive about his health, food, and diet. He exercised daily and took several vitamins, minerals, and other uncommonly eaten foods such as tomato paste.

Mark was hospitalized twice (the first time after the unsuccessful attempt to kill his wife and the second 2 years later after he killed his wife). He was treated with antidepressants, and discharged with a diagnosis of major depression with psychotic features and obsessive compulsive traits. Shortly after his admission to the prison system,

his treatment with an antidepressant was no longer needed. His depression disappeared, and there were no indications from his close associates in prison that he had experienced psychotic episodes or noticeable depressive moods.

From a diagnostic perspective, we believe Mark's basic personality disorder was of a schizoid type. The crucial distinguishing features of schizoid personality disorder, as in the case of Mark, are that the person appears to have a defect in the capacity to form social relationships and consequently is emotionally cold, aloof, or detached; has flattened affectivity; lacks close friends or confidants other than first degree family relatives; has little, if any, interest in having a sexual experience with another person; takes pleasure in few if any activities; and almost always chooses solitary activities. In terms of Axis II differential diagnosis, Mark did not seem to show any clear evidence of the suspicious and/or paranoid ideation that differentiates schizoid from paranoid personality disorder, even though, from his behavior, we cannot exclude paranoid features. Also, there were no signs of consistent cognitive distortions that distinguish schizotypal from schizoid personality. Mark had a pervasive detachment and showed no desire or capacity for social intimacy, which distinguishes his personality from both avoidant and obsessive compulsive personality disorders. He did, however, show obsessive compulsive traits complicated by hypochondrias, but he did not meet the criteria of obsessive compulsive personality disorder. He had episodes of a depressive disorder with psychotic symptoms. These episodes were of short duration. The remission of his depressive and psychotic symptoms did not change his inflexible maladaptive pattern of behavior. That indicates that his Axis II diagnosis (personality disorder) was his main diagnosis. For at least the 2 weeks before Mark committed suicide, there were no overt indications of depressive or psychotic symptoms (delusions, hallucinations, disorganized speech, etc.).

Based on the above information, we believe that the outward violence against his wife and the violence committed by Mark against himself were the result of a decompensation of his schizoid personality disorder. People with schizoid personality disorder are predisposed to develop brief psychotic episodes. That may have been the case with Mark at the time of his wife's homicide and his suicide. Indeed, prior to his suicide, there was no clear evidence of severe depression or psychotic symptoms. Of those who maintained contact with him up to a few hours prior to his suicide, no one reported any unusual behavior from him. They were all shocked to hear about his successful suicidal attempt.

Although mental illness is only one of the variables associated with violent acts and the relationship between mental illness and violent recidivism has not been decisively settled (Loza, 2003), we believe that a relationship exists between schizoid personality disorder and violent acts. There is a paucity of research in this area, and further research should closely examine the relationship between violent behavior and those character traits associated with schizoid personality disorder (i.e., inability to form social and intimate relationships, inability to appropriately respond to social cues, depression, restricted range of emotions, disintegration of self based on incorrectly perceived threats or criticism, a drive to destroy themselves and others, and the difference between what occurs in the inner world and that which one displays in the out-

ward appearance). If such a relationship is found, these character traits could be integrated with other risk factors known to predict violence. We hope that this article will stimulate researchers to focus attention on this line of research.

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