

Uncompleted extended suicide – discussion on the boundaries of psychosis based on a case study

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Summary

The article describes the case of a 40-year-old woman who attempted suicide and killed two of her own children and was examined by three teams of forensic psychiatrists and psychologists for the purpose of judiciary. This woman was somatically healthy, did not use psychiatric or psychological help. The authors were the third team of experts and, after conducting double psychiatric and psychological examinations and analysis of documents from the case files, which include the course of forensic-psychiatric observation, recognized the symptoms of dependant personality disorders and acute stress reaction, which resulted in a complete loss of the ability to recognize the meaning of the act and to manage proceeding. The paper discusses the diagnostic process as well as the analysis of psychotic disorders in relation to specific clinical diagnoses in accordance with the current classification of mental illnesses and disorders. Attention was paid to the problem of differentiating individual disorders and the way of defining psychotic disorders. The existence of difficulties in drawing the line between psychotic and non-psychotic disorders in the context of forensic psychiatric evaluation is emphasized.

Key words: suicide, homicide, forensic psychiatry

Introduction

The term ‘extended suicide’ is not unambiguous. In the Polish naming tradition, it usually denotes a situation of suicide combined with killing of people from the victim’s close surrounding, and the most frequent motivation is protection of the close ones against a potential threat. The English-language term ‘dyadic death’ only describes the phenomenon, without specifying its motivation [1]. In the German literature, the naming discussion has been going on for more than 100 years. In 1907, a session of a conference of the German Society of Forensic Medicine was devoted to this matter. The term

erweiterter Suizid had crystallized there from the earlier proposal: *kombinierter Suizid* [2]. Currently, both the term *erweiterter Suizid* and *Mitnahmesuizid* are used, in addition to more descriptive terms: *Doppelsuizid* and *Homizid-Suizid*, modeled on the Anglo-Saxon literature [3]. All of the above terms are frequently criticized and none of them is flawless; therefore, application of each of them requires detailed substantiation.

The study on extended suicide covers its potential causes, motivations and perpetrator profiles. In one study from 1995, five main determinants were distinguished on the basis of analysis of causes of such incidents. The most frequent cause was a relationship break-up (as much as 46%); the distribution of the other groups was as follows: mental illnesses – 21%; criminal activity – 11%; somatic illnesses – 10%; financial problems – 11% [4]. In 2010, Galta et al. analyzed the phenomenon of extended suicide in the international literature and in Norway. Their study implies that persons who commit extended suicide usually suffer from depressive or psychotic disorders and display delusional jealousy [5]. Another study, conducted in Switzerland, showed that the main mental factors for extended suicide are depression and psychosis [6]. In overview studies concerning this issue, depression is mentioned as the most frequent cause among mental illnesses, closely followed by psychoactive substance abuse and psychoses [7, 8].

The inspiration for the considerations of the present study has been a case of a proicide on whom three forensic psychiatric opinions were issued, with differing diagnostic conclusions. Experts among the authors had to face certain theoretical problems; their diagnosis was rather unusual for a person committing extended suicide, by which they raised the issue of determination of a boundary between psychotic and non-psychotic disorders.

Case study

The data of the described person have been anonymized, details that are irrelevant to the presentation of the case and that could enable the identification of the patient were omitted.

A forty-year-old woman with tertiary education, married, mother to a teenage daughter and several-years-old son, unemployed since the birth of her second child, was accused of killing of both of her children, followed by an unsuccessful suicide attempt. The bodies of all three were found by the husband who came home earlier than he had announced. Due to successful resuscitation, the woman was saved, whereas both children were dead – 11 incision/puncture wounds to the neck were found on the girl and 1 such wound on the boy. The mother had incision and puncture wounds to the neck. Moreover, a metal can punctured with a knife was found in the kitchen of the apartment.

Psychological development, life pattern

The patient and her younger brother were raised in a full family providing conditions for correct development. In her childhood, she had neither suffered nor witnessed

any physical or psychological domestic violence. During her early adulthood, her father abused alcohol for several years. She completed high school with very good grades and received a scholarship at the university. After graduation, she took up employment with an option of scholarly development, which satisfied her interests and ambitions. She had good relations with her superiors and coworkers. She maintained regular, close contacts with her parents and brother living abroad. She easily established social contacts and was involved in several romantic relationships. On the final year of the studies, she married out of love, while being pregnant. Until the killing of her children, the marriage had lasted for approx. 17 years.

