MENTAL ILLNESS AND HOMICIDE – PREVENTION OF RECIDIVISM

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SUMMARY – We hypothesized that the integration of forensic psychiatrists and the forensic system into the general stream of mental health should lead to better reintegration of forensic patients into the society. The aims of the study were to explore the link between violence, murder, psychiatric disorders and other variables, and to suggest a mode of prevention of criminal recidivism. This investigation provided a more reflective profile of mentally ill persons convicted of murder, hospitalized in Psychiatric Hospital in Demir Hisar in Macedonia between 2007 and 2009. Study results indicated the offender with severe mental illness incarcerated for murder in Demir Hisar Psychiatric Hospital to be predominantly suffering from a mood disorder, to be a male with secondary school education, and to have significant intimate and family relationships characterized by rage as a frequently mentioned motive for murder. On committing homicide, they frequently used firearm or sharp objects. The offenders lived in dysfunctional families, had extensive histories of substance abuse and criminal activity before their murder conviction, and received inadequate treatment for their mental disorder and substance abuse. We suggest that the offenders (murderers) continue their treatment in mental health forensic services upon completing their obligatory treatment at a psychiatric hospital.

Key words: *Mental disorders; Forensic psychiatry; Homicide – prevention and control*

Introduction

In essence, the quality of interventions, tailoring to the needs, comprehensiveness, integration, seamlessness, accessibility and accountability are, among others, the key concepts to make the system work and be responsive to the needs of the patient. Poor implementation of the mental health reform policies are often given as the reasons for open forensic mental health services. We suggest that the offenders (murderers), upon completing their security obligatory treatment in a psychiatric hospital, continue their treatment in mental health forensic services, which we will open in the future within the frame of Demir Hisar Psychiatric Hospital. We suggest that the integration of forensic psychiatrists and the forensic system into the general stream of mental health should lead to better reintegration of forensic patients into the society.

The few descriptive studies that were focused specifically on violence among persons with mental illness have confined their analyses to the subpopulation of adults displaying symptoms of psychosis or schizophrenia and report only on clinical descriptions of the murderers. We describe the variables of a sample of 100 adults with a lifetime diagnosis of mania, major depression, bipolar disorder, schizophrenia, or other psychotic disorders, who were sentenced for murder and detained in Demir Hisar Psychiatric Hospital in Macedonia.

Considering established association between violence and mental illness[1-3], many studies have been designed to identify specific factors such as delusional or psychotic symptoms[4-11], or substance use[12-15], which

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are associated with violent behavior in persons with mental illness. Subsequent research has shown that individuals who are charged with different crimes (e.g., comparing sex crimes, threats, and murder) have different mental states and psychopathology[16-18]. These findings suggest that the characteristics of persons involved in lethal violence may differ from those of persons having committed nonlethal violence. Therefore, while previous studies have been useful in identifying variables that are associated with an increased risk of overall violence among persons with mental illness, these associations are likely to differ in the subgroup of persons with mental illness whose actions result in intentional death of the victim.

Persons who have been sentenced to a psychiatric hospital for murder are likely to have more severe mental illnesses than those who have been sentenced to the penal system. Indeed, Nestor and Haycock[19] have shown that those hospitalized are more likely to be seen as psychotic at the time of the murder than those who are incarcerated. This high level of severity of mental illness is apt to influence many of the variables under study (e.g., housing[20,21], employment[22,23] and relationships[24]) differently from a mental illness of lower severity.

Our aims were to explore the link between violence, psychiatric disorders and other variables, and to suggest prevention of criminal recidivism. We analyzed 100 offenders with severe mental illness according to the ICD-10 classification. All patients were hospitalized in Demir Hisar Psychiatric Hospital. The χ^2-test was used on statistical data processing.

Subjects and Methods

This investigation provided a more reflective profile of mentally ill persons convicted of murder in Demir Hisar Psychiatric Hospital, Macedonia, between 2007 and 2009. We included data on 100 offenders with severe mental illness and analyzed factors considered important in the study of homicide[25], already examined in previous studies of mental illness and violence. All patients were incarcerated for the crime of murder and hospitalized in the special forensic part of Demir Hisar Psychiatric Hospital. The following data were collected and analyzed: history of illness, forensic expertise, and program of mental illness management and deinstitutionalization of forensic hospitals. Study patients were diagnosed according to the ICD-10 classification. The procedures were in accordance with the ethical standards of the institutional or regional committee on human studies and Helsinki Declaration of 1975, as revised in 1983. All subjects were informed about the procedure and gave their informed consent. Statistica 7.1/2005 was employed on statistical analysis. In the series with attributive notes percents of

