Psychiatric Drugs and Homicide

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Presented at the 131st Annual Convention of the American Psychological Association in Washington, DC, August 3-5, 2023

Division 41 - American Psychology-Law Society

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Neurotoxicologist, trained at Mt. Sinai School of Medicine
Book, Neurotoxicity Guidebook
Research Publications cited over 240 times
Expert witness in toxic chemical litigation since 1983
Precedent-setting cases include

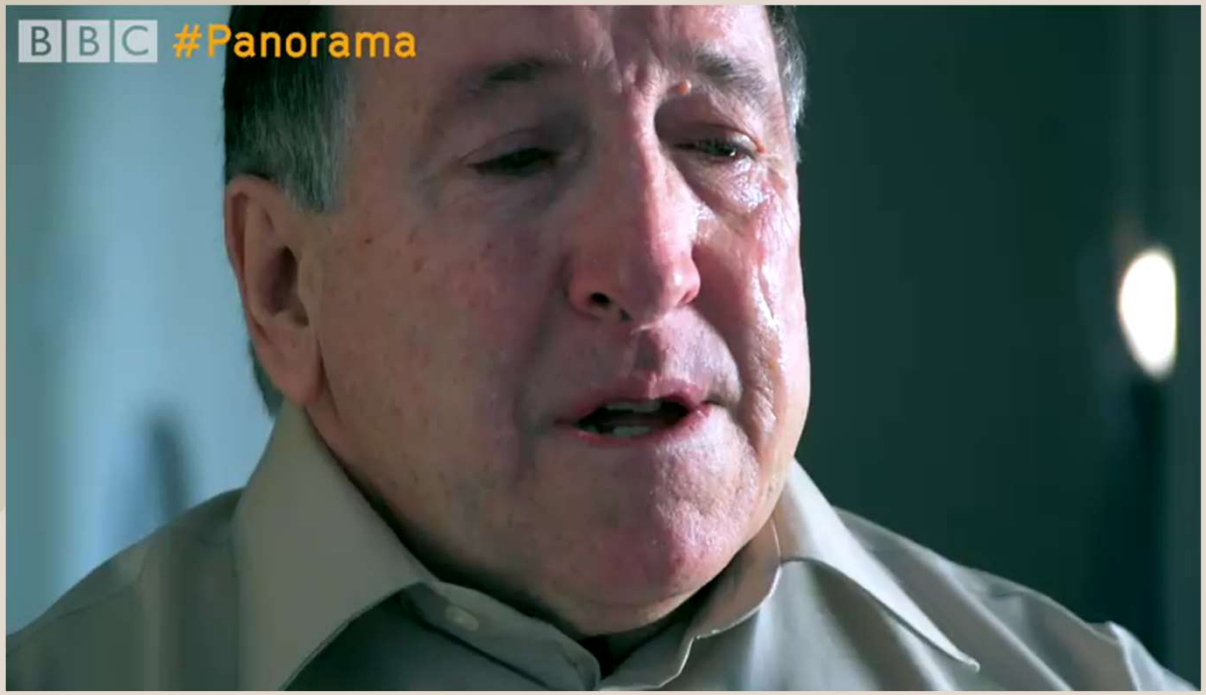
- Viet Nam Veterans Agent Orange Litigation
- USA Supreme Court opinions
- Unanimous Federal Appeals Court decision cited over 400 times
- Unanimous Ohio Supreme Court decision
- Numerous criminal cases

Speaker Introduction

Why study psychiatric drugs and homicide?

- In 2004 David Carmichael, suffering from psychosis, killed his 11-year-old son.
- Was his psychosis caused by the SSRI antidepressants he was taking at the time?

Why study psychiatric drugs and homicide?



Why study psychiatric drugs and homicide?

- From millionaire to murderer: Neal Jacobson and his heinous crime. Even he can't understand it
- Inside a Florida prison, Neal Jacobson talks to reporter Wendy Rhodes about the psychiatric prescriptions that he says drove him to fatally shoot his wife and 7-year-old sons.
- https://www.palmbeachpost.com/story/news/2022/01/21/ten-murder-cases-besides-neal-jacobson-where-people-ssri-antidepressants-killed/6460798001/

Why study psychiatric drugs and homicide?