According to the patient's account, the conjugal life was initially harmonious. After the birth of their daughter, her husband focused on professional activities and pursuit of his own interests, marginalizing his participation in the family life. In response to his wife's complaints, he broke off contacts with her family and demanded signing of a marriage contract, he also forbade her from meeting her friends. Due to the nature of her husband's work, they repeatedly changed their place of residence, which limited her options of employment. Due to unsuccessful investments, her husband ceased to provide for the family, pressed his wife to search for a job, and in view of lack of offers – to start a business. Upon several unsuccessful attempts, she started feigning employment. She stated that, with her husband's consent, she had been selling different valuables. The sale of those things also enabled her to hide the lack of earnings from work. She admitted to the lie when her husband urged her to take out a loan and she was unable to present a certificate from work. Several months before her critical act, she started simulating a neoplastic disease. She claimed that in the past, in order to obtain funds from her family, she and her husband had made up the necessity for her to undergo a surgery. In a later period, the patient herself started utilizing the lie about the cancer, exploiting her actual gynecological problems. Thus, she gained her family's compassion and 'deferment' of her return to work. She reported that, when she had revealed her lies to her husband, he said that the condition for maintaining the family was a written confession that she had been selling things from the apartment on her own account, without his consent, and that she also obliged to refund them and waived the rights to the jointly owned real property.

The patient has not undergone any serious traumas, accidents or surgeries. After her first pregnancy, she started treatment of adnexitis and uterine leiomyomatosis. Several times between the births of the children, she experienced natural miscarriages. She had no chronic diseases. She did not take any medicine permanently. She declared to never have received assistance from a psychologist or a psychiatrist. She had not abused alcohol and had never used drugs. She denied occurrence of any mental diseases or suicides in her family.

Picture of the family system

In the eyes of the neighbors, the family was "good and quiet", although, according to some of them, the perpetrator's husband was a despotic person. The husband's acquaintances described him as a confrontational person demonstrating high self-esteem

and convicted about his own infallibility, treating women instrumentally. He openly expressed his views concerning a subordinate role of a woman in a marriage – he expected her to take care of the housekeeping and raising of children on her own, he required her to care for her physical and sexual attractiveness and to maintain the good image of the family in its environment. He was the sole disposer of money and spent it largely on his own needs. He also exploited his physical advantage through jerking his wife, demonstrating the possibility to use violence, etc. In relation to his children, he assumed different attitudes in relation to his daughter and son. The daughter was not allowed to cry or express her views, he forced her to do the cooking and cleaning, he attached much importance to her appearance, he responded with verbal and physical aggression to her attempts to resist. He openly favored his son from the very beginning, paid attention to the stimulation of his development, e.g., he had his son taught to read letters at the age of two.

The picture of the family as provided by the perpetrator's husband diverts from the version presented above. In his opinion, they had been an absolutely well-matched relationship until the moment of reveal of his wife's lies. In the record of the interview, he confirmed the model of family responsibilities presented by his wife as one fully corresponding to his convictions concerning roles in a marriage, with a superior position of a man – provider for the family.

The perpetrator's personality

Psychological research indicated a high level of the patient's intellectual capacity, no indications of organic dysfunctions of the central nervous systems were found. However, a pattern of functioning typical of a dependent personality was recognized, consisting in consenting for her husband to assume the responsibility for her life decisions, subordination of her own needs to her partner, yielding to his demands and gradual marginalization of her own expectations in a sense of low self-esteem. The patient's statements, the course of her life pattern, as well as observations by her mother and acquaintances from the period of her study, indicate that she had never displayed such behavior prior to marriage – she considered herself and was perceived as an ambitious, active and independent person who was simultaneously inclined for agreeability and compromise. The two latter traits may be deemed predictors of her future attitude – in contact with her husband's strongly dominating attitude, these tendencies deepened and consolidated as consistent with her vision of a good, conflict-free relationship.