Table 1. Personal variables

	n	%
Sex		
Male	78	78
Female	22	22
Level of education		
Elementary school	46	46
Secondary school	53	53
College/University	1	1
Marital status		
Single	57	57
Divorced	22	23
Married	16	16
Separated	3	3
Widowed	1	1
Unknown	1	1
Parental status		
No	38	38
Unknown	2	2
Yes	60	68
Some contact with child	40	40
No contact	11	11
Unknown	9	9
Employment	41	41
Unemployed	48	48
Unknown	11	11
Transient or homeless		
Yes	4	4
No	89	89
Unknown	7	7
Abuse as a child	53	53
Physically abused	26	26
Emotionally abused	19	19
Sexually abused	8	8
Caregiver dysfunction	56	56
Caregiver alcohol abuse	41	41
Caregiver drug abuse	5	5
Caregiver criminal history	10	10

Table 2. Situational variables

	n	%
Victim sex		
Male	68	52
Female	62	48
Relationship to offender		
Family (not spouse)	37	29
Acquaintance or friend	36	28
Intimate	26	20
Stranger	11	9
Unknown	20	15
Day of murder		
Monday	14	11
Tuesday	13	10
Wednesday	16	12
Thursday	27	21
Friday	14	11
Saturday	27	21
Sunday	18	14
Unknown	1	1
Method of murder		
Firearm	67	52
Knife or other sharp instrument	27	21
Strangulation or suffocation	12	9
Bludgeon with object or fists	13	10
Automobile	7	5
Burning	3	2
Drowning	3	2
Other	1	1
Unknown	2	2
Location of murder		
Victim's residence	43	33
Victim's and offender's shared residence	26	20
Public area (e.g., street, park)	23	17
Other residence or victim's vehicle	22	17
Place of work	11	9
Other	2	2
Unknown	3	2
Alcohol use prior to murder		
No	19	20
Unknown	54	57
Yes	22	23
Alcohol impairment		
Yes	16	17
No	1	1
Unknown	5	5
Drug use prior to murder		
No	23	24
Unknown	51	54
Yes	21	22
Drug impairment		
Yes	14	15
No	1	1
Unknown	6	6

structures were defined. We used χ^2-test. Results are presented in tables.

Results

We analyzed 100 offenders with severe mental illness. Almost half of them reported that their caregivers had a history of alcohol or drug abuse, or a criminal record. It should be noted that the number of cases with missing data on these variables ranged from 20 to 50. Male sex (78%), secondary school education (53%) and single murderers (57%) prevailed, followed by those with parental status (60%), those with some contact with child (40%), unemployed (48%), transient or homeless (89%), with a history of abuse in childhood (53%) and alcohol abuse in caregivers (56%) (Table 1). There was no significant difference between patient sex and abuse in childhood (χ^2=0.92; P>0.05).

Data on the crime and victim are presented in Table 2. Ninety-five offenders were convicted for having committed multiple homicides. Three-fourths of the victims were known to the offender; nearly half were either a family member (n=37) or had been in intimate relationship with the offender (n=26). Not surprisingly, half of all murders were committed either in the victim's residence or the residence shared by the victim and the offender. Male offenders (52%) committed murders on Thursday and Saturday (19%), using firearm (55%), committed murder in the victim's residence (27%); alcohol use prior to murder was unknown in 60% and demonstrated in 15% of murders; drug use prior to murder was unknown in 58% and demonstrated in 14% of murders (Table 2). There was no significant difference between alcohol abuse and drug abuse prior to murder (χ^2=1.52; P>0.05).

Table 3. Motives and diagnoses

	Schizophrenia		Other psychotic disorder		Bipolar disorder		Major depression		Mania	
	n	%	n	%	n	%	n	%	n	%
Rage	5	33	2	40	3	50	9	26	1	50
Intimate or family situation	2	14	1	20	2	34	6	18	1	0
Non-intimate or nonfamily situation	1	7	0	0	0	16	6	18	0	0
Hatred, animosity or revenge	3	20	2	40	40	1	5	15	1	50
Related to other crimes	2	13	0	0	0	0	4	12	0	0
Money/property gained	1	7	0	0	0	0	1	3	1	0
Delusional	1	6	0	0	0	0	1	3	0	0
Gratification	0	0	0	0	0	0	3	5	0	0
Unknown	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0

While research has attributed violent behavior among persons with severe mental illness to psychotic symptoms and delusions of perceived threat, delusional thinking was not commonly identified as a motive for murder, perhaps because of the limited data which, for example, did not allow an in-depth analysis of the source of rage or anger that commonly motivated murder. Table 3 shows data on the motives according to diagnosis. For example, rage or anger was identified as a motive in 33% of persons with schizophrenia (n=15). This anger arose from an intimate or family situation in 14% of persons with schizophrenia (Table 3).

