Women, psychosis and violence

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Mainstreaming Gender: Women’s Mental Health Into the Mainstream

Implementation Guidance

Women’s Mental Health

September 2003

SUMMARY

Mental illness

“Difficult, disruptive, manipulative, volatile - turbulent beginnings on mental lines end up women over the edge.”

“Let us have a chance to prove ourselves.”

Making a difference

Women’s needs

“The Women have been rejected and dumped by society.”

Mental health care

Those who successfully move on from traumatic beginnings to build their lives and develop their abilities, often cite one person who believed in them and never gave up on them.

It need not be a life sentence from which there is no escape.

Women offenders and mental health issues
Women form a tiny proportion of the people resident in secure hospital services.

Women with psychosis constitute less than half of this group.

- What is the general female population based frequency of association between psychosis and violence?
- What is the life-course of violence for women with psychosis?
- What are the explanations for violence among women with psychosis?
- What specific factors may there be for treatment strategies?
Women, psychosis and violence

Taylor & Bragado-Jimenez, 2009 IJLP

- We reviewed literature in English, identified through PUBMED to 31.12.2007 & reviews, government reports and follow-up from reference lists

- Much research in the field excludes women
- Information generally has to be extracted from studies with a primary focus on men
- When studies do include both sexes, there is a tendency to
  - exclude women from analysis (small n) or,
  - to ‘control for sex’

- Arguments about risks to unborn babies may be exaggerated
- But, numbers of women in this precise field are undoubtedly small anyway
Women, psychosis & violence: frequency of associations

- Systematic review: 20 case control studies, schizophrenia/similar psychosis v gen. pop n 1970-2009 Fazel et al 2009
  >18,400 psychosis 10% violent
  >1.7m general pop 1.6% violent
  5000 women with psychosis: six studies
  psychotic women 6-7X risk violence
- Psychiatric hospital and offender register links 1988-2000 population attributable risk psychotic violence 5%
  for women % attributable to psychosis consistently higher
  c. 1/5 violent crimes by women aged 40+
  attributable to schizophrenia Fazel & Grann, 2006
- Hospital inpatient studies generally show women at least as frequently violent as the men
  More so in specialist secure units?
- Special risk of psychotic depression? Häfner & Boker 1973
Offence specific behaviour?

- None
- Killing infants < 12 months?
  Not in England & Wales
  NCI Flynn et al 2007

- Arson?
  More common in psychiatric samples

- Erotomania?
  Condition more common but not the stalking/other crime
And homicide inquiries?

Many fewer than for men
Perpetrator’s picture less likely?
And less likely to drive service change?

- Children of a woman with mi who stabbed to death a widow in a city shop call for an inquiry into their mother’s medical care
- The 45-year-old, diagnosed with schizophrenia in 1992, took an 8in carving knife from the shelf of the store and plunged it into Mrs. Thomas’ back. *BBC*
- Ms A’s contact with mental health services can be divided into two periods:
  * 1992-8, when given a diagnosis of schizophrenia, treated with anti-psychotics and followed up by services
  * 2003-5, when given a diagnosis of BPD, and not given continued treatment nor followed up. *Hom. Inq 2008*
If personality disorder and psychosis can be so easily confused -

To what extent might co-morbid personality disorder explain the differences between female and male offenders with psychosis?

Hypotheses

• In a high security hospital cohort, women would be more likely than men to have co-morbid personality disorder
• This would explain other gender differences in psychiatric and offending histories

Bragado-Jimenez & Taylor
Methods

• Records extracted from English high security hospital resident cohort
• 98 women & 837 men
  - psychosis at least 6 months
  - criminal offence
  - risk to harm to others at the admission

• Co-morbid PD defined as
  - PD continuous with conduct disorder in childhood/adolescence
  - and present before onset of psychosis

• Bivariate analysis of female: male differences in historical factors
• Multivariate analysis entering all significant factors (p<0.05), without PD co-morbidity, then
• with PD co-morbidity
Socio-demographic factors

IQ average
Literate
Unemployed
from institutions

Women
Men

*** p<0.05
Psychiatric history

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**Psychiatric treatment in childhood**

**Psychiatric treatment in adulthood**

**Previous suicidal behaviour**

**Previous parasuicidal behaviour**

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**Women**

**Men**

*** **p<0.05**

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History of violence

- Previous history of violence
- Previous personal assault
- Three or more acts of violence
- Homicide as main IO

*** p<0.05
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<th>CI (95%)</th>
<th>Sig</th>
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<td>HOMICIDE</td>
<td>.607</td>
<td>.338</td>
<td>1.092</td>
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... co-morbid PD
2x more common among the women; does not explain other differences

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<tr>
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<td>COMORBID PD</td>
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The life-course of violence for women with psychosis

- Similar to that for women without psychosis
- Different from men with psychosis

Later onset, earlier desistence
Sweden
Lindqvist & Allebeck 1990; Hodgins 1992

- Offending/violence before or after onset of psychosis?
  Very little evidence
  UK special hospital women 2X > men offending after 1st hospital
  Jones et al 2009

- Abuse histories? Predicting psychosis? Violence? Both?
If not pd – what explanations for violence among women with psychosis are there?

- Women have caught up with men in terms of co-morbid substance misuse
  
  US Brunette & Drake 1997
  UK McMahon et al, 2003

- Do women and men respond differently to psychotic symptoms?
  