The perpetrator's mental condition in the period before the incident

One month before the incident, the husband told her to take up employment again or move out of the house, with one month's period of ultimatum. Although he ceased to reproach her after that announcement, she was very tense, experiencing mood swings. Her feelings at the time were dominated by fear of the future, the sense of wrong, sorrow and grief. A death wish appeared occasionally, yet she pushed it aside for the sake of her children. She had no suicidal ideation but rather a feeling of being

overwhelmed by problems and fantasies that “it would be good not to live”. She also experienced self-blame and the sense of guilt that she was insufficiently strong to stand up against her husband. Her sleep at night was shallow, she frequently woke up in fear and improved her sleep and mood with herbs including St. John’s wort and valerian. She was also able to feel joy in that period, she enjoyed “different things,” especially related to her children. Despite her depressed mood, she sent several dozen covering letters to different workplaces, she had been to several interviews and awaited following ones. The testimony of one potential employer, a head of a scientific institution, as presented in the case file, reveals that upon an hour-long conversation, he deemed her an “ahead-thinking person interested in pursuit of doctoral studies.” He considered her a serene, communicative person with a lot of plans for the future and proposed another meeting within a time limit exceeding the husband’s ultimatum. Other people from the patient’s environment perceived no distinct change in her mood and behavior either, except her children’s teacher who considered the patient “sad.”

The perpetrator’s account of the day of the incident

Inquired about the course of the critical day, she described that, according to the previous arrangements, her husband was to leave with their son for winter holidays to his mother, and their daughter was to stay home, as she was preparing for a competition. The husband unexpectedly told her about a change of his plans: he said that the “trial period had expired,” he was taking both children to his mother, and his wife was to move out in the meantime. He also forbade her from speaking about that with their children so she would not “spoil their vacation.” He left for the dentist’s; subsequently, he was supposed to go to a shopping mall. The patient was convinced he would carry out his threat that time. As she described, “she had been like in trance,” she remembered having dinner with her children and laying her son for an everyday nap. Her daughter did not want to leave, she had plans of her own. She had had a quarrel with her father, went upset to her room and ostentatiously went to sleep. The patient had difficulties recreating the further course of events, presenting fragmentary images. She left for the kitchen; she remembered putting on water for tea, she was sitting by the table with a multitude of thoughts in her head, “A rush of thoughts, how to convince my husband ... what arguments to use so he would give me a chance ... how to convince him I am not a bad person ... how to find money...” When asked about feelings, she mentioned fear, despair, anger at herself “that I was unable to resist, that I had such a weak character ... I was afraid what would become of the children...” The predominant feeling was the sense of being lost; “I did not understand that situation ... I had not expected such a drastic decision.” Asked why she had not been taking such a reaction from her husband into consideration, she said, “there were always negotiations with my husband ... he knew I cared most about my children, that I would do everything for them ... I would always yield when he threatened to take the children away ... and that day, he said the time was up ... he was taking the children away.” The last thing she remembered were the knives: “I do not know if I took them out ... I must have ... these were my husband’s knives ... he collected them ... I do not remember what happened later...”

In her testimony, she stated that she did not know how it had happened, she could not leave her children to her husband and had to take them away, “he came back too soon and I had not enough time to die.”

Psychiatric opinions

Three forensic psychiatric opinions were presented in the case under consideration. In the first one, issued shortly after the perpetrator’s awakening, the experts stated that she was “not mentally disabled, revealing depressive disorders manifesting clinically in psychomotor retardation, inner anxiety, depressed mood, stiffness of affective reactions, occurrence of suicidal ideation, resonating and balancing thoughts, depressive evaluation of the future and of her own situation, a sense of fear, threat, nervous hyperactivity, occurrence of suicidal tendencies”. They recorded the perpetrator’s statement concerning the declared motivation for her act: “I could not have left my children with him, they would not be safe, I did not want to do that to them.” The experts requested forensic psychiatric observation.

The second opinion was issued upon three-month forensic psychiatric observation. The psychological examination found an above-average level of intelligence, lack of organic changes in the central nervous system, and a possibility of occurrence of depressive disorders. Moreover, personality examination indicated a possibility of decompensation “in situations of considerable emotional overload (strong stress, prolonged state of frustration), in which the patient may reveal impulsive and violent attitudes or behaviors, with significantly limited (diminished) capacity of control of their course by way of intellect.” Expert psychiatrists stated that, at the moment of perpetration of the acts alleged against her, the patient suffered from affective disorders with an image of a severe depressive episode with psychotic symptoms and had diminished capacity for understanding of the meanings of actions and for directing her own behavior within the meaning of Article 31(1) of the Criminal Code [9].