There was no significant difference between the patient diagnosis and rage or anger, and intimate or family situation (χ^2=0.58; P>0.05).

Table 4 identifies major depression as the most common diagnosis, followed by schizophrenia and other psychotic disorders. Less than two-thirds of offenders had been treated at least once, as inpatient or outpatient, for their mental illness; less than half had been treated more than once. Nearly half of the offenders had a history of suicide attempts, the majority (35%) of which were associated with having a diagnosis of major depression. In addition to psychiatric disorders, about one-fifth of offenders possessed myriad physical disabilities that were determined to be 'stigmatizing' by the researchers (e.g., hepatitis, a deformed limb, or speech impediment).

There was a significant difference between the patient diagnosis and history of suicide attempts (χ^2=13.37; P>0.2).

Discussion

Study results characterized the offender with severe mental illness and incarcerated for murder in Demir Hisar Psychiatric Hospital to predominantly suffer from a mood disorder, to be a male with secondary school education, and to have significant intimate and family relationships associated with rage as a frequently mentioned motive for murder. On committing homicide, they frequently use firearm or a sharp object. The offenders lived in dysfunctional family, had extensive histories of substance abuse and criminal activity before murder conviction, and had received inadequate treatment for their mental disorder and substance abuse. These findings are consistent with previous studies of persons with mental illness who exhibited violent behavior and were hospitalized as murderers with psychoses or schizophrenia, performed in countries other than the United States.

Our previous knowledge of the study subjects was very rich. The corresponding author had tackled the issue in her MS thesis about two years ago and we have reported on our work on violence and offenders in a number of papers and congress reports.

Table 4. Clinical variables

	n	%
Diagnosis		
Major depression	35	35
Schizophrenia	15	15
Other psychotic disorder	5	5
Bipolar disorder	6	6
Mania	2	2
Drug abuse and treatment		
Age at first use		
Never used drugs	8	8
Unknown	48	48
History of drug abuse		
No	27	27
Unknown	5	5
Yes	68	68
Drug of choice		
Marihuana	43	43
Stimulants	14	14
Inhalants	3	3
Other	8	7
Drug treatment		
No	42	42
Unknown	7	7
Yes	19	19
Once	4	4
More than once	8	8
Unknown	5	5
Mental health treatment		
None	20	20
Once	17	17
More than once	44	44
Unknown	19	19
History of suicide attempts		
Yes	49	49
No	26	26
Unknown	25	25
Physical disability		
Yes	17	17
No	72	72
Unknown	11	11
Alcohol abuse and treatment		
Age at first use		
Never used alcohol	2	2
Unknown	35	35
History of alcohol abuse		
No	25	25
Unknown	7	7
Yes	67	67
Alcohol treatment		
No	34	34
Unknown	5	5
Yes	25	25
Once	8	8
More than once	15	15

Results from one study[26] show no difference in the prevalence of violence across psychiatric diagnoses. Our results suggest a different conclusion, as 35% of offenders had the diagnosis of major depression, 6% of bipolar disorder and 2% of mania, while psychotic disorders including schizophrenia was diagnosed in only 20%, although there was some overlap among the diagnoses. These figures indicate that mood disorder offenders with comorbidity prevailed over offenders with schizophrenia or other psychotic disorders.

According to literature reports assessing the relationship between mental illness and general violence, substance abuse appears to be a consistent predictor of violent behavior[26-31]. Some studies support the role of the early onset of substance abuse[32] in violent behavior among persons with mental illness. The first use of alcohol before the offenders' 15th birthday indicates that substance abuse probably began at an early age.

In many offenders with severe and persistent mental illness, not receiving treatment was associated with violence in adult age[33], or with not taking medication for their severe mental illness at the time of the murder.

The literature implicates delusional thinking and psychotic symptoms in violent behavior among persons with serious mental illness[34-36]. In our study, 9% of the offenders had delusional motives, in comparison with other studies stating that delusional think-

ing, specifically threat/control-override delusions[37], may play a role in homicide.

