

Older Adults Killed by Family Caregivers: An Emerging Research Priority



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Abstract

Caring for older relatives can have serious negative effects on the behavioral health of family members. Lethal violence may also emerge as a possible risk when caregivers become desperate and overwhelmed. Family caregivers who kill medically ill and/or disabled older adults violate moral and legal standards, and these occurrences likely have long term consequences. However, for whatever reason, they have not attracted sustained public debate or stimulated an investment in research and policy studies. Caregiver homicides do not appear to be high frequency events, but they are an extraordinary form of family violence, and it is important to identify what combination of factors mediates family members' decisions to kill in order to develop intervention and prevention strategies. The purpose of this article is to examine what is known about the prevalence and characteristics of family caregiver homicides and present research priorities for all health care disciplines involved with older people and their family caregivers. Little has been written, and despite the relative rarity of these events, they beg us to understand why violence erupts in caregiving situations and what can be done to stop it.

Keywords: Caregiving; Family Issues; Homicide; Homicide-Suicide; Lethal Violence; Mercy Killing

Introduction

Family caregiver homicides (FCHs) involving older victims, which include homicides, homicide-suicides, and attempted homicide-suicides, have often attracted considerable media coverage, but they have not led to sustained public attention or stimulated epidemiologic, clinical, psychosocial, and criminology research. Prevalence in the United States (U.S.) is unknown because there is no national surveillance mechanism, and knowledge about characteristics of victims and perpetrators is limited by the scant research [1-2]. This lack of data is also true for countries around the world.

Prevalence and Characteristics of FCHs

FCH will not be a frequent occurrence because older persons have a low rate of homicide victimization in the U.S., and most are killed by nonfamily members, usually during a felony. The latest report from the Bureau of Justice Statistics revealed that the annual percentage of older victims from 2002 to 2011 remained stable, 4.4% and 4.8% of all homicides, a frequency that has stayed steady since the 1990s [3]. In 2011, 2410 victims were 50-64 years old and 510 were 65 years and older. It is not known how many of these victims were killed by family caregivers, because the two federal data systems for homicides, the Federal Bureau of Investigation's (FBI) traditional Uniform Crime Reporting Program (UCR) including its Supplementary Homicide Reports (SHR), and the National Vital Statistics System (NVSS) managed by the Centers

for Disease Control (CDC), do not identify perpetrator and victim-perpetrator caregiving circumstances. However, the expected low prevalence of FCHs does not negate the importance of conducting research about these incidents. FCHs are an extraordinary form of family violence, and it is important to identify what combination of factors mediates family members' decisions and actions to kill relatives to develop strategies for intervention and prevention.

If funding becomes available in the future, a data reporting system maintained by the CDC, the National Violent Death Reporting System (NVDRS), will provide a national surveillance system to identify violent deaths, including FCH. The NVDRS collects de-identified information about homicides, suicides, legal intervention deaths, unintentional firearm deaths, and deaths with unknown causes, and it links data from death certificates, medical examiner/coroner records, law enforcement reports, and crime lab report [4,5]. Begun in 2002 with six states, it currently includes 40 states, the District of Columbia, and Puerto Rico. The NVDRS includes a general database as well as a restricted access database (RAD) with detailed information to which qualified researchers and professionals can apply. RAD codes can identify FCH cases, including whether the homicide perpetrator is a caregiver, perpetrator-victim characteristics, and known antecedents from the available sources. No analyses of FCH prevalence have been published using the RAD.

However, one paper has been published by CDC investigators identifying three FCH categories, and it is the most extensive of the few studies of FCH. Karch and Nunn [6] ascertained 68 caregiver homicides of older persons and other adult victims in 17 states from 2003 to 2007: 21 (31%) were intentional homicides of the victim only, 17 (25%) were homicide by neglect, and 30 (44%) were homicide-suicides. Overall, the victims were women (63.2%), widowed (42.6%), non-Hispanic (97.1%), white (88.2%), killed in their homes (92.6%) with a firearm (35.3%) or by intentional neglect (25.0%) by a husband (30.9%) or son (22.1%). A total of 48.5% were 80 years and older, 42.6% were 50-79 years, and 8.9% were 18-49 years.