The third opinion (by the authors of the study) was issued on the basis of two psychiatric and psychological examinations with access to the observation data. The experts have recognized depressive symptoms in the patient at the moment of examination but did not find any characteristics of a severe depressive episode before the act. The psychological examination determined a pattern of functioning typical of a dependent personality, with marginalization of one’s own expectations in a sense of low self-esteem and fear of functioning outside the relationship. In the analysis of the situational and motivational background, attention was paid to the overlapping of an intense stress stimulus with a chronically difficult family situation. It was also emphasized that the perpetrator’s action at the moment of the act was inconsistent with her personality, it was accompanied by narrowing of attention, experience of despair, pain perception disorder, maladjusted activity. Expert psychiatrists decided that, at the moment of perpetration of her acts, the patient manifested symptoms of acute stress reaction on a psychotic level, due to which she had diminished mental capacity pursuant to Article 31(1) of the Criminal Code [9].

Discussion

In the case under consideration, all expert teams have observed depressive disorders in the patient, whereas all of them only had an opportunity to observe the patient after the act and the realization of its consequences. However, a detailed analysis of the perpetrator's functioning before the act does not allow for a diagnosis of a severe depressive episode during the act. Obviously, the prolonged mood and self-esteem depression is beyond doubt, as are recurring fleeting thoughts about dying, but the patient definitely met neither the criteria of a severe depressive episode pursuant to ICD-10 nor the criteria of major depression pursuant to DSM-5 [10, 11].

What predominantly stands out in the psychopathological picture as of the day of the act is the tremendous dynamic of the course of the disorder. The symptoms crystallized over 1–3 hours and reached extraordinary impetuosity, and the patient's act was inconsistent with her personality. An attempt at classification of the observed disorder must lead towards acute stress reaction, and depressive disorders could have merely been a factor facilitating its occurrence. The diagnostic criteria of ASD according to ICD-10 DCR include: exposure to stress of extraordinary power, instant occurrence of symptoms, narrowing of attention, anger or aggression, despair or sense of hopelessness, as well as maladjusted or aimless activity [10].

The construction of Article 31 of the Criminal Code [9] requires experts issuing opinions in the area of mental incapacity to specify which one of the three prerequisites of incapacity, as mentioned by Cieślak: mental illness, mental disability, or other mental distress, serves as the base of the decision [12]. Already at this level, an expert encounters difficulties of definitional nature, as the concept of mental illness has yet to gain a generally-accepted interpretation. The Criminal Code gives no guidance in this regard, which, incidentally, seems appropriate, as it is not the right place to define the limits of mental disorders. The Mental Health Protection Act is more helpful, as Article 3, presenting a division of mental disorders analogous to the one in Article 31 of the Criminal Code, mentions mental illnesses (psychotic disorders) in the first clause [9], thus identifying mental illness with psychosis [13], which conforms to traditional views of psychiatry. As Pużyński [14] says, a mental illness may be identified with a psychosis and in this meaning, it is a disorder limiting insight, hindering maintenance of contact with the reality and impairing the ability to cope with everyday problems. Among symptoms of psychosis, he mentions qualitative disorders of thinking, intellect, consciousness, perception, feelings, psychomotor drive, and other mental functions. It is also worth stressing that psychosis has not been defined in DSM-5 which only mentions “psychotic traits” and “psychoticism.” In this context, “psychosis-like” terms referencing the undefined concept of psychosis become unclear [11, 15]. A tendency to identify psychosis with positive symptoms (illusions, hallucinations or delusions, sometimes with extreme anxiety, e.g., in catatonia) appears in some newer publications [16], however, such an approach seems too narrow and contrary to the European tradition of psychiatry. Jaspers and Schneider attempted to define psychosis as “a global change of personality” [17] and although they failed to specify the nature of such change, this view can also be

found in Polish definitions. *Encyklopedyczny słownik psychiatrii* [*An Encyclopedic Dictionary of Psychiatry*] from 1986 emphasizes “pathological changes in the area of thinking, consciousness, intellect, will, feelings, actions, and other mental functions”; it is only in the further part that it mentions psychotic symptoms, including “hallucinations, delusions, paralogical thinking, dissociation, autism, consciousness or mood disorders” [18, p. 452]. In the current edition of the currently valid textbook of psychiatry, Wciórka mentions different principles of distinguishing of psychotic disorders, defining them as occurring with an existing or threatening distinct disruption of the sense of reality, i.e., incapacity for critical, realist assessment of oneself, the environment or the relations between them. It is only later that he mentions typical symptoms, not limited to hallucinations and delusions [19]. This definition is formulated in a very similar way, as a “state of mind in which one experiences strong disruptions in perception of reality,” by Gałęcki and Szulc [20, p. 554]. This approach, present in Polish textbooks, is less doctrinarian and closer to the clinical reality, enabling inclusion of such disorders as anorexia nervosa, deep dementia or reactive psychoses into the range of psychoses.