Since most of the killings were attributed to rage or anger toward the victim, it is possible that these emotions were stirred by a delusional threat and that the data collection methods were unable to distinguish between fury resulting from a real or imagined threat. The findings reported by some authors point to the time of the offender's avoiding incarceration and thus being possibly underrepresented in the study sample[38]. Murder victims were primarily family or intimate relations of their attackers and were as likely to have been killed in their own residences as elsewhere. This result is consistent with research findings[39] and reviews of the literature on mental illness and violence[40,41] that show that public fears[42] of violent victimization on the street by an unknown person with mental illness are not supported by the empirical evidence. In our study, the majority of offenders sentenced for murder were either married or in a significant relationship at the time of the offense. In addition, most were parents, many were employed, and nearly all had stable housing. Educational programs aimed at family members and intimates of persons with severe mental illness that provide information about mental illness, coping strategies, and how to manage aggressive behavior could be helpful in reducing the murder rates among close relations of persons with severe mental illness[42].

We have previously suggested that persons who have been sentenced to a psychiatric hospital for murder are likely to suffer from more severe mental illness than those with mental illness who have been sentenced to the penal system for murder, and that findings from studies of this population would not transfer well to the prison population.

Rates of the types of murder weapons and common murder locations similar to our findings have also been reported from another study[43].

As such, findings from analyses conducted in persons with psychotic or schizophrenic disorders who have been convicted of murder may not adequately reflect the more psychiatrically heterogeneous population of incarcerated severely mentally ill murderers. Comparing data on the average age at the time of murder, the influence of alcohol and the days of the week on which most murders occurred reported in the literature[44,45], we found that the offenders detained in Demir Hisar Psychiatric Hospital had a much more extensive criminal history before the murder, lower rates of physical disabilities, were much more likely to use a firearm to kill and to kill a family member rather than a stranger, had lower rates of psychotic disorders and of experiencing active delusions at the time of the offense, had higher rates of major depression, and had much higher rates of killing for financial gain.

While some of our findings were similar to those in the aforementioned studies, many pointed to the distinctive characteristics of persons with severe mental illness who had been convicted and sentenced to prison for murder in Demir Hisar Psychiatric Hospital.

However, it is the first step toward providing a more complete overview of the characteristics of persons with severe mental illness who have been sentenced to prison for murder in the United States. The findings will allow for future analysis of risk factors for murder among persons with mental illness by comparison to non-mentally ill murderers and to persons with a mental illness who engage in violence.

Conclusion

We suggest that the offenders (murderers), when finishing the obligatory treatment in a psychiatric hospital, continue their treatment in the mental health forensic service, which will be opened within the frame of Demir Hisar Psychiatric Hospital. We suggest that the integration of forensic psychiatrists and the forensic system into the general stream of mental health care can be expected to result in better reintegration of forensic patients into the society.