An examination of the three FCH groups reveals a number of differences in homicide characteristics and motivations of caregiver perpetrators. Perpetrators of intentional homicides and homicides by neglect largely have a history of inflicting domestic/intimate violence, abuse/neglect, criminal activity, aggression and serious mental illness, or have been motivated by financial gain. Homicide-suicides generally appear to be characterized by a history of a caring long-term relationship between older perpetrators and victims, where perpetrators become overwhelmed and depressed by the burdens of caregiving and often their own health problems.

A handful of empirical studies of homicide-suicide in addition to Karch & Nunn [6] identified the caregiving status of FCH perpetrators [7-9]. Malphurs & Cohen [8] ascertained 671 homicide-suicides in the U.S. from 1997 to 1999 in a newspaper surveillance study, and of the 25% committed by people age 55 and older, 77% of which were spousal, 31.6% were described as caregivers for the victims. Malphurs and Cohen [9] also conducted a case-control study in Florida using medical examiner records to identify 20 spousal homicide-suicides and 20 couples where one spouse suicided. Cases were age 55 and older matched for age, race, marital status, method of death, and medical examiner district. Forty percent of the homicide-suicide offenders were caregivers for their wives; none of the suicides were caregivers.

Legal Consequences of Caregiver Homicides

U.S. criminal law does not distinguish between caregiver homicides with compassionate motivations and other homicide motivations. A compassionate/mercy killing is still an intentional, deliberate homicide. However, the response of criminal law has been markedly inconsistent [10-11]. A review of the outcomes of criminal proceedings from case studies and one paper analyzing mercy killings shows that there is significant variability in the way law enforcement, prosecutors, and judges deal with caregivers [10-15]. The analysis of Hemlock Society mercy killings by Canetto and Hollenshead [12] included initial charges for 97 of the 109 offenders: 24% of offenders were charged with first-degree murder, 12% with second degree murder, 22% with third degree murder, 13% with manslaughter, and 4% were charged with another crime. Specific charges were not listed for 25% of the offenders. Final disposition was known for 65 of the 97

cases: 53% of offenders were convicted of the charge, 7% were acquitted, and 7% had charges dropped.

Research Priorities

Estimating Prevalence and Characteristics of Caregiver Homicides: Although FCH are not frequent events, understanding their prevalence as well as demographic and characteristics may provide important clues about their occurrence. In the absence of a national surveillance system, newspaper surveillance over several decades could provide the first national estimate of incidence and prevalence, basic characteristics about the homicide and persons involved, as well as legal disposition. Newspaper studies have clear limitations because of the nature of journalistic data sources, but they provide the basis for future research to create detailed caregiver homicide databases collaborating with law enforcement, prosecutors, and other researchers. The results would also inform research priorities for intervention and prevention as well as recommendations for practice, policy, and criminal justice considerations regarding compassionate caregivers.

Antecedents of Caregiver Homicides and the Vulnerability of Women: About 70% of FCH are the result of a confluence of factors that overwhelm devoted family caregivers with no history of violence [2,16]. Their decision-making becomes impaired by overwhelming stress, depression, anxiety, physical exhaustion, extreme frustration with the lack of knowledgeable physicians, other health professionals, and home-based services to support their efforts, and isolation. The pressures of these multiple interacting stressors fuel hopelessness and helplessness about the circumstances which compromise rational thinking leading to lethal violence. These antecedent conditions do not excuse killing, but these circumstances are different from caregiver homicides because of neglect/abuse motivated by financial gain and intentional homicides motivated by domestic violence. The interactions between these multiple biopsychosocial/environmental antecedents remain to be identified. The reasons that men, usually husbands, kill women, usually sick older women, and not men, also need to be clarified. One factor may be that men are more violent than women and more likely to kill themselves and other individuals [17]. Another factor affecting the vulnerability of women may be a male cultural devaluation of women, especially older women [15-18]. Creating small, detailed qualitative datasets based on psychological autopsy studies that include health and other personal records of the deceased and interviews with family members and other informants may elucidate the interactive influences of individual, family, and socio-cultural factors. Interviews are important to assess long-term precursors (e.g., marital interactions, lifestyle, and personality) and more proximal antecedents (e.g., level of dependency and severity of illness). Clarifying the role that depression and other forms of psychopathology is also an important target for future study.

