

HOMICIDE/SUICIDE

By Kenneth Norton LICSW

Though a relatively rare occurrence, situations involving a homicide followed by the suicide of the perpetrator grab headlines and draw a great deal of attention. More importantly, they have a devastating impact on the families, and communities who are touched by these tragedies. Social workers may be involved in having provided treatment to the perpetrators or victims or they may also be involved in providing treatment or supports to family members or communities in the aftermath of these incidents. The incidence of murder suicides is estimated to be 0.21-0.38 per 100,000 accounting for somewhere between 1,000 and 1,500 deaths in the US per year. In NH, statistics indicate that of the murders classified as domestic violence 25% of them also involve a suicide.

There is no clear consensus on exactly what constitutes a murder suicide in terms of time between the two events. Most researchers have looked at the suicide occurring between 1 and 3 days after the homicide. Some studies have extended this out to 30 days. More recently, the National Violent Death Reporting System (NVDRS), which is used in 18 states, categorizes murder/suicide as occurring within 24 hours. Thus, although some might argue the recent suicide death of the alleged "Craigslist killer" is directly related to the murders he is alleged to have committed, the fact that his death occurred over a year after the murders would rule this out as being classified as a murder suicide.

There are common factors in homicide/suicide cases. According to NVDRS data over 90% of murder suicides involve a male perpetrator and about 75% of the victims are females. Incidents involving strangers are extremely rare with 95% of victims having known their perpetrator. 85% of the murder suicides involved a single victim. Most incidents involve whites. Many of the perpetrators had a history of depression or other mental illness although it is likely these often went untreated. Alcohol and drugs are a contributing factor with 34% of the perpetrators having alcohol and 18% having other substances in their system at the point of death, though these figures are likely low as data is inconsistent because toxicology samples are not always taken. Most murder suicides involve the use of firearms typically handguns.

Homicide/suicides have been classified according to the relationship between perpetrator and victim as well as by looking at what the precipitants and motives may have been. Since both the victim and perpetrator are dead, it can sometimes be difficult to determine what the motives or precipitants really were. The categories below were first identified by Marzuk et al in 1992

Consortial are the most common and involve an intimate partner relationship which is often characterized by jealousy and possessiveness. Many of these relationships involve domestic violence and/or frequent separations.

Consortial/Medical deaths involve intimate partner relationships where one or both of the partners have a real (or perceived) medical condition. Evidence suggests that these incidents

are rarely impulsive and are often thought about (or planned) over a long period of time. Typically the victim (usually female) is not aware of the plan and is killed in her sleep, though occasionally evidence indicates it is consensual. Often these conclusions are drawn from conjecture as there is no way to know for certain.

Fillicide/Suicide is when a parent kills their child before killing themselves. Estimates are that 40-60% of father's and 16-29% of mother's take their life immediately after killing their children. For women, a common diagnostic feature is depression with psychosis that may involve believing that they would all be better off in heaven or similar belief .

Familicide/Suicide involves the murder of family members and may include the murder of both the consortial partner and children or other family members. Most often the male is the perpetrator in these tragedies. Marital problems and suspected infidelity, or anticipated or actual separation or divorce are also common precipitants.

Extra Familial are situations where there is no intimate relationship between the perpetrator and the victim. However, in most of these situations there is some connection and/or relationship between the perpetrator and victim such as a disgruntled employee or school shootings. It is very unusual for these incidents to involve random victims. Extra familial incidents are rare occurrences though when they do occur they dominate headlines (which may actually increase the risk of further incidents). Perpetrators often show symptoms of depression and may also have paranoid and/or narcissistic tendencies. Often times, the perpetrator has no escape plan and take their life when confronted by authorities or set up a scenario where they have a showdown with authorities (if law enforcement kills the perpetrator it would not technically be called a murder suicide).

Over 25% of murder homicides incidents involve people over the age of 55. Many of these are consortial/medical incidents with some studies showing that up to 50% of these incidents the male perpetrator was the primary caregiver. It is important to note that psychological autopsies indicate that many of the perpetrators in these situations had unrecognized and subsequently untreated depression even though many of them had visited a primary care provider shortly before the incident. This should serve as another reminder for social workers and health care providers working with older adults that depression is not a normal part of the aging process and needs to be assessed particularly in situations involving a dependent caregiver relationship or serious medical conditions.

Social workers and providers should also carefully monitor and assess situations where they are working with individuals (either a potential victim or perpetrator) in a relationship where there is a history of controlling behavior or domestic violence; particularly when there is a recent or anticipated separation or divorce.

It is everyone's responsibility to prevent suicide. Warning signs include: talking about death or dying, isolation, anger/rage, hopelessness, increased use of alcohol or other drugs and mood

changes. If you are worried about someone you think is at risk of suicide call the National Suicide Prevention Lifeline 1-800-273-TALK (8255).

This is the fifteenth in a series of articles for the NH NASW newsletter on suicide prevention. Previous articles include: Suicide as a Public Health Issue, Suicide Prevention In NH, Survivors of Suicide Loss, No Harm Contracts, Military/Veterans and Suicide, Restricting Access to Lethal Means, Suicide and Older Adults, Suicide Risk and LGBT Youth, Clinicians as Survivors of Suicide Loss, Suicide and the Economy, Media, New Media, Safe Messaging & Suicide Prevention, Ethics and Suicide Prevention, Suicide and Self Harm, and Homicide and Suicide. Previous articles can be viewed in the news and media section of the Connect Program website

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