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References

1. MONAHAN J. Mental disorder and violent behavior: perceptions and evidence. Am Psychol 1992;47:511-21.
2. LINK BG, ANDREWS H, CULLEN FT. The violent and illegal behavior of mental patients reconsidered. Am Sociol Rev 1992;57:275-92.
3. MULVEY EP. Assessing the evidence of a link between mental illness and violence. Hosp Community Psychiatry 1994;45:663-8.
4. SWANSON J, BORUM R, SWARTZ MS, *et al*. Psychotic symptoms and disorders and the risk of violent behavior in the community. Crim Behav Ment Health 1996;6:205-15.
5. SWANSON J, BORUM R, SWARTZ MS, *et al*. Psychotic symptoms and disorders and the risk of violent behavior in the community. Crim Behav Ment Health 1996; 6:309-29.
6. TAYLOR PJ, LEESE M, WILLIAMS D, *et al*. Mental disorder and violence: a special (high security) hospital study. Br J Psychiatry 1998;172:218-26.
7. FRESAN A, APIQUIAN R, De la FUENTE-SANDOVAL C, *et al*. Violent behavior in schizophrenic patients: relationship with clinical symptoms. Aggress Behav 2005;31:511-20.
8. HODGINS S, HISCOKE UL, FREESE R. The antecedents of aggressive behavior among men with schizophrenia: a prospective investigation of patients in community treatment. Behav Sci Law 2003;21:523-46.
9. NORDSTRÖM A, DAHLGREN L, KULLGREN G. Victim relations and factors triggering homicides committed by offenders with schizophrenia. J Forensic Psychiatry Psychol 2006;17:192-203.
10. BJORKLY S, WAAGE L. Killing again: a review of research on recidivistic single-victim homicide. Int J Forensic Ment Health 2005;4:99-106.
11. SWANSON JW, SWARTZ MS, Van DORN RA, *et al*. A national study of violent behavior in persons with schizophrenia. Arch Gen Psychiatry 2006;63:490-9.
12. PUTKONEN H, COLLANDER J, HONKASALO M-L, *et al*. Personality disorders and psychoses form two distinct subgroups of homicide among female offenders. J Forensic Psychiatry 2001;12:300-12.
13. FAZEL S, GRANN M. Psychiatric morbidity among homicide offenders: a Swedish population study. Am J Psychiatry 2004;161:2129-31.
14. HALLER R, KEMMLER G, KOCSIS E, *et al*. [Schizophrenia and violence: results of an enquiry in an Austrian province.] Schizophrenie und Gewalttätigkeit Ergebnisse einer Gesamterhebung in einem österreichischen Bundesland. Nervenarzt 2001;72:859-66.
15. DUBREUCQ JL, JOYAL C, MILLAUD F. [Risk of violence and serious mental disorders.] Risque de violence et troubles mentaux graves. Annal Med Psychol 2005;163:852-65.
16. COCHRANE RE, GRISSO T, FREDERICK RI. The relationship between criminal charges, diagnoses, and psycholegal opinions among federal pretrial defendants. Behav Sci Law 2001;19:565-82.
17. FIORITTI A, FERRIANI E, RUCCI P, *et al*. Characteristics of homicide perpetrators among Italian forensic hospital inmates. Intl J Law Psychiatry 2006;29:212-9.
18. KOH KG, PENG GK, HUAK CY. Are homicide offenders psychiatrically different from other violent offenders? Psychiatry Psychol Law 2005;12:311-8.
19. NESTOR PG, HAYCOCK J. Not guilty by reason of insanity of murder: clinical and neuropsychological characteristics. J Am Acad Psychiatry Law 1997;25:161-71.
20. MARTELL D, ROSNER AR, HARMON RB. Base-rate estimates of criminal behavior by homeless mentally ill persons in New York City. Psychiatr Serv 1995;46:596-601.
21. MICHAELS D, ZOLOTH SR, ALCABES P, *et al*. Homelessness and indicators of mental illness among inmates in New York City's correctional system. Hosp Community Psychiatry 1992;43:150-4.
22. ANTHONY WA, BLANCH A. Supported employment for persons who are psychiatrically disabled: an historical and conceptual perspective. Psychosoc Rehabil J 1987;11:5-23.
23. MUESER KT, SALYERS MP, MUESER PR. A prospective analysis of work in schizophrenia. Schizophr Bull 2001;27:281-96.
24. LINK BG, CULLEN FT, FRANK J, WOZNIAK JF. The social rejection of former mental patients: understanding why labels matter. Am J Soc 1987;92:1461-500.
25. MacDONALD HM. The murderer and his victim. Springfield, IL: CC Thomas, 1961; 420.
26. SWANSON JW, HOLZER CE, GANJU VK, *et al*. Violence and psychiatric disorder in the community: evidence from the Epidemiologic Catchment Area surveys. Hosp Community Psychiatry 1990;41:761-70.
27. STEADMAN HJ, MULVEY EP, MONAHAN J, *et al*. Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Arch Gen Psychiatry 1998;55:393-401.
28. SWARTZ MS, SWANSON JW, HIDAY VA, *et al*. Violence and severe mental illness: the effects of substance abuse and nonadherence to medication. Am J Psychiatry 1998;155:226-31.
29. SWARTZ MS, SWANSON JW, HIDAY VA, *et al*. Taking the wrong drugs: the role of substance abuse and medication noncompliance in violence among severely mentally ill individuals. Soc Psychiatry Psychiatr Epidemiol 1998;33(Suppl 1):S75-80.
30. SWANSON JW, SWARTZ MS, ESSOCK SM, *et al*. The social-environmental context of violent behavior in persons treated for severe mental illness. Am J Public Health 2002;92:1523-31.