Session Description:

Psychiatric drugs can create a risk for violence or precursors of violence, such as anger, hostility, and agitation. This risk is often described on the product label. Prescribers need to monitor patients carefully for such potentially adverse outcomes. We will describe the transformation of a normal person into a killer.

Takeaway 1:
Attendees will become aware of psychiatric drugs' potential role in violent behavior

Takeaway 2:
Attendees will become aware of methods to assess pre-existing sensitivity to psychiatric drugs based on genetic testing

Case Description:

- Name: Mr. Smith
- Age: 50
- Gender: Male
- Race: White
- Education: Masters in Education
- Marital status: Married at the time of 2014 criminal offense
- Children: 1 son, 2 daughters, all minors at time of criminal offense
- Occupation: 20+ year Special Education Teacher currently incarcerated

Employment and family history

- Mr. Smith was a husband, father of three minor children and a teacher of special education in the Albany Central School District for over two decades.
- His extended family was close, saw each other frequently, and often had daily contact. His sister described him as a "fun person". Colleagues described him as "fun loving," "loving," "calm," and "reassuring". Employment records showed he has "excellent rapport with his students".
- Prior to March 2014, he had no criminal record and no history of violence. His father, a retired police officer, "had never seen a hint of violence" in his son towards his wife, children, or anyone else. A colleague concurred in never seeing any violence or aggression demonstrated by Mr. Smith.
- Mr. Smith had no history of mental illness. He had a "years-long" history of chewing tobacco use.

First episode of sensitivity to psychiatric drugs

- Decades-long user of chewing tobacco
- First episode of severe mental illness:
  - 2010:
  - Quit tobacco use cold turkey, became anxious
  - Treated with psychiatric drugs for anxiety
  - Became severely anxious, manic at times, and suicidal.
  - He discontinued psychiatric drugs and recovered

Second episode of sensitivity to psychiatric drugs

- 01/01/2014: Mr. Smith again quit the use of chewing tobacco "cold turkey".
- 01/20/2014: Complaint of anxiety and depression
- Cymbalta to start at 30 mg and gradually increase to 60 mg.
- 01/27/2014: Diagnosed with generalized anxiety disorder and major depressive affective disorder, single episode, severe.
- 02/06/2014: Isolated himself
- 02/07/2014: Crying, he "just shuts down".
- 02/10/2014: Suicidal.
- 02/13/2014: Dread of being placed back in the psychological ward.
- 02/14/2014: He texted his sister that he was "worse than ever" and to leave him alone.
- 02/25/2014: Inconsolable. Has had a brief shoving match with his father that was "unprecedented and way beyond the bounds of his normal behavior." His father spent the night with him after everyone else left.
- 02/27/2014: Complaints of anxiety, depression and insomnia. The doctor discontinued Cymbalta without weaning and replaced it with trazodone 50 mg.
- By 03/06/2014: Doctor doubled trazodone to 100 mg. Mr. Smith's mental health was rapidly deteriorating.

Second episode of sensitivity to psychiatric drugs

- 03/12/2014: Intake at Samaritan Hospital. Still taking 100 mg trazodone. He presented with flat affect, appeared depressed, stated he did not believe he needed inpatient treatment, complained of helplessness, burnout, concern that medication is not right, belief that Cymbalta caused insomnia and requested higher dose of trazodone. He was not admitted.
- 03/15/2014: Mr. Smith stayed at parents' house. Barely slept, parents had stayed awake through the night for a week to watch him, they took his car keys. They left him with his sister so they could get rest. Sister described him as yelling and obsessed with concern of job loss, pacing, gnawing on lower lip until bloodied and staining front of shirt.

Attempted murder

- 03/17/2014: Mr. Smith left his parents' house in the morning with a kitchen knife, drove to his home and stabbed his wife multiple times.
- His father discovered where he had gone and went after him.
- On arrival the father saw him in the front yard with blood on his shirt and right hand and found the daughter-in-law bleeding and crying for help. The father physically struggled with Mr. Smith and called 911.
- Mr. Smith had a blank face and a "complete absence of any emotion" while pacing in the front yard.
- The police took a statement in which Mr. Smith said he wanted his wife to die "because she was going to put me in the hospital."
- He was placed in the Rensselaer County Jail (RCJ) where at intake he was "very fidgety", moved frequently in his seat, rubbed his face, wringing his hands, and he reported hopelessness, suicidal ideation, and a suicide attempt.
- His trazodone prescription was noted at intake.