Acute stress reaction has only been included in DSM-IV and ICD-10, so it is a relatively young construction [10, 21]. This entails certain fluidity of the diagnostic criteria. Attention should also be paid to the difference between DSM-5 and ICD-10 concerning formulation of criteria. Under the APA classification, the criteria of acute stress disorder do not bring psychotic symptoms to mind, whereas the research diagnostic criteria of international classification – including, in particular, severe acute stress disorder (F43.02) – approximate reactive psychoses, because how else should one understand narrowing of attention, withdrawal from the expected social interaction, clear disorientation, maladjusted activity or dissociative stupor [10]. It should also be noted that PTSD and ASD have been classified in DSM-IV as anxiety disorders, whereas ICD-10 puts them in the category of stress-related disorders [22]. Within this context, requests to consider psychosis an exclusion criterion of acute stress disorder defined as in DSM-5 [19, 22] become understandable, however, they do not apply to this diagnosis, made in accordance with the ICD-10 criteria, approximating the former “short-circuit reactions” [23]. Describing PTSD and ASD, Heitzman also emphasizes the presence of dissociative states beyond conscious control, or even beyond consciousness [22].

Recapitulation

Extended suicide is a well-known phenomenon in forensic psychiatry, and interest in it is increasing in extremely dramatic cases. For example, after the tragic end of the flight of Germanwings 9525 [24], a number of studies on this topic appeared, among which the work of Gunn should be highlighted, which emphasized, inter alia, the phenomenon of underdiagnosis of psychotic symptoms [25]. However, the case of Germanwings pilot was described not only as an example of extended suicide, but above all as an image of difficulties in establishing a diagnosis and its judicial interpretation.

The first controversial issue was the diagnosis of ASD, although the perpetrator was not put in a life-threatening situation. There is no doubt, however, that there was a sudden threat of the collapse of an important fragment of the social network by losing contact with children, which meets the criteria of a stressor of exceptional strength [22]. Moreover, the systematic review of Geoffrion et al. published last year indicates that the greatest risk of ASD occurs precisely due to disorders in interpersonal relations [26]. Moreover, there was no doubt about the presence of the remaining symptoms of ASD with dominance of dissociative elements. As the opinion concerned the mental state at the time of the act, the authors did not consider the possible development of PTSD in the perpetrator.

An important requirement for a well-thought-out forensic-psychiatric opinion is to name the reason of insanity. The presented case is a good illustration of these difficulties, since ASD can be interpreted both as “other mental disturbance” and as a short-term mental illness. The first interpretation is more widespread, and its example can be the judgment of the District Court in Bialystok in 2013, which equates ASD with a state of severe agitation [27]. Both Heitzman [22, 28] and Golonka seem to support such an interpretation, identifying ASD with pathological affect [29] and probably such an interpretation is adequate in a large number of cases. However, this cannot close the way for a different interpretation, situating ASD in the area of psychotic disorders, if dissociative elements dominate the clinical picture and cause a break in contact with reality, as it was in the case described here.

Issuing of opinions in the area of forensic psychiatry requires utmost precision from physicians and psychologists, with regard to both nomenclature and conclusions. When developing a forensic opinion, an expert has to look for definitions and boundaries of the used terms. One of the greatest problems in this regard is definition of the boundaries of psychosis, and the attempt to maintain an elementary compliance of the term psychosis with both one’s own experience and textbook criteria does not allow one to identify it with so-called ‘positive symptoms’. Thus, an expert is forced to take a stand in the years-long discussion on the boundaries of psychosis and to opt for classification of disorders as ‘psychotic’ not due to their etiology or statistical number but because of sudden loss of contact with reality or disruption of relations between cognition and action.

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