  Yes, maybe Teasdale et al 2006
  Otherwise doubtful Freeman et al 2007; Link & Stueve 1994;
  Krakowski & Czobor 2004,
Specific factors for treatment strategies

Psychological treatments for psychosis with violence
Nothing but anecdotal evidence
Women more likely than men to want to talk about ‘personal concerns’

Hormonal interventions?
Cochrane review: no benefit  Chua et al, 2005

Drug treatments
Dose for dose, women tend to have higher serum levels of neuroleptic than men and higher risk of hyperprolactinaemia  Radler & Naber, 2007
Improvement in illness, reduction in violence & reduction in being victim of violence; women in trials, but data not analysed separately  Swanson et al, Hiday et al, 2000

Risks in pregnancy/post partum?
No RCTs; examine the risk benefit ratio carefully  Webb et al, 2004

But women with psychosis rarely get pregnant?
Motherhood is unique to women
What is known about motherhood among women with psychosis in secure care?

- 38% of women in high security hospitals have at least one child (SH case register 1972-2000)
- 70% of women in prison have at least one child
- 42% of women in prison have at least one child <16
- 5.6% of women in prison are pregnant at reception

Characteristics of a consecutive series of 50 women admitted to an MSU

with R Jones, M Lougher, T Amos, P Huckle & J Short

- Median age on admission = 34 years (IQR 19-56 years)

- Diagnoses
  - Psychosis = 33 (66%)
  - Affective disorders = 12 (24%)
  - Personality disorders = 21 (42%)

- Number of previous admissions
  - Median = 5
  - Range = 0-20

- Index offences
  - Arson = 19 (38%)
  - Violence = 14 (28%)
  - Other 15 (30%)
  - No index offence = 12 (24%)

76% previously violent 58% previously fire setters
Trauma history

- Sexual abuse
  - history of rape: 26 (52%)
  - other sexual abuse: 15 (30%)
- Physical abuse
  - history: 30 (60%)
- Emotional abuse: 28 (56%)
- Age at first trauma
  - 25% < 5 years
  - 49% aged 6-11
  - 17% 12-16
  - 8% >16

- NO record of these abuses:
  - 3 (6%)
Children of the women admitted

- 60 pregnancies
- 44 live children, median age: 12 years (range 1 -36)
- 34 children age 16 years or under
- 15 children under the age of 5 years

12/23 women with 1\textsuperscript{o} psychosis
16/27 women with 1\textsuperscript{o} pd or affective disorder
Reason for mother-child separation

22/28 mothers separated from at least one child while the child still dependent
Child age at separation: median 4 yrs (range 1m-7y)

<table>
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<tr>
<th>Reason for first separation</th>
<th>Number of children</th>
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<td>Mother’s mental illness</td>
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<tr>
<td>Index Offence - hospital admission</td>
<td>14</td>
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<tr>
<td>Indirect harm to child</td>
<td>8</td>
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<tr>
<td>Deliberate harm to child</td>
<td>3</td>
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<tr>
<td>Other</td>
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## Contact arrangements for women with dependent children

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<tr>
<td>in supervised face to face contact with child</td>
<td>8</td>
</tr>
<tr>
<td>in phone contact only</td>
<td>1</td>
</tr>
<tr>
<td>in letter box contact only</td>
<td>6</td>
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<table>
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<th>Contact Arrangement</th>
<th>Number</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>in unsupervised face to face contact with mother</td>
<td>5</td>
<td>14.7%</td>
</tr>
<tr>
<td>in supervised face to face contact with mother</td>
<td>18</td>
<td>52.9%</td>
</tr>
<tr>
<td>in phone/letter box contact only</td>
<td>9</td>
<td>26.7%</td>
</tr>
<tr>
<td>in no contact</td>
<td>2</td>
<td>5.9%</td>
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Number of women: 18 (12 with psychosis)

Number of children: 34
Complex stories of loss

Unremitting loss
- Jane: termination of pregnancy (ToP) after rape
- Ali: 1 still birth aged 14
- Mary: 1 in care; 1 adopted; 1 died
- Rita: 4 children adopted away; 1 late miscarriage; 2 ToPs; 1 ectopic pregnancy

Survival and loss; circumstances change
- Ann: 1 grown up child; twins adopted away at 2 weeks old; 1 infant death (2months)
- Sue: 1 grown up child, 1 miscarriage
- Ruth: 1 grown up; 1 ToP; 1 in care

Special needs
- Shelley: dependent child with learning disabilities
What is known about motherhood and secure care?

The emotional costs:

Of motherhood (or not) – hardly studied
The range of needs?

• Just over 50% of women of around age 33 have not had children and are locked in a secure hospital, with psychosis or not,
  * How do they feel about this?
  * Do we ask?
  * Why not?
  * Is it relevant?
The range of needs?

- Managing loss: most of the women who become pregnant suffer repeatedly with miscarriages and/or having live children removed
  - * How do they feel about this?
  - * Do we ask?
  - * Why not?
  - * Is it relevant?
The range of needs?

- How many of these women’s childhood experiences are being replicated with their own children?
- How many of these women are reliving their own childhood experiences through their own difficulties with parenthood?
  * How do they feel about this?
  * Do we ask?
  * Why not?
  * Is it relevant?

And other questions we neglect to ask?
Women, psychosis and violence

- Psychosis seems to confer a disproportionate risk of violence on women compared with men.
- This is probably not simply accounted for by comorbidity of personality disorder.
- There may be some critical life course differences: possible later onset of psychosis; probable later onset of offending with earlier desistance among women.
- This may be a factor in rates of motherhood – about 50% - among women with psychosis in specialist health service placements.
- But this uniquely female characteristic is largely ignored in clinical practice.
- Except maybe to exclude women from relevant research.
- We know very little about the unique clinical needs of women with psychosis who become violent.