Can trazadone increase the risk of violence?

Product label

- Activation of Mania or Hypomania
- Potential for Cognitive and Motor Impairment
- Common Adverse Reactions include confusion, decreased concentration, disorientation, dizziness/lightheadedness, nervousness, incoordination, and tremors.
- Postmarketing experiences include agitation, anxiety, hallucinations, insomnia, paranoid reaction, psychosis, stupor

Trazodone Adverse Events

- FDA Adverse Event Reporting System (FAERS) Public Dashboard for Trazodone. There were 24,748 adverse events pertaining to psychiatric disorders, and 7614 pertaining to nervous system disorders. There were 3091 completed suicides, 759 confusional states, 708 suicide attempts, and 622 cases of depression. There were 7614 cases of nervous system disorder.
- Looking more deeply into the psychiatric disorders, there were 526 cases of agitation; 166 cases of aggression; 98 cases of mania; 37 cases of hostility; 14 cases of acute psychosis; 4 cases of "violence -related symptom"; and 1 case of psychiatric decompensation. There probably were additional search-terms to use.
- In summary, adverse events for trazodone are significant, and include adverse events that would increase the probability of a violent act.

Brief neuropsychological evaluation - CNSVS

Patient Profile	Percentile Range			
	Standard Score Range			
Domain Scores	Patient Score	Standard Score	Percentile	VI**
Neurocognition Index (NCI)		96	40	Yes
Composite Memory	89	83	13	Yes
Verbal Memory	50	93	32	Yes
Visual Memory	39	81	10	Yes
Psychomotor Speed	143	83	13	Yes
Reaction Time*	570	116	86	Yes
Complex Attention*	6	102	55	Yes
Cognitive Flexibility	42	97	42	Yes
Processing Speed	51	102	55	Yes
Executive Function	42	96	40	Yes
Social Acuity	9	104	61	Yes
Reasoning	-1	76	5	Yes
Working Memory	12	111	77	Yes
Sustained Attention	31	108	70	Yes
Simple Attention	40	107	68	Yes
Motor Speed	92	78	7	Yes

NEO-PI-3 Data Table – Part 1

Scale	Raw Score	*T* Score	Range
Factors			
(N) Neuroticism	---	53	Average
(E) Extraversion	---	51	Average
(O) Openness	---	53	Average
(A) Agreeableness	---	62	High
(C) Conscientiousness	---	53	Average
Neuroticism Facets			
(N1) Anxiety	15	53	Average
(N2) Angry Hostility	12	46	Average
(N3) Depression	16	57	High
(N4) Self-Consciousness	12	49	Average
(N5) Impulsiveness	12	43	Low
(N6) Vulnerability	13	58	High
Extraversion Facets			
(E1) Warmth	23	55	Average
(E2) Gregariousness	21	61	High
(E3) Assertiveness	19	55	Average
(E4) Activity	14	41	Low
(E5) Excitement-Seeking	20	54	Average
(E6) Positive Emotions	18	48	Average

NEO-PI-3 Data Table – Part 2

Openness Facets			
(O1) Fantasy	13	41	Low
(O2) Aesthetics	19	58	High
(O3) Feelings	21	56	High
(O4) Actions	16	51	Average
(O5) Ideas	20	54	Average
(O6) Values	19	49	Average
Agreeableness Facets			
(A1) Trust	21	55	Average
(A2) Straightforwardness	23	58	High
(A3) Altruism	25	57	High
(A4) Compliance	20	60	High
(A5) Modesty	21	56	High
(A6) Tender-Mindedness	22	57	High
Conscientiousness Facets			
(C1) Competence	23	53	Average
(C2) Order	18	48	Average
(C3) Dutifulness	23	53	Average
(C4) Achievement Striving	21	52	Average
(C5) Self-Discipline	21	50	Average
(C6) Deliberation	22	59	High

CONCLUSION

Susceptible individuals can inexplicably turn to violence with unmonitored psychiatric drug administration