Dynamics of Compassionate Homicides and Legal Responses: Mercy is an attributed motivation, and there is no con-

sensus about an operational definition. The singular and/or mutual involvement of perpetrators and victims in the decision to die or be killed, as well as when, where, and how, are often unclear [13]. The lack of trained geriatric health care professionals as well as the lack of adequate health and community-based care for older persons are also important considerations in the context of these killings [1-2]. Victims usually have many painful, disabling health problems, even if they are not terminally ill. Perpetrators typically have had difficulty accessing appropriate care, because most physicians do not have adequate training in geriatrics or palliative care [16].

Legal scholars in the U.K. have developed two approaches that could be considered for criminal proceedings and policy considerations in the U.S.: partial defenses of provocation and compassion. Both provocation and compassion are based on the premise that mercy killings are intentional and deliberate, but differences in the offenders' motives and the context distinguish them from other homicides. Both also reduce the charge from murder to manslaughter if specific criteria are met.

Williams [11] proposed adapting the partial defense of provocation which currently has criteria to identify circumstances where a victim's behavior elicits anger in the offender, causing a loss of self-control [19-20]. Since U.K. law now recognizes that other emotions can cause loss of self-control, including despair, hopelessness, and futility, the provocation partial defense could be extended to compassionate killings. However, the following three conditions need to be documented: the stress of the caregiving relationship between the offender and victim occurs over time; things said and done during caregiving adversely affect the offender's emotional distress; and a reasonable person stretched to their limits in similar circumstances might also kill.

Keating and Bridgeman [21] argued for a new partial defense of compassion, where three requirements must be met: [1] the killing must be in response to an individual's suffering; [2] the offender's actions must be motivated by the suffering of that individual; and [3] the offender and victim must have a longstanding, close relationship. The creation of a compassion-based approach to law and policy must be guided by systematic research to operationalize the components of compassionate emotions, thoughts, and actions that underlie a caregiver's response to end the suffering of a loved one. Understanding the dynamics of compassionate killings is also important to create a knowledge base for law enforcement investigation protocols as well as sentencing and parole guidelines. The gender differential where women are most often victims of male family members underscores the importance of also examining the ethical implications of new legal responses.

Conclusion

The purpose of this article was to examine what is known about FCH and present priorities for a research and policy agenda for all disciplines in gerontology involved with older people and their family caregivers. Very little research has been done, and despite

the relative rarity of these events, they beg us to understand why violence erupts in caregiving situations and what can be done to stop it. It is likely that some combination of factors is necessary to cause these events, and the available literature suggests testing a theoretical approach that posits that at least four conditions are essential but not sufficient conditions for caregivers to kill: [1] the perpetrator is a captive of their role and perceives themselves to be socially isolated from others; [2] the caregiver has mental health problems which distorts their cognitive and emotional reasoning and compounds their isolation; [3] the caregiver is not on the radar screen of health care professionals, family, and friends, and thus the seriousness of their depression is undetected and untreated; and [4] the caregiver has access to firearms and other lethal means. This framework may be useful to understand the low frequency of caregiver homicides, since the absence of one or more of these elements may decrease the risk of violence. Hopefully, this brief review of the clinical, psychosocial, and legal issues about this extraordinary form of family violence is useful to a number of professionals and stakeholders-- health care professionals, the leadership of scientific, clinical, and advocacy organizations, law enforcement, attorneys and judges, government officials and community leaders. The ethical and moral complexities of FCH where caregivers kill dependent older family members when stretched to the limits of their caring responsibilities also need to be understood [22]. An ambitious research and policy agenda lies ahead.

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