31. LANGEVIN R, PAITICH D, ORCHARD B, *et al*. The role of alcohol, drugs, suicide attempts and situational strains in homicide committed by offenders seen for psychiatric assessment: a controlled study. Acta Psychiatry Scand 1982;66:229-42.
32. FULWILER C, GROSSMAN H, FORBES C, *et al*. Early-onset substance abuse and community violence by outpatients with chronic mental illness. Psychiatry Serv 1997;48:1181-5.
33. SWANSON J, ESTROFF S, SWARTZ M, *et al*. Violence and severe mental disorder in clinical and community populations: the effects of psychotic symptoms, comorbidity, and lack of treatment. Psychiatry 1997;60:1-22.
34. JUNGINGER J. Command hallucinations and the prediction of dangerousness. Psychiatr Serv 1995;46:911-4.
35. JUNGINGER J, McGUIRE L. Psychotic motivation and the paradox of current research on serious mental illness and rates of violence. Schizophr Bull 2004;30:21-30.
36. JUNGINGER J, PARKS-LEVY J, McGUIRE L. Delusions and symptom-consistent violence. Psychiatr Serv 1998;49:218-20.
37. LINK BG, STUEVE A. Psychotic symptoms and the violent/illegal behavior of mental patients compared to community controls. In: MONAHAN J, STEADMAN HJ, editors. Violence and mental disorder: developments in risk assessment. Chicago: University of Chicago Press, 1994;137-59.
38. TAYLOR PJ, GARETY P, BUCHANAN A, *et al*. Delusions and violence. In: MONAHAN J, STEADMAN HJ, editors. Violence and mental disorder: developments in risk assessment. Chicago: University of Chicago Press, 1994;161-82.
39. ESTROFF SE, SWANSON JW, LACHICOTTE WS, *et al*. Risk reconsidered: targets of violence in the social networks of people with serious psychiatric disorders. Soc Psychiatry Psychiatr Epidemiol 1998;33(Suppl 1):S95-101.
40. TORREY EF. Violent behavior by individuals with serious mental illness. Hosp Community Psychiatry 1994;45:653-62.
41. SOLOMON PL, CAVANAUGH MM, GELLES RJ. Family violence among adults with severe mental illness: a neglected area of research. Trauma Violence Abuse 2005;6:40-54.
42. WAHL OF. Media madness: public images of mental illness. New Brunswick, NJ: Rutgers University Press, 1995.
43. LEONG GB, SILVA JA. A psychiatric-legal analysis of psychotic criminal defendants charged with murder. J Forensic Sci 1995;40:445-8.
44. GUDJÖNSSON GH, PETURSSON H. Some criminological and psychiatric aspects of homicide in Iceland. Med Sci Law 1982;22:91-8.
45. PETURSSON H, GUNDJÖNSSON GH. Psychiatric aspects of homicide. Acta Psychiatr Scand 1981;64:363-72.

Sažetak

MENTALNI POREMEĆAJI I UBOJSTVO – PREVENCIJA RECIDIVIZMA

V. Talevska i *B. Stefanovski*

Naša je hipoteza da bi se integracijom forenzičnih psihijatara i sudske medicine u matičnu zaštitu mentalnog zdravlja obuzdalo širenje sudske psihijatrije i postiglo bolje ponovno uključivanje ovih bolesnika u društvo. Cilj ove studije bio je ispitati povezanost nasilja, ubojstava, psihijatrijskih poremećaja i drugih varijabla, te predložiti metode prevencije ponavljanja zločina. Ovo ispitivanje daje promišljeni profil mentalno bolesnih osoba zatočenih zbog ubojstva u Psihijatrijskoj bolnici Demir Hisar u Makedoniji u razdoblju od 2007. do 2009. godine. Prema dobivenim rezultatima, počinitelji zatočeni u ovoj bolnici najčešće boluju od poremećaja raspoloženja, muškog su spola, imaju srednješkolsko obrazovanje i značajne intimne i obiteljske odnose obilježene bijesom i gnjevom, koji se često spominju kao motiv ubojstva. U počinjenju ubojstva oni često rabe vatreno oružje ili neki oštar predmet. Počinitelji su živjeli u disfunkcionalnim obiteljima, imali su opsežnu povijest zlouporabe psihoaktivnih tvari i kriminalnih djela prije počinjenja ubojstva, dok je liječenje njihove psihičke bolesti i zlouporabe psihoaktivnih tvari bilo nedostatno. Stoga preporučamo da počinitelji (ubojice), nakon što odsluže obvezatno liječenje u psihijatrijskoj bolnici, nastave s liječenjem u službi sudske medicine u okviru zaštite mentalnog zdravlja.

Ključne riječi: *Mentalni poremećaji; Sudska psihijatrija; Ubojstvo – prevencija i kontrola*