Violent Crime Arrests and Paranoid Schizophrenia: The White House Case Studies

by David Shore, C. Richard Filson, and Wayne E. Johnson

Abstract

We have previously reported on typically paranoid schizophrenic patients who attempted to see the President or other prominent American political figures based on hallucinations or delusional beliefs. By obtaining arrest records on these White House Cases (WHCs), we were able to determine which individuals had murder or assault arrests before and/or after their WHC hospitalizations. During the 9-12 years following discharge, 31 of the 217 male WHCs (for whom adequate clinical records were available) had murder or assault arrests. Demographic characteristics such as prior violent crime arrest and male gender proved to be much better predictors of future violence than clinical symptom, history, or behavior items. Hospital incidents requiring seclusion and a history of weapons possession were both associated with later violence in WHCs with prior violent crime arrests, while certain clinical symptoms (e.g., persecutory delusions and command hallucinations) may be linked to future violence in WHCs without prior violent crime arrests. These data need replication in other patient samples.

A number of the people who approach a major government office, such as the White House, asking to see the President (or some other prominent political figure) are found to be psychotic. A few of these individuals—those who make a clear-cut threat against the President or other prominent political figure (PPF), those who are carrying a weapon, or those who are wanted by police elsewhere—will be arrested and processed through the judicial system. Individuals who are not subject to arrest but who demonstrate signs of psychosis and are preoccupied with a PPF are taken by the U.S. Secret Service (USSS) or U.S. Park Police to St. Elizabeth's Hospital in Washington, DC, for evaluation and treatment as White House Cases (WHCs). We have previously published a description of WHC patients (Shore et al. 1985) and reviewed other reports on such patients (Hoffman 1943; Keller et al. 1965; Sebastiani and Foy 1965).

WHCs are typically chronic paranoid schizophrenic patients, most often unmarried men, acting on the basis of delusions or hallucinations. They come to the White House for several reasons:

- To provide special information or advice—for example, a patient whose auditory hallucinations told him that he had the power to help the President by sharing with him the voices' interpretation of Biblical prophecies.
- To request relief from imagined persecution—for example, a patient requesting that the President remove a radio transmitting device he believed had been implanted in his brain by the CIA.
- To warn of impending danger—for example, a patient who believed aliens were taking over the earth.
- To obtain money or other reward—for example, a patient who believed he was responsible for an undercover investigation of drug smuggling and expected to be given a $1 million reward.

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Most of the patients in our sample had previous hospitalizations and three-fourths had come to Washington, DC, from outside the metropolitan area. The USSS is required to investigate WHCs and to maintain files on these individuals for a specified period of time. Because the National Institute of Mental Health (NIMH) has intramural schizophrenia research programs located at St. Elizabeths Hospital, we were able to review medical records of WHCs who had been discharged from the hospital during the early 1970s. The USSS Intelligence Division provided FBI arrest records for these WHCs, enabling us to determine which WHCs had arrests before and/or after their WHC hospital admissions.

We found that the WHCs who had arrests for murder or for aggravated or other assault (our index violent crimes) were more likely to be male and to have a record of prior arrest(s). Although females made up 25 percent of our WHC sample, only 1 of the 32 WHCs with post-WHC discharge violent crime arrests was female.

For this reason we focused on the 217 male WHCs with valid arrest records who had been discharged from St. Elizabeths Hospital on or before July 1, 1974. We were able to locate medical charts for 217 of these patients. Two raters without knowledge of arrest data reviewed the charts for information about circumstances of admission, clinical symptomatology and behavior during admission, past history noted in the charts, and other data such as educational level and duration of admission. After exclusion of the items rated "present" less than 5 percent of the time and those with interrater reliability (kappa) ≤ .60, Pearson correlation matrices and stepwise logistic regressions for the 217 male WHCs were carried out, using violent crime arrest record following WHC hospitalization as the dependent variable.

For the overall group of 217 male WHCs, the following factors were most strongly associated (on the basis of stepwise logistic regression) with subsequent arrest for violent crimes: prior violent crime arrest, any threat against a PPF, nonwhite race, and residence in an urban locale outside the area of Washington, DC. Since the best predictors of violent crime arrest in the general (nonpatient) population are prior violence, male gender, nonwhite race, youth, and urban residence, our initial results were neither surprising nor particularly exciting. However, because schizophrenia itself is considered a heterogeneous disorder, we hypothesized that our WHC population would also be heterogeneous. In other words, WHCs with prior violence might differ considerably from those with exclusively nonviolent or no prior arrests, and different clinical, behavioral, or history items might predict future violence in the different subgroups.

By forming subgroups based on prior arrest history (prior violent crime arrests, exclusively nonviolent arrests, and no arrests), we were able to find associations of clinical and behavioral factors with later violent crime arrests. In the group with prior violent crime arrests, hospital incidents involving seclusion of the patient and a history of weapons possession were most strongly associated (Pearson correlation coefficients) with future violence. No other items were useful for these particular patients. In contrast, for male WHCs without prior arrests, traveling to Washington from an urban area outside the District of Columbia, a history of threats against a PPF, and command hallucinations during hospitalization (nonsignificant trend) were associated with later violent crime arrest. For the WHCs with exclusively nonviolent prior arrests, only persecutory delusions were significantly associated with future violence.

Race and prior arrest history were significantly intercorrelated, and when data were adjusted for prior arrests, the effect of race on violent outcome prediction diminished greatly. In fact, race did not enter into any of the three subgroups’ stepwise logistic regressions as a significant predictor. While threats appeared in several of the prediction regressions, there was little temporal relationship between threat against a PPF and violent crime arrest. Also, none of the WHCs made an actual attempt to harm a PPF, supporting the idea that an eventual victim may be someone other than the person threatened. It should also be emphasized that these factors are being related to long-term violent outcome, since the first violent crime arrest occurred (on average) over 4 years following WHC hospital discharge. Other clinical or situational factors may be of greater utility for short-term predictions (McNeil and Binder 1987).

We wish to emphasize the limitations and the preliminary nature of these results, which need to be replicated by other investigators. During a followup period of about 11 years, 14 percent of the male WHCs had a violent crime arrest. We suspect that non-WHC paranoid schizophrenic patients are less likely than this to have violent crime arrests following hospital discharge. One reason the WHCs probably constitute a "high-risk" group is their having acted on delusions or hallucinations in coming to the White House or other gov-
government office. In this regard, ongoing data analysis suggests that WHCs from outside the DC metropolitan area had a higher rate of subsequent violent crime arrest than those living in the DC area. Those schizophrenic individuals with a combination of intensely believed delusions and/or hallucinations and the behavioral competence to get to the White House from considerable distances may be at higher risk than the more disorganized and flagrantly psychotic patients. This is consistent with the work of Rada (1981).

As psychiatrists and psychologists continue to be forced to predict dangerousness to self or others, a task everyone seems to agree we do not do very well, we believe that additional research in this regard is important. We believe, in agreement with Lion (1984), that patients and families should be questioned about a history of violent behavior and weapons use or possession. We also suggest that threats, persecutory delusions, and command hallucinations may be associated with increased risk of violent crime arrest in some paranoid schizophrenic patients with a history of acting on their psychotic symptoms. We hope that larger scale studies in the general population can test this more rigorously. It is clear that most paranoid schizophrenic patients will not commit violent crimes, and we believe that by better identifying the few who are likely to be dangerous, we will destigmatize the majority who are no more dangerous than the general population. Our work so far indicates that certain demographic factors associated with violence in the general population (especially prior violence and male gender) are better than any clinical features for the prediction of violence in a group of mainly paranoid schizophrenic WHCs.

References


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